HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Jack W. Owen

JACK W. OWEN

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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CHRONOLOGY

1928	Born Union City, PA, September 21
1951	Western Michigan University, B.S., Business Administration
1953	Western Michigan University, B.A., Occupational Therapy
1953-1955	Army Medical Corps
1956	University of Chicago, MBA
1957-1963	American Hospital Association, Assistant Director
1963-1982	New Jersey Hospital Association, President
1964-1982	HRET of New Jersey, President
1971-1982	New Jersey Hospital Service Corporation, President
1975-1982	Health Care Insurance Exchange of NJ, President
1982-	American Hospital Association, Executive VP in charge of Washington, DC office

MEMBERSHIPS AND AFFILIATIONS

American Hospital Association, Council on Allied Health Associations, Past Chairman

Bank of Central NJ, Rocky Hill, Member of the Board

Capitol Hill Club

City Club of Washington

City Tavern Club, Georgetown

Essex Club, Member

International Hospital Federation, Washington Director

Middle Atlantic Health Congress

Montgomery Little League

Nassau Club, Member

National Council on International Health, Member of the Board

New Jersey Foundation for Health Care Education, Member

New Jersey Medical Society, Ex officio Member

Princeton University, Lecturer

Regional Medical Program NJ, Member

Rider College, Lecturer, Member of Advisory Board

Robert Wood Johnson Foundation, Member of the Board

Rutgers University, Lecturer

Westfield Childrens Hospital, Advisory Board

AWARDS AND HONORS

American Hospital Association

Trustees' Award 1982

WEEKS:

We are going to talk to you, Mr. Owen, about your professional life. It is sort of an autobiography. I have a few notes here. One is that you were born in Union City, Pennsylvania in 1928. I have learned in our conversation on the way out that you lived around Erie, Pennsylvania much of your younger life.

OWEN:

That's correct.

WEEKS:

And that you attended Western Michigan University and have a B.S. in business administration from there in 1951. The next item is of interest to me because I see you entering the health field, and that you also have a bachelor's degree in occupational therapy.

OWEN:

That's correct.

WEEKS:

How did you happen to...

OWEN:

The way it started was I had finished my bachelor of science degree in business and the Korean War was going on and I was waiting to get drafted. At that time I was dating a young lady who was an occupational therapist, and I used to go to O.T. meetings in Battle Creek and Kalamazoo and other places around Michigan. I decided that this might be a nice thing to get into since I was going in the army and the chances of doing this in the army sounded better than driving a tank. So, I stayed on and got a bachelor of arts degree in occupational therapy, and became a registered occupational therapist. I

did my affiliation, as they called them in those days, in Battle Creek at the Kellogg Sanitarium. I had a couple of months with a cerebral palsy children's clinic in Kalamazoo. I spent three months at Cook County Hospital in Chicago and three months at Kalamazoo State Hospital. Then when I finished I went to the Veterans Hospital in Battle Creek and worked there for a few months. Then I was drafted for the service.

WEEKS:

It seems to me that the sanitarium would be a good place for occupational therapy because they do so much in the physical therapy. I was just thinking that the two are connected in many ways. I can see where a physical therapy patient could also use occupational therapy.

OWEN:

That's true. Although I think most of the time when I was there it was not so much physical but the mental stimulation, getting people to get back to the lifestyle of actual daily living and being back into a lifestyle that they would enjoy and be more productive in their later years. More so than when you get into a rehab hospital or something where you really design an occupational therapy procedure which is going to help make that person stronger or to use his facilities better. This was more the mental attitude of the patients at that point.

WEEKS:

Then you went into the Army Medical Corps.

OWEN:

Right. I went into the Army Medical Corps as a private. In those days, if you were a female, you went in as a second lieutenant if you were a nurse or an occupational or physical therapist. If you were a man you went in as an

E2, a private. So that was reverse discrimination. If somebody says to me, you don't know anything about discrimination, well, I was discriminated against back in 1953 when I was drafted. That was changed by the Bolling Amendment, in Congress. Congressman Bolling put in a bill that would give to any man, as well as a woman, a commission -- I guess that's what they called it. So that is not true today. If a man is a nurse he can go in as a second lieutenant, but it was not true back in 1953.

I spent two years in the army, enjoyed it. I was stationed at Fitzsimmons Army Hospital in Denver for about six months after I finished basic. Then I went overseas and was at the Ninety-Eighth General Hospital in Neubrucke, Germany. When I left I thought I was going to Garmesch where the hospital was originally located, but it had been moved to the Saar border. It was in a little farming community in Germany. It was a one thousand bed hospital. We had probably a half dozen patients, mostly skiing accidents. It was designed primarily for the purpose of should something escalate with the Russians, this would be the last hospital before the line in France. I spent two years doing that, mostly playing tennis on weekends in Germany because we never did have more than, I think, a hundred patients or so to take care of the whole time I was there.

WEEKS:

That's better than going to Korea.

OWEN:

It had certain advantages, let's put it that way.

WEEKS:

How did you happen to go to the University of Chicago to take the hospital administration course?

OWEN:

That's an interesting story. When I was in Denver at Fitzsimmon I went to an occupational therapy meeting at the Denver Jewish hospital. It was a chest diseases hospital. The administrator of the hospital, the chief executive officer, was Louie Liswood. Louis Liswood happened to be at that meeting. it was a meeting for occupational therapists, primarily. We got to talking and he found out that I had been a business school graduate and that I was also a registered occupational therapist. He said, "What you ought to do is go to the University of Chicago (which was where he was a graduate) and combine the two and get into hospital administration." Which sounded pretty good to me because I liked running an occupational therapy department. Running a whole hospital would be that much more fun.

So, on the way to my assignment in Germany I stopped in Chicago and talked to Ray Brown and Richard Johnson, who was there at the time, and said that I was on my way to Germany and would be over there for about fourteen months and when I came back I would like to consider going to the University of Chicago in their master's program. I really didn't know very much about it beyond that.

I went over to Germany, didn't hear anything at all from the university. I came back -- I was offered a job up in Rhinebeck, New York as an occupational therapist, working with disadvantaged children from New York City. Before I took the job I called out to the University of Chicago and asked, "Was I accepted into the program. I had heard nothing from them."

They said they had lost track of me, and that I had been accepted and they didn't know how to get in touch with me. So I turned down the job in Rhinebeck and went out to Chicago. I had no idea about what hospital

administration courses were or anything else. I got into the master of business administration and discovered there were only twelve students there which surprised me. I had no idea it was such a small class.

I got a job in the medical records department at Billings Hospital. Ray Brown was instrumental in helping me get that. That's how I got started in the career of hospital administration.

WEEKS:

Would you like to say something about Ray Brown? He had died before I started this program, so I didn't have the opportunity of interviewing him.

OWEN:

I had the utmost respect for Ray Brown. I thought he was one of the real leaders in this health care field. I say that because, not only was he a great thinker and a good writer, but he questioned so many things that we just took for granted. I remember being in a debate with him one day on the whole issue of could you survive as a hospital administrator when you didn't have a cost reimbursement system. I remember him saying if you give me a price, whether it's per day or per case or whatever you want to do, I will manage within that price. I guess that kind of stuck with me as we moved through the different kinds of reimbursement in New Jersey and now nationally. Watching what he said come true. I think it has happened. Almost every good administrator I know of has been able to manage pretty much within a price that is struck.

He had a lot of other interesting concepts and theories that, as a student and knowing him afterwards, he always challenged you to think is this the best way to deliver health care. What can we do?

I think he always wanted me to go into the hospital administration rather

than stay in the association work. He used to get me job interviews pretty regularly when I was at the American Hospital Association. Then when I went to New Jersey he would keep track of me to see what was going on and say, "Isn't it time you got out of the association business and really ran a hospital?"

I guess the first time he really realized what I was trying to do was when he had a seminar on economy of scale. I was invited to come out to Chicago in about 1964 or thereabouts. I had told him what we were doing with shared computer systems, with group purchasing and things that were not that common such as an industrial engineering program. That what we were trying to do was to get the hospitals to work together to utilize the economy of scale. New Jersey was really the kind of forerunner for a lot of things that were going on. I think that was the first time that Ray suddenly recognized what I was doing. He said to me, "You know, you are probably better off where you are. You are doing something for the health care field."

WEEKS:

You probably were one of the exceptions to Chicago graduates who went somewhere other than a hospital. Apparently this was evident to others that they were steering people into hospital jobs rather than association jobs or Blue Cross or whatever. I wondered in looking at Ray Brown's life and his moves after he left Chicago. First he became a vice president, didn't he?

OWEN:

You mean at the University of Chicago?

WEEKS:

Yes.

OWEN:

Yes. Well, he left Chicago. I think Dr. Beetleston was the president at that time, if I remember right. Then he went back to North Carolina, I think, to Duke.

WEEKS:

He was also in some coalition in the Boston area.

OWEN:

Yes. From Duke he went up to Boston. He was going to practice what he had been preaching to us about how to bring doctors and hospitals together. He found out that staid old Boston didn't quite move the way people thought it should. He left there and came back to run the complex in Chicago which was the Evanston/Northwestern complex which John Stagl took over after he left.

I think his reason for going back to North Carolina primarily was to write and to do some of the things he wanted to do. I think when he got down there he probably realized that what he really liked to do was hands-on administration. This Boston challenge was so great he couldn't turn it down. I suspect today -- well, we know that a lot of these same institutions now have gotten together. But it was probably ten years later. The timing was wrong. He was just ahead of the game.

WEEKS:

Somebody told me too that they thought the coalition was a necessity because they couldn't merge due to endowments and things. Specified money going to a certain place. They couldn't merge it legally and still retain their money.

OWEN:

By the way I have run into a number of places where this has come up and

also a number of places where they have corrected the problem by going back to the courts and getting those endowment funds redirected. Sometimes I am suspicious that the reason for not merging is our endowments won't let us merge.

WEEKS:

That could be. The board might use that as a good excuse.

Before we leave the University of Chicago I would like to ask you about Richard Johnson. Isn't he a brother of Everett Johnson?

OWEN:

Yes. They are twin brothers.

WEEKS:

Twin brothers? I didn't know that. They are quite an unusual pair, aren't they?

OWEN:

Yes, they are. Both extremely bright, competitive brothers. Everett ran a hospital in Gary, Indiana for many years. Richard was at the University of Chicago for a long time and then went out to Missouri and I guess got into some kind of a problem with either the medical staff or the board. I don't know exactly what it was. It was one of those things that happen all the time in the health care field. Then he came back to the American Hospital Association, worked with Madison Brown. That's when he hired me, or shortly thereafter. I left before he did. He left and went into the consulting business where he has been very successful. Doing a fine job.

WEEKS:

I have never met Everett, and I don't know....he's in Georgia now?

OWEN:

Everett is in Georgia at Georgia Tech with the hospital administration program.

WEEKS:

I remember one time we were talking about the Abstracts. Andy Pattullo called me and said Everett was doing something and he wanted an extensive bibliography so we compiled a bibliography for him, hundreds of items. He used it for his purpose, whatever it was, and apparently was very well satisfied with it. That was my only contact with Everett. That was by telephone mostly.

OWEN:

Dick probably did more on the writing side of it and Everett probably did more of the actual hands-on administration, spent more time in the hospital.

WEEKS:

I have often heard about them, but I have never had anything on record so I am glad to have your comments on the two brothers.

How did you happen to go to the American Hospital Association in 1957?

OWEN:

Well, I was a resident at the Indiana University Medical Center which is where I met my wife who is a nurse. I was looking for what I was going to do at that point. I was offered a job at the medical center. Ed Shea was the director at the time. They offered me $300 a month to stay there. They were paying their occupational therapist $325 a month. I thought I could be an occupational therapist and make $25 more a month, and I just got my master's degree. That didn't make any sense.

I spent a couple of weeks with Everett Johnson in Gary to see if I

couldn't learn a little bit more about how community hospitals run because my experience had been primarily in state hospitals or government type institutions as an occupational therapist. Now, after spending a year down at the medical center, I was not enamored with what I had seen at that point in time and how government hospitals operated. I felt they were terribly slow and ponderous and very difficult to accomplish very much the way they move. So I spent two weeks with Everett and told him I was really not that interested in staying at University of Indiana Medical Center. At the same time, Ray Brown had gotten me an interview with a little hospital in southern Indiana with about thirty beds. That didn't exactly excite me a whole lot either.

So Everett said, "Why don't you talk to my brother Dick who is with the American Hospital Association and see what might be available there?"

I went over to talk with Dick. He offered me a job as secretary of the Committee on Organization. It was kind of an agreement at that time that I would only stay about a year. That was on my part, not on his part. I would stay about a year and that would give me a chance to look around and see what was available in the health care field and the hospital field. So when I went with the American Hospital Association my primary reason in going was to use it as a stepping stone. And here I am thirty-one years later.

WEEKS:

You are pretty well settled now.

Dr. Crosby was there then.

OWEN:

Yes, that's correct. He was a fabulous guy. Probably, to be perfectly honest, I learned an awful lot from Dr. Crosby both from a negative standpoint

and from a positive standpoint. He was not the best administrator I have ever run into, but he had a sense of timing and understanding of issues like no one I have ever known. He could separate the wheat from the chaff, unbelievably. But when it came time to administer something then he had some shortcomings, like we all have shortcomings in one way or another.

WEEKS:

Someone told me -- it may have been Maurice Norby -- that if Dr. Crosby had an idea on the way down to the office in the morning he might walk into the office and the first person he saw he would delegate that duty to that person, irrespective to where he was in the organization. I don't know how true that was.

OWEN:

That's pretty true. I owe much of my career success to Dr. Crosby because I would happen to be the one he ran into. I started out on the Committee on Organization and I went -- in the six years I was with the AHA the first time -- all the way from the Committee on Organization to Assistant Director of the Association. I was fairly young and without too much experience in the field. It wouldn't have happened if there hadn't been a person like Dr. Crosby who said do this and never mind where you are in the organization. If you did it, he moved you forward.

WEEKS:

I am trying to get a picture here of what AHA was like in 1957. You were still on Division Street, weren't you?

OWEN:

Yes, we were.

WEEKS:

How big an organization were you?

OWEN:

AHA at that time was about fifty to fifty-five people, I guess. We were in the old Boys' Latin School, 18 East Division. They had filled in a running track over the library so we had the steno pool up there. My department was under Madison Brown -- there was Madison Brown and Dick Johnson, Elton Tekolste, myself and Robert Derzon and Jack Dillman. We were the staff that handled the administrative side of working with the hospital people.

It was a small organization and it was a fun organization. The big problems hadn't really hit hospitals yet. Everybody was worried about what was going to happen with the elderly, worried about what to do with the care of the indigent and so forth. There were some interesting programs that developed about that time. I remember when Kerr-Mills came along as one of the first general health assistance programs. I, again, happened to be fortunate that Dr. Crosby assigned me to do something about the program with the American Medical Association. I was assigned to work with somebody in the American Medical Association. This was back when Blasingame was the president of the AMA. For the first time we put out a little brochure, booklet, that had the AHA seal and the AMA seal on the cover. That was the first time. Dr. Crosby was very, very pleased with that. Here was the AHA and the AMA doing something together. We sent it out to the state hospital associations that were functioning at that time and the state medical societies. It was how to handle the Kerr-Mills program both from the physician's standpoint and from the hospital standpoint. The Kerr-Mills program, as you know, was a mish-mosh in some sense because it was left to the states to do what they wanted. But

it was a forerunner and you could see what was going to happen with Medicare and Medicaid. That was an interesting period of time.

WEEKS:

I think Wilbur Mills had a soft spot in his heart for that program and believed that if it had worked -- there were only six or seven states that really did much in that with Kerr-Mills, weren't there?

OWEN:

Yes, that's right.

WEEKS:

I talked with Mills years later and I think he thought it never really had a fair trial.

OWEN:

I think that's right. In fact, when I went to New Jersey in 1962, New Jersey still hadn't implemented it. They implemented it the first year that I was there, put a bill in and accepted their state's responsibility for picking up some of the activity.

WEEKS:

I have read somewhere, I think it was an article written in Modern Hospital at the time that you went to New Jersey, that the author listed a number of things that you were responsible for at AHA. Personnel was one. Is that correct?

OWEN:

That's right. I had just about everything in the course of those first 6 years. I started in organization, I became their labor relations specialist when 1199 union started in New York. Dick Vanderwalker came out to Chicago and was concerned about what the AHA was going to do about labor unions in the

hospitals and what was going to be our role. So I became a labor relations specialist. At one point I was responsible for the accounting program. We had a little office out in Lincoln, Nebraska. Bob Linde was responsible for it. We were going to do pegboard accounting for rural hospitals and we discovered they were way beyond pegboard accounting. So we changed it into the program that it is now, Monitrend.

WEEKS:

I'm not sure I know what pegboard accounting is.

OWEN:

It was a system where you had a board with pegs on it and you put these accounting sheets on a peg and the columns would come out properly as you transferred your receivables and payables and so forth. You could keep your books that way. It was before computers.

At one point Dr. Crosby asked me to be responsible for the Hospital Research and Educational Trust. There was a period of time when they had some difficulty and he asked me to take on that. Internally I had personnel, the Blue Cross financing, association relations.

WEEKS:

I might check a couple of these as we go along if you don't mind.

When you talked about 1199, did you ever meet Leon Davis?

OWEN:

Yes.

WEEKS:

He just celebrated his eightieth birthday. I talked with him about three years ago. He had had some trouble, a stroke.

OWEN:

I met him longer ago than that. It goes back about ten years or longer.

WEEKS:

I was quite impressed with the guy.

OWEN:

Yes. He had a cause, there is no question about it.

WEEKS:

I think he had a lot of good pension plans and insurance systems and everything. The fringe benefits were pretty good. I think he was a man who really was concerned about the way people were treated. Labor unions have never really caught on in hospitals very much, have they? In some areas they have.

OWEN:

Yes, it depends on the area how strong labor is within the hospitals, but it has never been really solid. I think part of it is that it is so dominated by women which is always tough to organize. Although the garment industry is very well organized. The professional, the nurse and some of those, do not lend themselves well to...

WEEKS:

It's against their idea of propriety.

OWEN:

And professionalism.

WEEKS:

Did you know that Anne Somers had been active in the union, leading the garment-workers union as a young woman?

OWEN:

I knew that back in her history she had done that.

WEEKS:

I also talked with a woman in Michigan, a nurse, who had organized about seventy-five hospitals in Michigan. I mean organized in the sense of getting labor contracts. I don't know whether there was one union or several unions or whether they had independent unions. But her work was to outline what should go into a labor contract and what they should do to have good labor conditions. The state as a whole I don't think has ever been subject to complete unionisms.

OWEN:

No. And as soon as you get out into the more rural areas it is very difficult. I think Minnesota is probably the most unionized if you look at a state. New York has quite a few in its cities but when you get out-state there are not many there. New Jersey has about a third to maybe a half...

WEEKS:

It seems to me that your professional life falls in three divisions; your first AHA experience in 1957-63, then your New Jersey experience from 1963-82, and your present position as executive vice president in charge of the Washington office from the beginning of 1982. So, if you don't mind, I would just like to check off a couple of these items because this may give us a picture of how AHA works. You have already told me about Division Street back in the days when you were in the Boys' Latin School. Were you there when the new building was finished?

OWEN:

Yes. In fact I was there the night we moved out in February, a cold

wintery night. We moved after the office closed on Friday night. My job was to make sure that the furniture left 18 East Division. Ed Lanigan was on the other end seeing that it got placed properly in North Lake Shore Drive.

WEEKS:

That was the front building on Lake Shore Drive, wasn't it?

OWEN:

That's right. We had only one building there at that time.

WEEKS:

Do you want to tell me anything about the building? How it came about?

OWEN:

Well, I don't know whether I was privy at the time to all of the reasons that there were. You've got to remember that I was just starting out at the time and it was pretty much decided somewhere in the late fifties or middle fifties that we were going to build a building for the American Hospital Association. We had outgrown the 18 East Division. We had moved to 22 East Division for some of the offices -- in the connecting building, like a row house. Then we had the Research and Educational Trust at another location. I think down on Superior Street. It became obvious that as the Association started to grow under Crosby's tutelage that there was no way in which we could take care of handling it in the 18 East Division.

I was involved with the discussion that took place on the financing because one of my jobs at that point was working with the state hospital associations. I used to do a lot of traveling around the country meeting with state associations. Those states that didn't have state associations one of my jobs was to talk with the leadership in the state and try to convince them that they ought to have a state association. In the course of doing that

there was always the discussion of how much the dues would go up to pay for this building. Part of the concern that was raised by some of our more conservative administrators around the country was they found out that Blue Cross was going to share this building with us. It was probably just about the start in some states where Blue Cross and the hospitals were beginning to come together head-to-head rather than being a so-called partnership as they were for so long. There were quite a few states where that was the case. New Jersey happened to be one of them. That was before I knew I was going to go to New Jersey. There were some problems in Oklahoma, and a few other states. A hospital would say to me, "Why should we put our dues up to build this building in Chicago which you are going to share with Blue Cross? Let them build their own building and we won't have to put up as much money."

But overall the general feeling of the field was that they ought to put an assessment together and pay for this building and they did without too much difficulty.

A couple of other things happened during that period of time. We had billed dues on the basis of patient days. One of my jobs was to see if -- working with Elton Tekolste who was also at AHA at the time heading the accounting division -- if we could figure out a better way to bill for the AHA dues. We came up with several different proposals, one on revenue, one on expenses, one on patient days, and what was needed from an assessment standpoint. We moved to dues being based on expenses, as you spent money that would be the rate you would pay.

Also at that time there was some question raised about a full-time treasurer -- we used to elect our treasurer of the Association. John Hatfield, for years and years, was the treasurer of the American Hospital

Association. I had a committee that was looking at how we might change the rules and regulations and eventually the bylaws of the Association. I remember the chairman of that was a fellow from the state of Washington, John Dare. We did convince the House that we should have an appointed treasurer. I think Mr. Tillinghouse was the first one, if I remember right, from a bank.

So there were some changes that kind of slowly happened that Dr. Crosby had instigated that began to change the way the AHA functioned. We began to see the growth that was going to happen. Of course this was about six or seven years before Medicare. But from Kerr-Mills, we knew that the government was going to get involved in it sooner or later.

WEEKS:

Isn't this land owned by Northwestern?

OWEN:

Yes. Northwestern owned the land. There is a ninety-nine year lease on the property that the American Hospital Association built the building on. I guess you would look at it the same way you would look at Hong Kong when the British were there. You thought it was going to last forever. Well, sometime down the road those ninety-nine years are going to run out. Then somebody's got a decision to make.

WEEKS:

That'll be here before we know it.

Somebody told me that there was some difficulty in financing in that the number of floors that were to be put into that building was changed because they didn't have enough money to complete all that they had hoped to complete. Is that true?

OWEN:

I remember that. I guess you are bringing back some memories that I had kind of forgotten about. I think it was going to be something like fifteen stories. Then the question was could we finance fifteen stories. Then it was going to be seven stories. I guess we ended up with a twelve story building that was somewhere in the compromise of what we could afford and what was out there. I had forgotten that. You are right, there was some talk about it going to be bigger than what it turned out to be.

WEEKS:

Someone I have talked with said that they remember those days when the building was being built. First the basement had been dug and had remained as a hole for a while and filled with water and nothing happened. It became a joke that people with the American Hospital Association had to suffer from people making jokes to them about this hole in the ground. But it finally was built.

OWEN:

I'm not sure the hole in the ground had anything to do with the financing. I think that was more due to working with Mayor Daley and the city.

WEEKS:

This was a case of representation?

OWEN:

Yes, it was. That's right. He was there for the dedication, I remember that.

WEEKS:

How about the second building?

OWEN:

I was not that involved in the second building. That was after I left. All of my involvement with the second building really was on the basis of hospitals in New Jersey who were members of the AHA asking me about what was the need for it and why. But I was not involved at all in that.

WEEKS:

The first time I went there was about 1965, so I didn't realize that Blue Cross had just been built about that time. There were other organizations in the building too, weren't there?

OWEN:

Yes, that's right. There was the American College of Hospital Administrators, ACHE now. The seventh floor MacEachren room was really their board room. That was designed for them. The Illinois Hospital Association was located there. The Chicago Hospital Council, Dave Kinzer and Howard Cook were both there. Then Blue Cross. You can see that the AHA staff was still small, even though it was a twelve story building, there were at least four floors out of that twelve stories that were rented. The top floor was the board room and the Pan American room. There were only a couple of offices up there. So, really, we were only using five or six floors for AHA staff.

WEEKS:

I was asking someone about the revenues and finances of the AHA, where the money came from -- conventions, subscriptions, memberships, publishing and so on. I raised the point about revenue from rent and I was told that the rent was very reasonable and that there really wasn't much profit in it. The objective was to get all of these various organizations together in one place so that it would be more convenient for everybody and would add prestige to

the general health picture. I don't know how true that was.

OWEN:

I think that's very true. I don't think there was any indication that I ever had that rent was a major income. It was really to get all of these groups together. Ed Crosby had a strong feeling that Blue Cross and hospitals ought to be tied together very closely. He was really responsible, in my opinion, for the development of the Blue Cross Association from the old Commission as they called it. He just felt that this was the way we ought to go. Hospitals and Blue Cross were tied together intrinsically and would always be that way. One of the things, I think, that hurt him more than anything else was to see this fighting that was developing between hospitals and Blue Cross. The boards were even tied together at one point. Then they were split as well.

WEEKS:

When we get to the appointment of McMahon, that period, I would like to bring that point up again and talk about McNerney and Kauffman and see what your opinion about that is.

You mentioned that you worked for the state association. I have you down for hospital planning and financing.

OWEN:

That's correct. It was a council. You remember that this was just about the time that Ray Brown and George Bugbee and Jack Haldeman were going around the country and saying that the way to stop the rising price of health care was to have planning, areawide planning. Areawide planning was going to be the panacea for everything. We did not have certificates of need at that time. Ray Brown called them franchises. That was the code word at that

point. I think probably certificate of need had as much to do with coming out of New Jersey as any place because that is, I think, where you could track back where that first certificate of need title ever came from. It came from a bill that we put in.

In any event, planning was very important and I was responsible for the planning side of what was going on. On the financing side, it was Blue Cross relations. I had two responsibilities at that point. The Council on Blue Cross Financing Relations -- also the AHA owned the seal. Our job was to go and look at the Blue Cross Plans and see if they met the criteria in order to keep the Blue Cross seal. Dick Jones, who was with the old Blue Cross Commission, worked for me in that department and Hiram Sibley was on the planning department.

WEEKS:

I didn't realize he worked for you in AHA -- Sibley. He later ran the Chicago group, didn't he?

OWEN:

Yes, that's right. I was kind of a youngster at that point, both with Hy and Dick Jones. I'm sure, as I look back on it, they must have thought, "Who is this young kid that Crosby has in here that we are supposed to report to." It was rather difficult times.

WEEKS:

Was Karl Klicka in Chicago at that time?

OWEN:

Karl was at Presbyterian Hospital. Then he left and went down to Appalachia.

WEEKS:

In the meantime he was at some kind of planning group. I thought Hy Sibley and ...

OWEN:

That was quite a while later. That was after I had left.

WEEKS:

Could you explain the difference between a committee, a department, and a council to me?

OWEN:

The committee and the councils are the membership side of the organization. The way the AHA was organized was that the board of trustees would appoint councils. Councils were usually made up of ten people. There was on the average about six, although more than that later. Everybody would serve there for a three year term. The nine council members had three year terms that were staggered. Then the chairman made the tenth one. They were all usually hospital CEOs, administrators. The councils would appoint committees. For instance the council on financing might have a committee on, now, Medicare and Medicaid. They had at that point a committee on indigent financing, another on Kerr-Mills, or something like that. The staff, then, would staff those committees as a staff person for the AHA. On the department side -- the AHA was broken up into departments really. Back in those days when I was there there was sort of three divisions or departments, as they were called, that dealt with membership. One was Kenny Williamson in Washington, the second one was Dick Ackert, with the professional side hospital activities, nursing, etc. The third was myself and that dealt with financing, planning and administration. Our job was primarily to deal with

the membership.

Jim Hague handled the publications and other people dealt with internal kinds of things. Maurice Norby was sort of the deputy over all of it. That was the point where the organization was when I left the AHA. Within my department, there was Hy Sibley who directed planning, Dick Jones who directed Blue Cross and financing. They had quite a staff along with them. Tom Callahan had Association services which dealt with all of the hospital associations. Bob Linde had the Monitrend programs.

WEEKS:

Did Monitrend go back that far?

OWEN:

Oh, yes. That was the program that was the pegboard system when it started out. The one I was talking about. It was called HAS, Hospital Administrative Services, before the name Monitrend was used.

WEEKS:

I may have my time frames a little out of whack here, but on the IRS ruling on publications, taxing your publications because they were making money from advertising. Did that begin while you were there?

OWEN:

No. That was after I left. There was a lot of talk about it at the time I was still there because the AMA was being looked at about that time -- early 196Øs -- the AMA was going through a court battle on their advertising of drug firms in their journal as unrelated business income. It was only a matter of time until they got around to the AHA. But I was gone when that happened.

WEEKS:

I have you at all of these various jobs that you have been talking about.

Before we leave the AHA could we talk about a few people?

OWEN:

Sure.

WEEKS:

I'll just run down the list. You haven't said much about George Bugbee.

OWEN:

Well, George Bugbee had left the AHA before I got there. I knew George really from the University of Chicago connection. I'm a great admirer and had a lot of respect for George Bugbee. George Bugbee was in New York with Kenny Williamson...

WEEKS:

May I tell you what I remember?

OWEN::

Yes.

WEEKS:

George left AHA in about 1954 or 1955.

OWEN:

Right. I went there in 1957.

WEEKS:

He went to the Health Information Foundation. But, Kenny Williamson had gone before him.

OWEN:

That's right.

WEEKS:

George was still in Chicago and he wanted to appoint Kenny Williamson to run the Washington office. He didn't know -- George didn't know -- that he

was going to go to the Health Information Foundation. This came up rather abruptly. After he had appointed Kenny Williamson to Washington, Kenny said he was leaving HIF. In the meantime George took Blandy's position at HIF and George felt very, very badly about it, but Kenny didn't. Kenny realized what had happened and I think he had worked with George long enough to know what kind of person he was. So, Kenny went to Washington and George went to New York. Then he later moved it back to Chicago and HIF became a part of the university when the grant ran out. This came about because HIF was supported by the pharmaceutical industry. They were beginning to get some flack from reformers or somebody who felt that there was a conflict of interest. So they wanted to get out of this Health Information Foundation. They phased it out to the University of Chicago. That's the way I have it.

OWEN:

That's right.

WEEKS:

You told me quite a little about Crosby. Do you want to talk about his Salvation Army background?

OWEN:

I don't know enough about that. I know he was an advocate of the Salvation Army and thought highly of them. I don't really know about it.

WEEKS:

I think his father had been an official, probably one of the highest ranking officers in the United States. It's basically an English outfit, isn't it?

OWEN:

I think so.

WEEKS:

Do you want to say anything more about Madison Brown?

OWEN:

Madison -- I just had dinner with him Sunday -- he was the chief honcho next to Crosby and Maurice when I first went to the AHA. I don't have a whole lot to say about it. Our relationship was always very good. I admired the man. He reminded me of a vice president in Washington. That is, he was always there to support the chief, but he was never out front. He was always just kind of there, helpful, handy.

WEEKS:

He was a good man to have there for an interim president too.

OWEN:

Yes. He did a fine job when Crosby died. Probably did as good a job as anybody could have done under those circumstances.

WEEKS:

You, of course, had contact with McMahon.

OWEN:

Alex I didn't know really until the last five years. I knew Alex only as a council member. He was on the council of finance. I didn't have any relationship with him in his Blue Cross job because I had left the AHA where my responsibility was looking at the Blue Cross seal before he was involved that much in North Carolina. So he was kind of an unknown to me when he came. Now over the course of the years that I worked with him as a state association exec I got to know him fairly well. Alex had offered me a position with the AHA early on in the game. About the same time that Bill Robinson went with AHA. At that point I was not interested in leaving New Jersey.

WEEKS:

What is Bill Robinson's specialty? I have never been able to quite understand. I have been in his office. I interviewed Jim Hague in his office while he was away on vacation or something.

OWEN:

Bill, when he was with Alex, looked after the relationship with state associations primarily. He did some work with the AAMC, the Association of American Medical Colleges, sort of a liaison. Then he got involved with the insurance business. His background originally was insurance before he went into association work. That's what he is doing now. He's not with the American Hospital Association.

WEEKS:

Isn't he?

OWEN:

No. He's with the Health Providers Insurance Company. It is a re-insurance company owned by the AHA.

WEEKS:

I didn't know that. I have never met him.

OWEN:

He's an Army man. He'll let you know about that.

WEEKS:

I saw his paratroopers' boots in there.

You are just nicely getting acquainted with Carol McCarthy, I suppose.

OWEN:

Actually, I have known Carol for a long time. I knew Carol when she was in Long Island. Then, of course, when she was in Philadelphia I was in New

Jersey, so I saw her fairly regularly at meetings back and forth. Carol, I probably know as well as I do Alex, I guess you might say.

WEEKS:

When I get to the Washington episode I have some questions I want to ask you about representation.

Another thing that has puzzled me is regional offices and regional advisory boards.

OWEN:

I guess I did have a little bit to do with that too, if you go back in history. Just about the time I was leaving the American Hospital Association I had a conversation with Dr. Crosby about the possibility of decentralizing. When I got to New Jersey and I was working with the Johnson & Johnson people and I saw how they had decentralized so much of their operations with different kinds of companies, I suggested maybe it was time we ought to take a look at doing that. It would be a better way of bringing a closer relationship with the AHA and hospitals. He said write it out and come back with it. I did that and brought it back to him. He got kind of excited about it. George Graham was the president of the AHA at that point. At first it was Owen's idea and I remember a lot of the people out in Chicago were upset at me because I thought this up. But once George Graham and the officers decided they liked the idea of regionalizing why then my name got dropped.

In any event, what I had suggested to Ed Crosby was that we really decentralize and make these regional advisory boards have their own budget and hire their own staff. That upset a lot of the staff people in Chicago. They didn't like it. They thought that would be just too fragmented. They were

frightened of it. So it was kind of watered down from the original concept. But, basically, what it was was to bring the AHA closer to the membership, and let them have a bigger say in what was happening. It worked pretty well. It worked as well as the chairman of the RAB and its board and the staff person assigned to it. Some were good, some not so good.

WEEKS:

Well, the regional offices -- Norby, when he retired in 1963, the last year from what I understand, from what he told me, he asked Crosby if he could take the last year and try to set up a little office out in California and then work up and down the coast and call on hospitals. Did that ever go beyond three or four of those offices? Do you have a Washington office and a California office?

OWEN:

Yes. We have nine regional offices.

WEEKS:

All of your regional advisory boards have an office?

OWEN:

Yes. That's right. I manned the first RAB II office. That was located in New York, but I was in Princeton. We kept an office up there with the advertising sales staff. Mike Lesparre was there and the advertising staff for the journal. I would go up there once in a while, but it was really run out of the Princeton office. Dave Kinzer ran RAB I. This was just in addition to our other work. Maurice Norby was out in IX. Maurice started a little bit before that. His was really a regional office, not connected with a RAB. His job was different than our job was. Then as they grew, the New

York office was moved to New York City. Sandy Williams had it after I had it. Then we moved it to Princeton. There is one at Princeton now. There is one in Washington -- separate from the Washington office. Princeton, Boston, Washington, Atlanta, Chicago, Denver, Dallas, Sacramento, Kansas City, -- nine regions in the country. They each have a staff composed of a director of the regional office and a secretary, and maybe an assistant director. That's as far as the decentralization ever went.

WEEKS:

The point that I was trying to make was -- I'll use the word legislate in a general term -- what if AHA wants to pass some legislation or policy majors and its working up from out in the grass roots here somewhere. Its considered by the advisory board first? Or the council?

OWEN:

Normally it would not be considered by the advisory board first. The way it would happen would be the board, policy committee of the board, or the board itself or staff would take to a council, normally in the old days -- with this new direction there won't be councils. But they would take to a council a suggestion that we would take a position on AIDS, let's say right now. The board would then say, this is what we think we ought to do with the staff recommendation. Now let's farm this out to all of these regional advisory boards. They would take a look at it. They'd say, this is what we think we ought to do in the way of informed consent or testing or what have you. Then it goes back to the board for a final policy determination. So, normally, the regional advisory boards review and provide input.

Under the new regional policy boards, which we are going to change the name to instead of advisory boards, it is expected that there will be policy

implementation or policy formation starting at the regional meetings. Rather than coming down, it will go up as well as down. That's the idea.

WEEKS:

But it can go both ways?

OWEN:

Goes both ways.

WEEKS:

This is valuable in that the people out in the country feel that they have some input in it.

OWEN:

Have a stake in it.

WEEKS:

This is what I was wondering about. So a staff member could be secretary of more than one council. Will there be councils anymore?

OWEN:

No, there will not be councils. 1987 will be the last year. In fact, why I am here today is to go to the last general council meeting. There will be several committees of the board. There will be a committee of state hospital associations, allied hospital associations, a committee of trustees, a committee of physicians, and probably a special nursing committee. The only committees will be the board committees, that will be all. Everything else will be done on an ad hoc task force basis. The only other thing then will be the regional policy boards which will be the nine boards out there.

WEEKS:

Now how does the House of Delegates enter into this?

OWEN:

The House of Delegates is really the whole of all the regional advisory boards. In other words, each regional advisory board is made up of delegates. Under the new future directions that is going to be implemented the first of the year, the house will only meet once a year and will have primarily ceremonial functions rather than policy functions. They will elect the officers and do that kind of thing. All of the determination will really be made by the quarterly policy board meetings and the board of trustees. There will be a lot more authority in the board of trustees than there was in the past.

WEEKS:

I see.

OWEN:

And it should speed up the process.

WEEKS:

I have heard some complaints about the length of time it takes something to pass.

OWEN:

Yes, it sometimes takes as much time as a year or so.

WEEKS:

Jim Neely left about the time you came there, didn't he?

OWEN:

Jim Neely -- our paths have kind of criss-crossed over the years. When I first went to the American Hospital Association in 1957, Jim Neely was there at the time. He worked in the Hospital Research and Educational Trust for a gentleman who ran it by the name of Alan Treloar. Jim left at about that

time, shortly after I came. Sometime in the late 1950s, 1957-58, he went to South Carolina. Jim was then a state association executive in South Carolina while I was in Chicago. Then when I left the AHA to go to New Jersey, Jim came back from South Carolina and took I guess most all of the duties that I had back in Chicago. Although they did reorganize a little bit because Norby left shortly thereafter. Jim came back then.

Jim was at the AHA while I was in New Jersey for quite some period of time and then he went to Pennsylvania. He came out there, I guess, shortly after Alex McMahon became president or maybe just before.

WEEKS:

He had the unfortunate experience with the insurance company, didn't he?

OWEN:

Yes. Again, that was one of those things where he got ahead of the curve. It sounded like such a good idea. I think he had some good support from some pretty powerful CEOs in this thing. But the problem was that the physicians were not ready at this time, and he didn't spend enough time working on the physicians, and too much time on pulling the company together.

WEEKS:

I think they were a little short of capital too.

OWEN:

Yes. But the physicians are what killed him.

WEEKS:

It is difficult to work with physicians. I won't say any more.

George Bugbee. I don't know whether he has ever told you about his retreats that he held when he first came to the AHA in 1943. He held retreats in some hotel in Chicago. He came up with the idea that there should be three

goals for any kind of organization, such as AHA. That is, representation, education, and research. Representation. George, I guess, was one of the first lobbyists, wasn't he?

OWEN:

Bert Caldwell was.

WEEKS:

I wish I had known Caldwell. He must have been a colorful character.

OWEN:

I didn't know him that well. I just knew who he was. He was just a little bit ahead of my time.

WEEKS:

Gary Hartman told me stories about being helped by Caldwell when Gary was at the College originally. Some of the stories he told about going to Canada for Association meetings when the College met at the same time and how Caldwell showed him how to work on a hotel manager and get all the things, freebies.

We'll talk about representation when we get to Washington.

What was going on in the way of education in the early -- your first experience with AHA?

OWEN:

A couple of things. They were mostly programs that dealt with basic kinds of education. I had a little traveling, one-day seminar on organization. I had some charts on staff responsibilities, line authority, staff authority, that kind of stuff.

Then we had an industrial engineering program. There were about ten or twelve industrial engineers maybe in the country. Harold Smalley from Georgia

Tech was the chairman of the committee. We had a couple of seminars on inventory, lifo and fifo methods, pretty basic kind of stuff. I used to go out on what we called caravans. You would go and spend a week in Iowa. You would be there one day, drive that night, the next day be here. You would hit like five cities in the state in a week. Iowa, Kansas, Nebraska. All through the Middle West. It was a pretty common kind of way to do institutes.

We had lots of educational programs at the Edgewater Beach Hotel. Education really was a pretty prime thing. I always did a lot of it. I'm not sure how great the education was, but it was a great way to reward employees who had done a good job. They could come to Chicago for a three to five day institute. That was basically what our educational programs were.

WEEKS:

I imagine the cost of the seminars was quite different from what it is today.

OWEN:

That's right.

WEEKS:

I wanted to ask you about HRET. I first became acquainted with it when Colin Churchill was there. When did it begin?

OWEN:

Actually, it began before I got there, which was 1957. Because the trust was headed by a Dr. Alan Treloar. The first grant came out of HEW, HHS was HEW at that time.

WEEKS:

The original grant?

OWEN:

Well, the grant that Dr. Alan Treloar was there for. I'm not sure where the original came from -- whether it was just organized and AHA put a little money from dues into it or whether there was an actual grant. But knowing Ed Crosby, and the biostatistician that he was, and his desire for that kind of thing, it was obvious that he was going to do something with it.

WEEKS:

I had forgotten about Ed's biostatistics at Hopkins.

OWEN:

Alan came when they had this grant. Jim Neely worked for him. It was the only grant that I think they had other than some Kellogg money.

WEEKS:

I was wondering about this Kellogg money because they couldn't accept a grant -- the AHA couldn't.

OWEN:

That's right. The reason for setting it up was the same reason that I set one up in New Jersey and everybody else has when they needed it. The AHA is a 501 (c)6 so it can lobby and so forth, but you can't give it money and get a deduction. We needed a 501 (c)3, which is a classical trust. That was why it was set up.

The thing I remember about Alan Treloar was that the Trust did a very poor job of whatever it was they were investigating and it was embarrassing to Dr. Crosby. I am trying to think who was Secretary of HEW at that time. It might have been Flemming, but I'm not sure. HEW started under Eisenhower, so that was about the time.

WEEKS:

Flemming was the third one, wasn't he?

OWEN:

Yes. Oveta Culp Hobby was there first. I think it was Flemming when the problem came up. There was a lot of concern about what was going to happen to the Trust. Dr. Crosby brought a young man from Minnesota, Vern Weckwerth, in to run the Trust after Treloar.

WEEKS:

Oh, yes. I know him. He's a character too.

OWEN:

Vern finally left and went to the University of Minnesota. I guess that's when Colin Churchill came. Or was there someone before him? There was an older man who was there for a little while. I can't remember his name. Colin came after I left.

WEEKS:

I met him in the late 196Øs. It seems to me sometimes he referred to himself as the barefoot boy or some such thing. He was bright, but a little unorthodox.

HRET is still going on. This program, what little expense there is on this program goes to HRET.

Basically, I wanted to talk about a few more AHA problems before we get to New Jersey. We were talking about representation as being one of the things that George Bugbee said an association should do, but in AHA, generally speaking, back when you were first there and I suppose true today, AHA represents state associations in the national picture too, don't they?

OWEN:

Yes.

WEEKS:

And many of the special interest groups.

OWEN:

There weren't so many special interest groups back then. There wasn't the Federation of American Hospitals and all of the groups. There was the Catholic Hospital Association, the Protestant Hospital Association, and the AHA. That was about it. Then there were about thirty states that had state associations.

WEEKS:

Has there ever been a Jewish Hospital Association?

OWEN:

There was a Jewish group of hospitals who met on a regular basis but I don't think they had any kind of formal organization. They do now. There is a group that Patty Sweeney runs out in Hinsdale, Illinois. I don't know what they call themselves. The Jewish hospital leaders used to meet twice a year someplace in a resort, kind of an informal group, no paid staff.

WEEKS:

I wondered. I had never seen any evidence of it.

OWEN:

We talked about representation. You can look at representation in two ways. One is representing hospitals with outside groups such as the AMA or the American Nurses Association, with labor, when you are providing a representative kind of function. Then there is a representative or advocacy approach where you are really dealing with Congress in trying to get something

passed or not passed.

In the early days when I was at AHA, the Congressional side, Kenny Williamson's side when he was in Washington, was not that demanding other than Medicare was just starting. Everybody seemed pretty happy. We had a cost reimbursement system which really was developed off the old Blue Cross cost reimbursement formula, so to speak. A congressman would start a bill and it would go for years before it would get through. It has only been the last few years that bills have been passed so rapidly.

WEEKS:

We can come back to the splinter groups later on.

Were the publications -- I guess we could call them educational too, the Hospitals journal and other publications, specialized publications. George spoke about when he went in in 1943 that one of their first jobs was to compile booklets. One maybe about laundries, housekeeping and so on.

OWEN:

I was responsible for a hospital chaplaincy manual.

WEEKS:

Apparently those things were needed and were useful.

OWEN:

Well, you have to take a look at the hospital at that time. The American Hospital Association was, in a sense, much stronger than it is today because an association is at its best when its members are weak. That is what drives people together to make an association. As your members get stronger then there is less need for an association. So while we were trying to beef up our members we were, in effect, cutting our own throat. If you want to look at it that way. I remember even when I first went to New Jersey, the hospital

didn't have professional personnel directors. There probably weren't more than a dozen CPAs as accountants across the country. We didn't have all of the kinds of professionals that we have in today's hospitals. So what the AHA did was develop ways in which you could take people off the street, so to speak, and teach them how to be personnel directors, how to keep charts of accounts, how to become hospital accountants, how to do all those other good things.

WEEKS:

Speaking of AHA today now. They are trying to spread a wider umbrella, aren't they? Aren't they trying to get in groups that are sort of related to the health field but...

OWEN:

Well, not so much. There is a feeling of "can we be an umbrella kind of organization?" because as groups, hospitals tend to splinter when they run into a problem. We are going to see more of that because when we have a downsizing of the total federal dollars available and we are all arguing and fighting for our piece of that downsizing then you can see why we are not going to stick together, whether we are a rural referral center or we are a teaching hospital, or a public hospital, or an under 50-bed hospital. The AHA has been trying to pull them together as groups like the public hospital section and the rural hospital section, multihospital section, within the AHA. Plus those groups there is the Catholic, Protestant, Federation, community hospitals, Voluntary Hospitals of America, Associated Hospital Health Systems all with their own Washington staff. There are seventeen groups in Washington now, with staff, all interested in their own areas. It is very difficult to try to pull that all together. Plus, you've got fifty states out there who

are all fighting with one another about where they fit into the picture.

WEEKS:

In a sense it must be irritating to people in government to have to deal with so many different...

OWEN:

Well, yes and no. It depends. If you are a congressional person who is going to pass a law, when you've got all this split it's great because for anything you do you have half of them are for you and half of them are against you. But if you are a regulator, part of the administration carrying it out, it's difficult because now you've got to satisfy every group there is pounding on your door. But from a congressional standpoint we get some pretty bad legislation because we are not united enough to defeat it.

WEEKS:

What about the multihospitals and the hospital groups giving up their individual memberships and wanting one membership for the whole group like the multihospital system?

OWEN:

You are bound to see that happen. I remember back when I was still at the AHA, I sent a memorandum to Ed Crosby saying I can see down the road when we are going to have a problem, once the federal government gets involved in financing, of a limit on paying the dues and where is it going. The hospital who belongs to the American Hospital Association, the Catholic Hospital Association, AAMC and a couple more, and the state association a metropolitan association, and the government says we can allow so much for dues. Okay, who is going to get knocked out? Well, the closest association to that hospital has got the best chance of getting its dues. So that when the multihospitals

came along it was only a matter of time until they were going to have to have a discount. You can understand. You look at a balance sheet and you see maybe you've got a hospital who is paying $20,000 in dues, which is a lot. But then you multiply that times 100 and you've got a $2 million figure that you are paying for dues. You look at it and say that's coming right out of the bottom line and we've got to do something about it. You begin to wonder, is $50,000 or $100,000 the most you can charge for organization dues. If you do that, and you've got a lot of multi-systems, then the question is how does the association downsize to meet that kind of drain in dues reduction?

WEEKS:

We get that in the universities too. The university may take out a membership for a program or a department or something of this sort, but the individual faculty members and people are going to have to pay their own dues. I have always paid my own dues in AHA. So, it's understandable. The federal government will probably be doing the same thing.

OWEN:

There was a feeling at one point that we were going to have seven big chains in this country and they were going to run all of the hospitals in the United States. But what people didn't realize was that health care is such a close-to-home kind of service that you can't run it from Nashville or from Washington or Chicago for the rest of the country. The people want to be close to it. You can have local hospitals as part of the chain, but you've got to have some tie to that local community. Even banks find that out. Watch what has happened to the banking system. If the bank disappears, people get very exercised about that.

WEEKS:

HCA and Humana and all of these others are finding that it doesn't take much to upset their delicate system. Nashville Medical Enterprise is now going into psychiatric hospitals and specialized hospitals of that kind because they figure they can't make any money on the others. So, it doesn't take much to change. And when you have a big organization, you are changing a lot when you change a little.

OWEN:

That's right.

WEEKS:

It means, as you say, millions of dollars.

OWEN:

When you've got a big organization under the AHA dues you could be paying $750,000 - $800,000 in dues. You can't justify that. I don't care how good an organization we are, that hospital chain who is buying into it just can't justify to the stockholders that they are going to put out $800,000 in dues.

WEEKS:

Another thing, you can't be all things to all people. So it is very difficult for you to operate on a national level and have a policy that everyone of your constituents likes. If they are not satisfied with what you are doing for them in Washington, they are likely to go to a consultant or set up their own office.

OWEN:

Exactly. There are a dozen lobbyists there all panting, waiting, for a hospital or a group to say, "Look, we can help you." Sometimes they can because of one interest subjects where we've got to be concerned about the

total field.

WEEKS:

This brings us to New Jersey. How did you happen to go to New Jersey?

OWEN:

Well, the honest reason is that one Sunday morning I came down to breakfast and I had little daughter who was three years old and she was delighted that I was going to be there for breakfast. I realized that I had been traveling about 80% of my time for the American Hospital Association and I thought this is no way to raise kids. We had two kids at the time. I thought I'm going to do something that doesn't require that much traveling. So I started to look. It just happened that about three weeks after this, at a convention, a fellow from New Jersey happened to be on the council, Ben Wright, said, "We are going to replace Harold Johnson, the first director of the New Jersey Hospital Association, and would you be interested?" I thought I'll go out and talk with them. I didn't know anything about New Jersey. So I went and met with the board. Monsignor Al Jess was on the committee, some old-timers in the health care field. They asked what I thought of the New Jersey Hospital Association. I said I didn't think very much of it. It was unknown outside of New Jersey. They said we're glad you said that because what we want is somebody who is going to speak up for hospitals. So they made me an offer, and I moved from nice 840 North Lake Shore Drive looking out over Lake Michigan to an address on Clinton Avenue in Trenton that looked across a cemetery and was next to a house of ill repute. Showed it to my wife and she said, "You mean you left Chicago for that?"

It was a good experience. At the time I remember Al Snoke said, "Don't go to New Jersey because it is a medical wasteland." That was his quote.

They don't have a medical school, they depend on Philadelphia and New York for all of their help. So it was kind of a challenge.

WEEKS:

This is before they had a medical school?

OWEN:

Well, they had Seton Hall which was the only thing. It wasn't much of a medical school and they went bankrupt.

WEEKS:

Now they have named the medical school the Robert Wood Johnson Medical School, haven't they?

OWEN:

That's the one in Middlesex. It's not a state university. It used to be the College of Medicine and Dentistry. It's the University of Medicine and Dentistry and has three campuses. It has a Newark campus, a New Brunswick campus, and a Camden campus. The Camden campus has the osteopathic school of medicine as well as an allopathic. But the New Brunswick school is the Robert Wood Johnson Medical Center. They use Middlesex Hospital as the hospital there and use Cooper Hospital in Camden as the hospital in South Jersey. They built a new hospital in Newark. It is interesting that when Seton Hall went bankrupt, literally, they offered it to the state. At that time the state was trying to decide what to do with the medical school in New Jersey. It was about 1967, when the riots came, Mason Gross was the president of Rutgers. What he wanted to do was to pull the medical school into Rutgers. But he made the legislature mad because he felt that the blacks in New Jersey were not getting good enough education to get into Rutgers so therefore he was going to have a pilot program, bring in a lot of people to Rutgers who really didn't

meet the criteria. Since most of the legislators in New Jersey were graduates of Rutgers, they got very upset about this downgrading of their degrees. So they really went out after Mason Gross and said no we'll have a separate independent medical school. So the school is independent of Rutgers. It still operates independently which was flying in the face of everything that everybody was saying about medical schools. But that's typical New Jersey.

Bob Cadmus was the first man to run it. It was a crazy situation.

WEEKS:

New Jersey has probably had a lot of trouble like Detroit has had with the riots and all.

OWEN:

Yes. The thing about New Jersey, though, that was most interesting to me was that there was no dominant hospital to call the shots. While it was challenging to me to go there, even though I said that travel was one of the main things I wanted to leave, another was that Ed Crosby had promoted me following the Peter Principle and I was getting way in over my head. I needed some practical experience. I was talking about negotiating with Blue Cross Plans when I had never negotiated with Blue Cross Plans. So I needed that kind of experience. I just recognized myself that I needed that kind of experience and that's what they were looking for in New Jersey. So it was very helpful.

But the other thing was that the hospitals averaged, at that point, about 225 beds, average size. There was no dominant hospital. There was no Johns Hopkins and there was no Massachusetts General. So it was an excellent opportunity for the hospital association to become the dominant organization in New Jersey. To me that was a real challenge.

WEEKS:

I hadn't thought of it in that sense.

Going back to the representation formula. What did the hospital association, after you rejuvenated it, what was your representation position? Did you represent all of the hospitals?

OWEN:

All the hospitals in New Jersey? Yes. We had 105 hospitals, something like that. They were all members of the new Jersey Hospital Association. My job when I first went there, what they hired me for, was to be the spokesman. The board said to me, "We have had presidents who speak for their hospital down at the state legislature, but they don't speak for the rest of the hospitals. What we want you to do is to speak for all of the hospitals. If we don't like what you say we will fire you, but we can't fire the president who has an honorary position and has his job in a hospital. We would rather have somebody there that listens to us and that we can get rid of if we want to." It made a lot of sense to me.

My major duty was to negotiate the Blue Cross contract. New Jersey was one of the few states that had a single Blue Cross plan. They had a cost reimbursement formula, but they did not include things like the losses on indigents or the cost of doing business, it was strictly an accounting cost formula. My job was to try and get as much money as I could out of the Blue Cross Plan and to testify before the rate commission when they needed a rate increase. The big issue was the care of the indigents. New Jersey did not have a Kerr-Mills program. New Jersey was the last state to join in the Kerr-Mills program. There is an interesting little story on that. I wanted to find out why that was so. I found out that there was a state senator who was

responsible for holding this bill up, and I went to talk with him. He said, "Why should I help the hospital association. In all the years I've been running down here every time I ask somebody to buy a ticket for one of my benefits to help me get elected they turn their nose up at me and say they don't want anything to do with it. At the same time they want me to do this or that."

I said, "What's it going to take? How many breakfasts do I have buy tickets for to get this ruling?"

He said, "Well, $300 worth of tickets will probably get the bill moving."

That's exactly what happened. We had Kerr-Mills at the end of the week.

WEEKS:

New Jersey has been noted for its rugged politics.

OWEN:

I thought Chicago had rough politics, but I learned a whole lot in New Jersey. New Jersey was a fascinating place to be in the 1960s. Hospitals had problems. Planning was coming along. There was no planning and no development. We established a certificate of need program. We had different kinds of formulas for paying hospitals. In fact there were seven different payment systems in my nineteen years in which hospitals were paid. All the way from controlled charges to -- uncontrolled charges, literally -- to some kind of a cost reimbursement system.

I guess why I liked New Jersey so much is that the people who ran the hospitals and especially the boards of trustees recognized their social responsibility for health care as well as the business needs. So, you worried about what was going to happen in the inner city hospitals as well as the suburban hospital who was making whatever they wanted to make. By bringing

those trustees together, although sometimes they were not pleasant meetings and there was some real bitterness that went on, we would always get it ironed out and would end up with what was best for the whole state, not just for this hospital or that hospital.

WEEKS:

There is quite a diversity in parts of New Jersey, isn't there?

OWEN:

Quite a bit, yes.

WEEKS:

I was thinking while we were talking about one of the first things I read about hospitals in New Jersey was the Hunterdon experiment. That is a rural...

OWEN:

A rural group practice. At least it was.

WEEKS:

Yes. Bringing in specialists from the city, weren't they?

OWEN:

Actually it was an experiment similar to the Geisinger approach. The idea was that the hospital would have all the specialists and the general practitioners and internists would be scattered around through the Hunterton County. They would refer all of their patients in to the specialists. Then, being a group practice, at the end of the year the physician would share in the income that this plan produced. It worked fine up until about five or six years ago when the specialists decided that because of the increase of the number of physicians in New Jersey that they needed to open offices outside the hospital as well as in the hospital. That created the first real major

breakdown in that whole concept.

WEEKS:

That's strange. It's sort of going against the tide, isn't it?

OWEN:

Yes.

WEEKS:

Dr. Andrew Hunt was at Hunterdon back in the days when they wrote the book about Hunterdon. He is now, or has been, dean of medicine at Michigan State University, the allopathic school.

OWEN:

I didn't know him. Lloyd Wescot was really the man behind the scenes on that one. He was a big dairy farmer from Rosemont, New Jersey. Raised cattle primarily. Wealthy. Was chairman of the Institutions and Agencies Committee. New Jersey had various so-called civilian committees that operated like boards for the state departments. Institutions and Agencies Department was responsible for hospital licensing and Medicaid. Lloyd brought a man from New York down to set up the Hunterton Medical Center. Hunt doesn't ring a bell with me.

WEEKS:

Maybe I've gotten his name wrong. I ran across him up at Michigan State a few years ago. It seems to me that he was in some way connected with Hunterdon. He may have been one of the physicians in that group health. Did they have a partnership of physicians?

OWEN:

Yes. It was a regular group practice kind of approach.

WEEKS:

And they charged on the fee-for-service basis?

OWEN:

Yes.

WEEKS:

What they were doing was going into an isolated area and bringing in sophisticated medicine.

OWEN:

That's right. Hunterdon County is a farming community primarily. It went from Princeton all the way over to the river, Lambertville. They would have doctors who referred directly, general practitioners who were stationed around the county, they would refer these people directly into the Hunterdon Medical Center. It was like a feeder service. It worked out very well. But the problem that they ran into was when the ophthalmologists, I think were the first group, said we've got to go out and open our offices outside of the hospital. Henry Simmons happened to be the person who was in charge of the Hunterdon when this all blew apart. It was too bad in a sense. They brought a doctor in to run it. When he got into as much trouble as he did, finally they just had to let him go. The doctors got rid of him. Then it just proliferated. Once the ophthalmologists opened their offices, then everybody else wanted to open an office too. So they are out there competing with the general practitioner as well. It's just another hospital now, but a good one.

WEEKS:

When you were saying that they were getting referrals from the general practitioners, I was wondering how well it worked because in Michigan we had a regionalization plan, back when McNerney was at Michigan, in which we tried to

develop a regional system up in northern Michigan. A hospital like Traverse City...

OWEN:

I remember one that goes back even before McNerney. It was in Niles and Dowagiac. They had one where you would first go to this small hospital. It was sort of like progressive patient care. Then all the way to the University of Michigan. That was quite a while ago.

WEEKS:

The stumbling block was that the specialists were accepting the referrals from the general practitioner, but nothing went the other way.

OWEN:

That was a problem in Hunterdon. I'll tell you where it has really worked. Are you familiar with the Geisinger Clinic? I was just out there. They had their twenty-fifth anniversary and asked me to talk. They had Bob Fleming down from Mayo Clinic as well. The Geisinger thing has just caught on in that section up there in the middle of Pennsylvania in the Poconos. It has just spread out. It now takes in three or four counties. They have done a fantastic job. How they take care of the general practitioner, I don't know. He's got to be part of the network. He has to get his share of the profits or forget it.

WEEKS:

If a general practitioner sends one of his patients to a specialist and never sees him again...

OWEN:

That's what happened to the Niles-Dowagiac thing back in the 1950s. The patient would go to the doctor up in Niles and the first thing he's

transferred to the University of Michigan. Then the family would go to the University of Michigan. First of all they didn't like to travel that far. Secondly, once they had gone there they didn't come back. You know, if you can't take care of me when I'm sick I'm going to go where somebody can. That's what is happening right now in the rural hospitals in parts of our country. People are bypassing the rural hospitals because they are being transferred to a bigger medical center.

WEEKS:

We see the helicopters every day going over. Of course those are the exceptional cases. This is the stumbling block that I see in regionalization. it has to be a two-way street.

You've got one of our graduates running that New Jersey Hospital Association now, haven't you?

OWEN:

Yes. Louis Scibetta.

WEEKS:

Is Joel May still about?

OWEN:

He still lives in New Jersey. He is consulting on his own. He set up his own little company. I talked to him this summer. That's the last I've talked to him. He seemed to be doing fine.

WEEKS:

I hope so. I like Joel.

OWEN:

I like Joel too. He and Lou didn't get along too well.

WEEKS:

Joel was in the HRET side of it for a while, wasn't he? Joel is a fast-talking man and you would have to be on your toes to keep up with him conversationally.

OWEN:

I brought him out there. I called him one time. I was looking for somebody to run the HRET. I had a physician. The physician just didn't turn out very well. So I was looking for somebody. I wanted to get a better tie in with Princeton University. So I called Joel, because I knew him, and said, "Joel, why don't you give up this soft life and come out in the real world for a while?" He said no, he wasn't interested. So I said tell me about some of the people who you know who might be good for this job. He gave me about four or five names. I called around. I got a call back from him and he said, "I talked to Helen and thought this thing over and maybe it is time for me to get out in the real world."

Joel, I think, did a fantastic job for us. We've developed what is called the Center for Health Affairs which has put together a whole conglomerate. When I went to New Jersey in 1963 the budget for the New Jersey Hospital Association was $60,000, total budget. When I left, the Center which is the whole thing, the budget was $120 million. So it changed considerably. I had set up nine corporations, had a large insurance company operation. I only set up the corporations, basically, because of tax purposes. Otherwise they could have all been part of the association. What I tried to do was put together an umbrella kind of operation that would take care of splinter groups -- I could see this splintering happening. Go ahead and splinter, but stay within the group. Lou is, I think, having some problems now by finding that the

splintering is continuing and he doesn't want them to have that much freedom. He has a different style of operation than I had. But when I left we had 24 acres of land in Princeton and two buildings. One of 55,000 square foot and another one of 60,000 square foot. The trust really raised all of the money to build those things. Joel didn't like to raise money -- I don't mind raising money -- he gave me the academic credentials that I needed out there. He did a good job.

WEEKS:

That's interesting. I haven't been in touch with him since he left Chicago.

Tell me something more about your HRET and then later I want to ask you about your different nine corporations.

OWEN:

Okay. Well the trust was -- again, I set it up right after I got to New Jersey -- basically because I needed some place where I could go out and look for some grants the same way that everybody else did. I hired Monty Brown. He was at the University of Chicago. He came out and was going to do some labor relations work for us and run the trust for me. Monty had a fantastic ability to convince a government official at a way down level that if we got a grant they were going to get moved clear to the top level. I think at one point we had probably a million dollars more in our trust than the American Hospital Association did in Chicago. Mostly on government grants.

After Monty left, the question became one of how might we use this trust vehicle. When I left 46 South Clinton down in the heart of Trenton, across the street from the train station, we bought a two-acre plot of land with a building of about 16,000 square feet up in the Princeton area, just a little

bit north of Princeton. We had been there for quite a little while and then had outgrown it. The question was where could we move or what need we do. I talked to Dick Sellers, who was then the chairman of the board of Johnson & Johnson. In New Brunswick they had some land that they wanted to start into sort of a health park. The New Jersey Dental Association had been given some land, about an acre or so. They had offered us ten acres. When we got to look at the piece of land, it was so swampy and was going to cost us so much money to drain it that it just wasn't going to be worth it for us. So I went back to see Dick and said we thank you for the land, but we just couldn't use it. So he said, "Well, have you found a piece of land?"

I said, "Yes, we have a piece down in Princeton."

He wanted to know how much it was and I told him $200,000 for ten acres, $20,000 an acre at that time. So he said, "Okay, give us back our ten acres and we'll give you $200,000 to buy that piece of land." That's pretty hard to turn down.

So, we had the land and then the board asked me go out and raise three million dollars to build the building. We were going to call it the Center for Health Affairs. They were going to free me up for a couple of weeks to do this. Of course, immediately the first thing that happened was we got involved in a tangle with the health department so I was spending all of my time fighting with the Commissioner of Health instead of raising the money. Julius Ripple, who runs the Ripple Foundation, had gotten to be a good friend and had given us a little bit of money. He said you can't do that unless the hospitals get behind it. So he came down and talked to the board of trustees of the hospital association and told them what he thought our problems were, sending me out to raise three million dollars without them giving me any

support of putting some money up. A couple of them came up to me afterwards and said they felt just like they had been caught with their hand in the cookie jar. So they came up with a million dollars to start the building and I had to raise two million dollars.

I was doing fine raising ten thousand here and fifteen thousand there and getting better acquainted with the corporate community in New Jersey. Then I had a very fortunate break. Mrs. Robert Johnson, Jr. with the Robert Wood Johnson, Jr. Charitable Trust said she wanted to talk with me at Thanksgiving time. I went down to Princeton Hospital on a Friday afternoon after Thanksgiving and told her what I was trying to do with the Center for Health Affairs. She came through with a $750,000 grant. That helped!

It was interesting because just at the time we started to build the building, which was in 1974, the malpractice crisis developed. In 1970, we had had Booz, Allen, Hamilton do a study for us as to whether we should get into the insurance business or not. Booz, Allen said yes, you can get into it. Here's the way to go, but we would advise you not to do it. Hospitals are not going to look on you as an insurance expert. You are a hospital association expert and as long as there is insurance out there it will be too difficult to get started.

Then in 1975 when the crisis really hit and Argonaut pulled out of New Jersey and so did all the other big insurance companies we got agreement from the Federal Insurance Company that for one year they would take care of the hospitals but within that one year we had to have the insurance company going. So, I went back to the hospitals and said, "You know that million dollars that you gave to build the building, I think we had better use it to set up an insurance company." I looked at all the ways it could be done. A stock

company was going to cost us three million dollars. A reciprocal was one million in New Jersey. We could go off-shore to Bermuda. We couldn't come up with three million, so that was out. Reciprocal looked like the best way. I had the million dollars, did not want to go off-shore because I felt it would be too difficult convincing boards of trustees with an unlicensed company and not having that much experience in what we were doing.

We took the million dollars and started the insurance company in 1976. I think of all the things I have ever done I am probably proudest of that because it was down to the wire. It was between Thanksgiving and Christmas 1975, and we had to have the company going by January 1 in order to pick up eighteen hospitals. Most of the insurance people I talked to said no way in the world could it be done. Can't do it that fast. Well, what I did was I retained the former insurance commissioner and the present insurance commissioner at that time was off on a holiday. So, the two of us went down to his office, used his secretary, and set the whole thing up. When the insurance commissioner came back all he had to do was sign it because it had been done by a former insurance commissioner, and we had the thing going and had eighteen hospitals in by January 16, into a company. It is now the second largest insurance carrier in New Jersey, eighteenth in the United States. We have all of the hospitals in New Jersey and we have 6,000 physicians.

WEEKS:

Oh, you cover both?

OWEN:

Oh, yes. Three thousand nurses, all the podiatrists, all the dentists. Then we've got general liability and clinics and offices to kind of spread that risk out a little bit. It's a nice operation. It's the kind of thing

that associations get an opportunity to do maybe once every so often. You've got an open door. You've got to take that time, if you don't take it, you lose it. Because the hospitals never would have probably agreed for us to have an insurance company by competing with Argonaut or with Aetna or somebody like that. But at a time when nobody else would take them, they had no way out, no way to go. So, this was the opportunity. We had the million dollars right there because I was going to build a building. What it meant was I had to go out and raise another million dollars. But it worked out fine. As I say, every hospital in New Jersey, except one, is in it now.

WEEKS:

Do you go outside the state?

OWEN:

No. I'm a firm believer in doing what you know best. I knew New Jersey best. Over the period of time the hospitals put $8 million in capital. That capital was returned in Blue Cross payments and Medicare -- which we fought through. So technically they had no capital investment. We carry it on our books as $8 million debt. We returned $17 million dollars to them in returned premiums over those twelve years that we have been in business.

A couple of other things. One, we hired nurses to be risk managers. We had one nurse for every eight hospitals. The biggest secret in malpractice is to keep the premiums down is don't get any claims. If you don't have any claims, you don't have an increase in premiums. We have kept the claims down mostly because these nurses are so good in the hospitals. They are watching all the time. Nurses talk to nurses, you know. They know when a doctor with a bad problem -- such as a drug habit -- is doing something he shouldn't be allowed to do.

WEEKS:

How about policing the physicians? What mechanism is there for that?

OWEN:

The only mechanism we've got is that when we know there is a physician with a problem, and we've had some cases where there was a physician who had such a problem is to act. When you finally reach a point of acting, we went first to the chief executive officer and if he says there is nothing he can do about this guy, that he's been here for years or whatever, you go to the board and say, "Look, we're insuring you. We will continue to insure you, but your premium is going to double and triple." They are not going to take that risk. It's amazing.

The other thing we did; the insurance company joined up with the medical society and we have developed a very good program for impaired physicians in New Jersey for which we both put in money and the physicians run it. So if you know a physician has an alcohol problem or a drug problem it is all handled confidentially. The board of medical examiners approved, and watches it. It has done a good job.

WEEKS:

But you have been able to work well with the state medical society.

OWEN:

I was on the board of the state medical society, not as a voting member but attended every medical society meeting and their president sat on the board of the hospital association. That was something that was started back in the late 1960s.

WEEKS:

Is the profession as a whole willing to admit that they have some

stinkers?

OWEN:

Oh, yes. The profession as a whole is. But like all medical societies there are a lot of very conservative members. Some in New Jersey still think Medicare was a mistake. If you talk to them about DRGs they go out of their mind.

WEEKS:

I started to ask you about your activities in budget review programs for all hospitals of the state for Blue Cross.

OWEN:

Yes, that right. It started out with Blue Cross. What happened was the insurance commissioner took an action one year about 1968, somewhere around that period of time, in which he said that he was going to limit the amount of money that he paid to hospitals. The top eight or ten hospitals would have to be reviewed in order to get their full payment from Blue Cross. At that point the dollar amount was $56 a day on a cost reimbursement system. If your expenses were over $56 you were not going to get paid any more than that unless you went before a review committee. He was going to let the hospital association be the review committee. We talked to a group of hospital trustees about what we might do to better this situation, because it was obvious that looking at $56 a day after the hospital had already expended more didn't make any sense. Why not see if he wouldn't approve a budget ahead of time before the hospital spent the money. If he wouldn't approve it then if you spent the money you were at risk, but you weren't going to get any more money.

We met with the insurance commissioner in Trenton. The commissioner's

name at that time was Charlie Howell. I went to see him with three or four hospital trustees and we talked to him about the possibility of a budget program. He said, "Okay. How will it work?" We told him we would have the hospital submit a budget. We would go through the budget and tell them what we thought about it and then he could approve or disapprove it if it was more than the $56 and they would know they were either going to get it or not. He said it was a good idea. Blue Cross wouldn't go along with it that year. Blue Cross came back and said this was going to cost them a lot more money because the money was going to come up front so they couldn't hold on to it until after the audit and then pay it.

We went through one year again with this so-called cap on hospitals. Then we convinced the insurance commissioner the next year to go ahead with those hospitals who the year before had had a cap if they submitted a budget. So we put together a committee composed of hospital trustees and physicians and administrators. The hospital would come in with a budget. We would go through the budget line by line and say okay, this looks good or you've got to knock that down or why are you spending this money.

I had a former hospital administrator, Frank Sauer, who has now passed away, but who had run the Muhlenberg Hospital, as the budget director. He was very good. Had a lot of respect in New Jersey. It worked very well. The commissioner was pleased with it. So, he just said eliminate the $56 at that point any hospital whose payments were going to over $56 had to go up for budget review. That worked out beautifully for us because the first year we had about eight hospitals, the second year about sixteen, the third year about thirty-two. You can imagine that by the time we got up in the seventies that the price of hospital care had gone up so much that $56 per day caught every

hospital in New Jersey. It gave us the chance to not have 100 hospitals left to do the first year, so we knew what we were doing.

It was very effective. We kept the rate of increase to down around about 8% when it was moving about 12 - 13% everywhere else. A lot of my peers in the hospital association business thought I was crazy to start up a program which told my members you can't spend money. In a sense it was kind of dangerous. But the hospitals liked it and the trustees liked it. Although they would bitch about it once in a while and say that we were unfair. we'd have guys come in with tape recorders so they could keep track of everything, and a stenographer. It was a non-legal kind of thing. It was only a recommendation to the insurance commissioner. But in any event, it worked very well.

Then we began to realize as we looked at the budget review process which was paying on a cost per day that it was a dumb way to do business. The hospitals that kept the patient a short period of time kept hurting themselves rather than helping the system. So, with the help of a couple of good hospital trustees, one, Jack Whitwell who was an engineer at Princeton, a professor, we decided that maybe we could come up with a way of looking at a cost per case. We did a lot of work, thanks to Jack and a big computer at Princeton, in doing retrogression analysis and so forth. We decided we could probably come up with a cost per case rather than a cost per day. We submitted a grant to HEW for $300,000. They came to Princeton and looked at the program. The insurance commissioner and the health commissioner both agreed that what we were doing made sense. We got the grant. But before we could implement the program, we had a change in the governor. Governor Brendon Burn came in. He appointed a new commissioner of health, Joann

Findlay. Joann Findlay said, "Wait a minute, we're not going to let the hospital association or the trust do this. We've got to do this. It's got to become an activity of the health department."

So, we lost the $300,000 grant, we made a lot of fuss with the legislature who called the insurance and health commissioner and said how can you let this money go out of New Jersey. They answered that they were going to do it instead, and they did. The grant was exactly the same one we turned in only they went from a cost per case to a cost per diagnosis. At the same time the people up at Yale had been looking at cost per diagnosis, on the basis of looking at utilization, actually, rather than a pricing mechanism. That's what DRGs were all about, utilization not price.

The trust just stepped out of the hospital reviewing. We did it for about ten years. We reviewed hospital budgets for the state and then just backed away. But it was probably the right time to get out because we were getting very, very close to conflict with our own members. They were fighting us because of the low increases that were being recommended. This way, once it got in the health department, we were free to sue or fight in any fashion. We could then become the advocate instead of being caught.

It was funny because the last year that we reviewed the budget they hadn't really gotten the DRGs started in New Jersey, there was an actuary in the insurance department who said, "We should figure out actuarially what they should get. We'll base it on inflation and a few other factors."

We said, "Okay."

The year before we had gotten an 8% increase, with the inflation factor formula we got an increase that was 14%. The hospitals all said, "See, Owen, you have been holding us down all this time. We would have gotten more money

if you hadn't even been involved."

Then the insurance department decided they weren't going to pay the 14%, it was just too much of an increase. So, we sued. And we won. We got the 14%. It was a crazy situation because the trust really did a beautiful job in my opinion. Those hospitals in New Jersey were well prepared to move into DRGs. It was an educational tool as much as anything.

WEEKS:

You were one of the exempt states, weren't you?

OWEN:

Yes.

WEEKS:

Because of your work. How did your DRG system differ from the one recommended?

OWEN:

The federal one, you mean? Our system was the first one. The grant really was based on something we had talked about in Washington. I'll tell you how we got into that DRG system to start with. Basically we were looking at a diagnosis related price. We didn't know it was going to go national. That was not the issue. The biggest difference was that we said we didn't want one average rate in the state of New Jersey. I am a firm believer that averages will lead to mediocrity. The question came then how do you set a rate for each hospital. We used what we called a coefficient of variation. The coefficient of variation really is a proxy for a lot of things like geography, wage, severity. They are kind of rough, but they work out pretty well. Each hospital in New Jersey has its own price established. Fifty percent is standardized, by the way, but fifty percent is based on their own

coefficient. Everybody who goes into that hospital as a patient pays the same rate.

So you've got two differences from the national program. One is each hospital has a different rate. The second thing is that everybody who goes to that hospital in New Jersey pays the same rate. Whether its Medicare or Medicaid, Blue Cross, pay out of your pocket, or what have you. All the patients pay the same for each diagnosis. In the national rate it is an average rate for rural, average rate for metropolitan, by region, and Medicare pays it.

Other than that, the way rates are determined is no different than in New Jersey. It's just a difference in whether it is a single hospital rate or an average.

WEEKS:

What is the status today? Are you still on your own system?

OWEN:

Yes. The hospitals keep talking about they'd make more money if they went on national rates, but my own personal feeling is that they are foolish to get out of it.

WEEKS:

Did I misunderstand, or is this for all patients?

OWEN:

All patients.

WEEKS:

We are not quite to that...

OWEN:

But there is a rate review commission. So you've got a chance to go in

and argue for your price. Where under the present...

WEEKS:

If you don't have the right coefficient or something.

OWEN:

Yes.

WEEKS:

I have a note I wanted to check with you. The New Jersey Utilization PRO Group for Quality of Care, is that your DRG?

OWEN:

No. The New Jersey Utilization Project was actually like HUP, Hospital Utilization Project out of Pittsburgh. What we did was keep track of quality of care through a medical records department. We had that in operation before DRG really became fully implemented. We had a combination of having our medical record administrators handling medical records in a different fashion than they used to and much more prepared to work with DRGs.

WEEKS:

I didn't know, so I thought I would ask you.

Going back to the insurance fund that you were speaking of. Do you also handle the pensions as well?

OWEN:

Yes. Well, we had a number of things going. We had an insurance trust fund which is a corporation, or a non-corporation as the case might be, which worked with pensions, life insurance, health insurance and a few other insurance programs that we provided for the hospital. We acted as an agent for a company, like Mutual Benefit or Prudential. Under the 403 (b) tax shelter annuity, which we did with Mutual Benefit, we negotiated interest

rates among other things. We had about $35 million in pension funds in that fund at one point.

We started another interesting program. We negotiated with the insurance commissioner and Blue Cross a method whereby we would set the rate for Blue Cross premiums for hospitals to pay. We would keep track of the usage of Blue Cross by the employees in those hospitals. We had sort of a group rate. We took an override on that rate and then we would turn it back to the hospitals, anything over and above what we didn't use for our operation of the program. That worked out very well. We turned back literally millions of dollars over the years to those hospitals from their health insurance premiums. We found out that as good as Blue Cross is they still would make mistakes and our hospitals would be charged experience-wise for patients who were not their employees. They may belong to some grocery store or some other business down the street. They'd get picked up on the hospital account. What we did was we started monitoring it, watching it, keeping their rates down. Then we had the ability to negotiate the premiums the hospitals would pay. It was the only association I know of doing this activity. I know it's the only business in New Jersey -- who was allowed to set their own Blue Cross rates.

WEEKS:

There is no more community rating anywhere except, I guess, in Rochester. They still have it?

OWEN:

Five years ago there was still some community rating in New Jersey.

WEEKS:

Was there?

OWEN:

Yes, for the man on the street. Once a year they had to open up the Blue Cross Plan to community rating. But businesses were all experience rated.

WEEKS:

I think you mentioned somewhere the New Jersey Service Corporation. Is that a shared service?

OWEN:

Yes. We asked ourselves what kind of services could we offer? We started with a shared computer system. One of the first ones, I guess, in the country at the time. We used NCR, National Cash Register, and developed an accounts receivable, accounts payable, general ledger system and offered that for about three or four years and then decided it was time to get out of it. McDonnell/Douglas was in it, SMS, all the big companies. So we sold it. We sold it to American Hospital Supply. American Hospital Supply was getting into the business. A year later they dropped it too and sold it to Shared Medical Systems. When we sold it, Karl Bays convinced me that they were going to stay in it forever. He called me one day and said that he was going to let it go to Shared Medical Systems. I said, "Karl, I got out of it when you took it away from me. I don't care."

We also had an industrial engineering program. At one time we had forty industrial engineers working for us. We did work in Virginia, Pennsylvania and Canada. We spread out internationally, you might say. We had group purchasing, which was a big one and always has been. Credit collections, and a few other programs.

WEEKS:

Mentioning Karl Bays. He has now left...

OWEN:

Yes. He is now with Illinois Central.

WEEKS:

They are a diversified corporation, are they?

OWEN:

Yes. I don't think they have anything to do with health care.

WEEKS:

Something to do with the railroads maybe?

OWEN:

No, I don't think they have anything to do with the railroads either. But they don't have anything to do with health care. When he left Travenol he really went out of the health care business.

WEEKS:

That was a strange takeover, too, wasn't it?

OWEN:

Karl was a very interesting guy. I think he's always thinking ahead about what works and what might be done. I believe he looked on American Hospital Supply as limited in growth and here was an opportunity to work at health care all the way from providing the supplies to the delivery in the system. HCA was an ongoing, up-and-coming company and it might be good to tie the two together. There were some other reasons that it shouldn't have been tied together, because he was going to alienate so many other hospitals who were not part of investor-owned chains. It kind of backfired. I think Travenol, Vernon Lutz, was sitting there watching this and decided this might be just the perfect time to get a distribution system that he needed which American Hospital Supply had. This just worked out perfect for him. I think

Karl was probably the most surprised guy in the whole world when that happened.

WEEKS:

Do you think so?

OWEN:

Yes. I don't think he expected that that was going to happen, that he would lose the company.

WEEKS:

How did he get squeezed out?

OWEN:

Well, basically when Travenol made their run, friendly takeover so to speak, they went to the board and said, "We'll give you more money than the HCA deal is." The board had to decide what was in the best interest of the stockholders. It became obvious to many of the board members that the best interest of the stockholders would be served if they went with Travenol. So they voted to go with Travenol. I think Karl certainly didn't want that to happen. But in any event when it went to the stockholders they agreed. So he was left hanging out there. They made him chairman of the board which was a good thing to do.

WEEKS:

Sort of a resting spot until he found a place to go.

OWEN:

Right.

WEEKS:

When I was in Nashville in 1984, it must have been about the time this was going on.

OWEN:

That's right.

WEEKS:

They were so confident that they were going to be able to take it over. I think this was off the tape, as I remember, but the elder Dr. Frist said that they were good friends of Foster McGaw and everything looked like go. They were very confident until this happened. They were just out-maneuvered.

In your computer operation you were mostly on business functions, weren't you? Not on patient characteristics?

OWEN:

No, this was strictly designed as a service to the hospital in getting their payroll, the accounts payable, accounts receivable, writing checks, all that kind of thing done for them on the kind of basis like a bank does for any other kind of a business. It worked pretty well.

The problem with operating this kind of a program for hospitals is that you have hospital people as your board members. They are the ones who are buying the service. What they want to do is keep the price down. Well, by keeping the price down you reach a point where you can't build up enough capital to explore new ways to gain business. It was obvious to me that down the road what they were going to want to get into was laboratory services and patient services. There was no way we could program for it. What we were doing was holding the price down so low that Shared Medical Systems and the rest were kept out of the state. So it finally came to the point where if we are going to get rid of this thing let's go out on bid now. We had twenty-five companies bid on it. We felt American Hospital Supply had most interest in our member hospitals. The interesting thing was how to sell a non-profit

company that had no assets. Because all of our equipment from NCR was rented, we had nothing to sell. We had no stock or anything else. Finally we came to the conclusion that they should donate a million dollars to our hospital research and educational trust for the program as good will.

WEEKS:

That's the way you...

OWEN:

Got out of it.

I think if I were ever going to sell anything again I would want to somehow make it into a stock company. It is very difficult to sell a non-profit.

WEEKS:

I can see where it is. But on the other hand you were probably wise to be leasing equipment rather than buying it because so many people -- well, Blue Cross got hurt on getting overly ambitious.

OWEN:

That was in the sixties. The state of the art was changing every year. We were going from one age to another age of computer. There was just no way that we could see to buy the equipment.

WEEKS:

CPHA did. They found themselves with a lot of out of date equipment that wasn't paid for yet. So they turned to Ross Perrot. I don't know how good a deal that was.

Now your Center for Health Affairs: is this a holding company?

OWEN:

Yes. The Center for Health Affairs is a holding company. The idea was

to bring all of these corporations that we have together. What they did was pay an administrative fee to get the center operating. We took a couple of people from each corporation to make up the board for the Center for Health Affairs. We had a couple of people from the hospital association, a couple of people from the trust, a couple from the insurance company, from the service corporation, from all these different groups that we had including the insurance fund. They would meet as a board to review contracts which were going to provide all kinds of services, office space, printing, stenography work, reception, and provide the educational facilities, for each of the companies. It was really bringing together in one place each corporation who had its own board. I had discovered that the hospital association people were more concerned about the economics of health care and what we were doing with the department of health. They really didn't care about research and education. Another corporation was more concerned about what we were doing with insurance, they were not concerned about something else. So by having separate boards, I kept the boards interested in the function that was going on but had to coordinate them for economic reasons, in what needs to be done for the good of the whole center.

WEEKS:

Your holding company center board, do they have representation from all nine corporations?

OWEN:

Yes, we would have two people which included the chairman of the board of each one of these other corporations who sat on the Center board. They were not weighted in any way, just a couple from each board.

WEEKS:

Are there any others of the nine that we should mention?

OWEN:

They all dealt with services. We had a stock company, we had a reciprocal company, we had an agency, we had an insurance fund. We had a for-profit, two of them were for-profit and three or four of them were not. They either dealt with service, insurance, research or association. There were literally four major things they did, but they had to break down into sub-corporations.

WEEKS:

Going back to HRET. Most all of your revenue was coming in from government research, was it?

OWEN:

When we started out originally, that's right. Most of it came from HEW, but the last few years hardly any came from government. Most of it came from private foundations. Robert Wood Johnson Foundation had given us quite a bit of money as well as the Ripple Foundation. There were a number of foundations. In fact, we even got $100,000 from the Kresge Foundation here in Troy, Michigan.

WEEKS:

You didn't have to build a building, did you?

OWEN:

That was for a building.

WEEKS:

It's a strange thing. I went to them back when we were trying to set up some money for the Abstracts journal. We were getting some money from

Kellogg. I went to Kresge and the man told me, without any question, "Do you want to build a building?"

I said, "No, we don't need a building."

He said, "I could help you. To be perfectly frank with you, if we can put up a building and put Kresge's name on it it is a lot better for us."

OWEN:

It was funny. I just wrote a letter saying that we were building this Center for Health Affairs. I had a book of foundations. I wrote to a whole slew of them. Most of the foundations didn't bother responding. I got a letter back from the Kresge Foundation saying yes they would be interested but the most they could give me was $100,000. It wasn't long afterwards and they wanted to know a little bit more about the building and so on. So, of course, I sent it to them. It wasn't long after that that I got a check for $100,000. The interesting thing is it was signed by Mr. Kresge.

WEEKS:

Yes. The son is still alive. Probably Stanley Kresge.

OWEN:

Yes. And above it said "Jesus Saves," and then it had his name.

WEEKS:

They were a very religious family, particularly -- it must have been either the mother or the daughter-in-law who was very strict. For years they wouldn't keep their stores open on Sunday, even after it was a generally accepted thing. Later, when they changed and made over the corporation into K-Mart and so on, a lot of things changed. I've been to some of their corporation meetings just to see what it's like. I saw Stanley Kresge as an old man, just nodding. They either give money to a university or to a non-

profit organization. For a building they put their name on it or if they build a Methodist church -- the Methodist Church really benefited a great deal from the beneficence of the Kresges.

OWEN:

We never put their name on the building of our Center for Health Affairs, but he sure was helpful to us.

WEEKS:

In passing we have mentioned a personality that I would like you to comment on if you would care to, Joann Findlay.

OWEN:

Joann Findlay was a most interesting lady. She came down from New Haven where she had been with the Department of Health. She also had been working with some Yale people. She had previously worked at Blue Cross in Philadelphia. Joann should never have been a public servant. She could not take criticism. I never knew where I stood with Joann. I would see her one day and we would be the best of friends; she would give me a kiss on the cheek. The next day I would run across her and she wouldn't even speak to me. She would turn her back on me. I would discover that I had either said something perhaps that the Department of Health wasn't doing something right and she took everything as if it was personal. You can't do that when you are in public office.

I remember one time when she hadn't spoken to me for about a week. She met me in an auditorium at a meeting. She grabbed me and gave me a big hug. She said, "I've just been to the medical society and they said that Jack Owen is a great guy. Those hospital people make him say all of those things about you, Joann." So, she said, "I was misinformed about you."

I guess you could say that Joann was misunderstood as much as anything, because she would come across sometimes with huffing and puffing and a great deal of emotion. But we needed Joann in New Jersey at the time when we had her, because in order to get the DRG system to work we needed somebody up there who was going to be bullnosed and push something through. We needed the kind of a person that we could play against to make the thing work out right. So that when she would push something through that wasn't proper we could yell and scream and make a lot of fuss about it and gradually moderate it. On the other hand, if she had backed away at that point and not been pushy, we probably never would have ended up with a system that made sense. I do really think that the DRG system does make sense and it is the best way that hospitals can possibly be paid if the price is adequate.

WEEKS:

It's good to hear that she was helpful to you, if maybe in an indirect way.

OWEN:

Yes, in an indirect way.

WEEKS:

Do you want to discuss planning? I'll just list these: your Health Facilities Planning Council, the Regional Medical Program, the Comprehensive Health Planning Act, the Certificate of Need, the Comprehensive Health Planning and Resources Act, and the growth of the federal influence. That is more or less chronological order, isn't it?

OWEN:

Yes. Areawide Planning, which was a voluntary program, I guess was the first approach to it. Then we had the CHP, Comprehensive Planning, and the

RMP, the Regional Medical Program. They got started about the same time. They were supposed to do different things. The Regional Medical Program was primarily to look at the medical school and sophisticated esoteric kinds of procedures like open heart surgery and things like that. There were going to be centers of neonatal and cardiac care and that kind of thing. The Comprehensive Health Planning was a start of the whole Health Facilities Planning Act which later we called something else, Health Planning Agencies was I guess the next term.

But basically in New Jersey planning was very important because it's a small state, heavily populated, and the issue of who was going to be the centers for neonatality, and for heart transplants and so forth became very important. It didn't make sense that every hospital would be a center, but on the other hand there had to be some kind of decision as to which hospital would be. You remember I said that New Jersey was interesting in that we had no dominating hospital. So, the question became one of if there is no dominating hospital, which five hospitals should end up being a center. Planning was performed originally, under the old Comprehensive Planning Council, with voluntary planning agencies. We had a pretty good system in New Jersey in which hospitals would present their plans to the council and Blue Cross supposedly would not pay unless it was approved. It was headed by a gentleman by the name of Paige L'Hommidieu who was a retired executive vice president from the Johnson & Johnson Company. He attracted some pretty top people, industrialists in New Jersey. The next step was a state planning council. There were regions throughout the state. They would plan things locally and then it would feed up to the state planning council.

The certificate of need followed, and we really got into that long before

the federal government. It was really based on the fact that we decided if we are going to make it work the hospitals ought to have protection for those who go through the planning process and not let anybody else move in and give them competition. The hospitals used the certificate of need almost like you would do in buying a franchise. It protected them. They looked on it as protection. I don't think the health planning ever stopped anybody from doing anything. It delayed some things. My biggest complaint about planning is that it didn't go far enough, that it didn't try to cover areas that were underserved by saying you should do this. It always waited until the hospital made its approach and said here's what we want to do and then they said yes or no or here's what you've got to do. They never said here's what needs to be done. That's where, I guess, I have always had a reservation about planning as not being very progressive, it has always been a negative approach to what needs to be done.

We put a certificate of need bill in our state legislature. The hospitals boards of trustees supported it. I used to use hospital boards of trustees pretty regularly in New Jersey to pull together when I had a problem with administrators. They were always helpful.

Out of 102 hospitals, 100 hospitals voted for a certificate of need policy.

WEEKS:

Is that right? You had a state agency to pass on these?

OWEN:

Yes, but not originally. Originally we had a voluntary group, like our budget review program. It was strictly voluntary. The only person that paid any attention to it was Blue Cross. Then when the federal government passed

health planning legislation in 1967 -- somewhere around there -- then we had a state agency. The state took it over and the voluntary planning went out of business. We were doing it like five years or so before the feds required the state planning agency.

WEEKS:

I have never gone into the CON mechanics, but we have a friend, a young woman who works up at the University Hospital. She spends all of her time on certificates of need, writing them. There are two other persons part-time, just for that one hospital.

OWEN:

That's the problem with them. They get to be so full of red-tape that you are spending more time trying to justify why you should do something than you are in actually carrying out the doing.

WEEKS:

Then I detect that once the hospital administration has the certificate of need in hand then the finance department lays all sorts of obstacles in the way.

OWEN:

We avoided that in New Jersey because we tied the two together. When you got the certificate of need you got the rate from the rate commission to go along with it.

WEEKS:

It was either or not.

OWEN:

That's right, you couldn't get one without the other.

WEEKS:

I was interested in your dialysis. Do you have special programs for -- I was thinking of mobile dialysis units. Did you set up dialysis centers? Are there certain hospitals that normally have dialysis service?

OWEN:

You are talking about the planning agency?

WEEKS:

Yes.

OWEN:

What we did was we had some outpatient dialysis that were approved. They were like storefronts. Then we had half a dozen or maybe eight hospitals that were where they put the shunts in and did all of the dialysis. They were looked at as the regional dialysis centers. We had regional centers for transplants. We had regional centers for neonatalogy. We had regional centers for catheterization.

WEEKS:

How about this expensive technology like scanners?

OWEN:

They started out with that. It worked fine on cobalt as a treatment modality, but they tried to do it with CAT scanners and too few centers with CAT scans just doesn't work. It's too much of a diagnostic tool. Almost every hospital needs one. We are talking about the average size hospital of over 200 beds. So you weren't talking about giving a 50 bed hospital a CAT scanner, but almost every hospital. They started out saying that we could have five in the state. Then they raised it to sixteen. By the time I left they were talking about every hospital having one.

The lithotripter was another one. I think they said there could be two of those in the state. Now that made some sense. But when you are looking at diagnostic versus treatment, you've got a different problem.

The other thing we had in New Jersey which was interesting, and was different I think from other states, was that we had a state regulation that you couldn't build a hospital of less than 100 beds. If you built a hospital you had to have all of the services, which means that you have to have a clinic for any in-service that you had. You had to have outpatient clinics in urology and cardiology, all of those things. Since you couldn't build a hospital of less than 100 beds, you couldn't find small doctors' hospitals like in other states. There were no investor-owned hospitals in New Jersey until some of the chains moved in. At one point there were four in New Jersey. They are all gone now too. The regulation has since been raised to 200 beds. In order to build a hospital in New Jersey today you have to start out with a 200 bed hospital. That's tough to finance.

WEEKS:

Did Hill-Burton build a lot of small hospitals?

OWEN:

No, there were no small hospitals, or not many. Most of the Hill-Burton money in New Jersey went primarily for remodeling. After the original Hill-Burton came out they had a program for bringing your hospital up to date.

WEEKS:

Renovating and all of that.

OWEN:

That's what most of it went for. A lot of the money in New Jersey came from the Farmers' Home Loan. Quite a few of our hospitals got money from

there. There was quite a bit from Hill-Burton, but not for new hospitals.

WEEKS:

I was wondering, with your average hospital size rather small, did you have difficulty bringing specialists?

OWEN:

Two hundred beds per average? No, I think that's pretty big. We had no fifty-bed hospitals. We had none of less than 100 beds. Even in Michigan you have a lot of little hospitals as in the Upper Peninsula. No, I think most of the hospitals stayed about the same size. Most of the hospitals were around 300 beds. They are about 325 beds now. We had some 500 beds, the St. Barnabas Medical Center, St. Joe's, teaching hospitals that were connected with some teaching institution in New York or Philadelphia.

The biggest problem I remember when I first went to New Jersey was in the emergency room department. They had had a great many foreign medical physicians in New Jersey. They used them in the emergency room. We had a terrible problem of unlicensed physicians in emergency rooms. They would go from one hospital to another. They would stay for years, every hospital had an internship program and always in the emergency room. You could stay one year as a foreign intern. They would just go from one hospital to another, one year here, one year there. I remember one morning going down to the state house and a state senator said to me, "I'm putting a bill in today that says every hospital shall have somebody who can speak English in the emergency room." What had happened was his child had fallen out of a tree on a Sunday afternoon and he took the little boy to the emergency room and there was no one present who could speak English. I don't know if it was a Philippine or an Indian doctor who couldn't speak English. He was trying to tell him that

the kid fell out of a tree and hurt his head. He got so frustrated with the young foreign medical graduate that he came back and passed a bill saying that you had to have an American in the emergency room.

New Jersey, in a sense, was a problem state. It wasn't a medical wasteland but it was lacking in teaching facilities. They never matched their matching on interns and residents. We had over twenty-five, maybe fifty percent of our interns and residents in the state were foreign. At one point, you know, the AMA took action that if a hospital had more than twenty-five percent foreign interns you lose your residency program. It was only because some doctors from New Jersey fought it at an AMA meeting that it changed.

So, there were some real problems. Those have swung around and changed now. We've got some very fine hospitals, 400 or 500 beds with everything you could ask for.

WEEKS:

We have some foreign people here on the staff too.

OWEN:

But you didn't have them like we had them.

WEEKS:

Shall we talk a bit about Medicare and Medicaid? When you went to New Jersey, that was before Medicare and Medicaid. Do you remember before you left AHA what the action was in Chicago on preliminary work leading up to Medicare and Medicaid? Did the Association take a stand on that? On the passage of that bill?

OWEN:

I had left AHA in 1962. The bill actually passed in 1965. I was at the edge of it when I left. Kenny Williamson used to come back to Chicago from

Washington about once every six months and say, "This is the year we are going to have national health insurance and it's going to go through. We are going to have a Medicare/Medicaid program." Only it wasn't called that then.

Ed Crosby would say, "No, Kenny, it's not going to happen this year." Sure enough it wouldn't happen.

I think when it got down right to the wire AHA was mostly interested in Part A of the Medicare program and to see that the hospitals got their full costs. As you remember, it was cost plus two percent. There was a nursing differential and all of those good things that we lost over the years. But those were all in there and that is what we looked at. I think in order to get it passed the question for Congress was how to get the doctors involved and that's when Part B became so important. They were going to give Part B to the doctors, separating the Part A and Part B. The doctors being able to charge over and above, under the Part B, and not accept assignments. That was kind of political deal that was made. I suspect that there was some compromising. Knowing Dr. Crosby there had to be some closeness that developed between Bing Blasingame and Crosby or maybe it was Bert Howard at that point who was the president of the AMA. But I'm sure there were some deals made as that went through.

WEEKS:

I have often wondered -- maybe it can't be described, maybe it can't be evaluated -- I wonder what Dr. Crosby's attitude was when it came to balancing pro-medical against pro-hospital.

OWEN:

I don't know. I've never seen him in that kind of a situation where it became an issue. I know how he felt, for instance, about Blue Cross. I

suspect he would be very disturbed to think that there might be a schism that would develop between the medical community, so to speak, the physician and the hospital. We are coming up to that one, I think, very, very, shortly. I think we are going to have a real testing of the relationships.

WEEKS:

Is that right?

OWEN:

Yes. With what is happening with Part B right now.

WEEKS:

I wanted to ask you about that too. One reason I was asking about Dr. Crosby is that from the stories I have heard before he became president of AHA he was waiting in the wings to become executive vice president, or whatever the title is, of AMA.

OWEN:

I think that's right. You know he was really quite a guy. I think he's responsible for the Joint Commission on Accreditation of Hospitals as well. They started out as the the College of Surgeons survey, and as it worked its way up I am sure he was responsible for the whole Joint Commission. He was probably a good, logical choice to move into the AMA. I don't think he was probably a good enough politician in that sense, to glad-hand people. Intellectually, he was well above and could have handled it without any trouble, but I don't think he could put up with the nonsense that goes with running for president of an organization.

WEEKS:

He couldn't get out and work the crowd.

OWEN:

That's right.

WEEKS:

I only saw him once or twice and heard him speak once, so I have very little to judge him by. I was under the impression that he was quite a reserved person.

OWEN:

Yes, definitely.

WEEKS:

Private person, as we sometimes say.

Then once Medicare was passed, Medicaid was passed, you were in New Jersey. Did your state association do any work on influencing hospitals to choose Blue Cross as an intermediary?

OWEN:

Definitely. We took the position that it ought to be split right down the middle. We were opposed to naming Blue Cross as the intermediary for all of the hospitals because we felt that we would not have as good a bargaining power as we would if we had it split. So half the hospitals took Prudential and half the hospitals took Blue Cross. It's still that way.

WEEKS:

Is that right?

OWEN:

Yes, and it has worked out very well. We found out that when one of them decides they want to interpret a transmittal letter from HHS the way they want to interpret it, the other one will usually get it to go the other way. We find that in the meantime neither one of them will do anything until they get

an interpretation and that's how it goes. It worked out very well. We definitely wanted both of them as intermediaries.

WEEKS:

This is rather unusual.

OWEN:

Only state I know of that did it.

WEEKS:

Because they had a very high percentage...

OWEN:

That did not make Dr. Crosby real happy with me, as much as I think we liked each other.

WEEKS:

I think you had a good argument there.

OWEN:

He didn't like it because one of the first things I did was to remove Blue Cross as a member of the New Jersey Hospital Association.

WEEKS:

While we are talking about Medicare and Medicaid -- this is jumping ahead in time, but if we can look at the present day -- would you like to comment on the rising price of premiums for Medicare Part B?

OWEN:

There are two ways to look at it. One is you can say, it's a five dollar increase why is everybody getting excited. But I don't think that is the issue. The issue is the percentage. Part B has gone up twenty-two percent this year versus about four percent for Part A. I think from a political standpoint, with an election year coming up, the doctors have got a lot to

worry about. If you had asked me two months ago do I think physicians are going to be included in this whole prospective pricing system, I would have said probably not. But now I would change my mind and say, yes, I think they are.

There was an editorial yesterday in the Washington Post, very good editorial, saying that although we appreciate the fact that doctors are entrepreneurs something has got to be done about the high increase in physician fees. What's happened is that they are being accused of, rightly or wrongly, since we have frozen the price what you are doing is you are seeing the patient more often. So what you have done is you have just increased the number of times you are going to see him. You decide you are going to take care of the patient for this diagnosis and make him come back to take care of him for another diagnosis instead of taking care of them both at the same time. They are talking about a DRG physician price the same way as they do for hospitals. It's going to take $200 for a gall bladder and you can see him once or you can see him ten times during the admission, I think it could well happen.

WEEKS:

Something has got to happen. It's got to show some merit in the plan. We can't continue this way. If I were the head of a corporation that was paying fringe benefits I think I would be very much interested in talking to my friends, the physicians, who may be in their same social class.

OWEN:

That's right. I think we are going to see it happen in the next couple of years.

WEEKS:

I think another thing you have commented on recently is HCFA's Medicare mortality data.

OWEN:

Right. There is a real push for quality of care and measuring it. The push is not so much from HCFA as it is from the AARP and some of the outside groups who say how do you measure hospitals? Is this a good hospital? We are paying them a lot of money to be good. The mortality data, unfortunately, is so limited, but it is the only thing available. So they are going to push it.

We know, for instance, going all the way back to the Regional Medical Programs that a hospital that does a lot of open heart surgery is going to have a better rate of recovery than one who doesn't. We know that people who want organ transplants are much better off going to hospitals who do a great many of these transplants than to hospitals who only do a few. But, you have to draw the line at some point as to whether death rates really tell whether quality is good or not, because there are just too many variables on the death rate. I don't think it is a good idea to use it, but I don't have any better answer. I have been in this business thirty-one years and people keep talking about quality and nobody can define it. They have been trying to define it for thirty-one years.

WEEKS:

Dr. Donabedian here at the School of Public Health is supposed to be an authority on the quality of care. He has read everything and written everything and done everything and I'm sure that he would tell us the same thing. That there is no way. I can remember one time we had a research project for which we were trying to get a grant from someone in which a

registered nurse who had been with AMA was coming to Ann Arbor and was going to use a camera and keep that camera on a patient about twenty-four hours a day and have a record of every possible thing that had happened in that patient's room. But I don't know, even then, whether they would be able to determine quality of care.

OWEN:

The other problem is: they are looking at the hospital and not the doctor. You can have a hospital with a high death rate and maybe one doctor is the cause of it. Granted, you can say now you had better correct that one doctor, which is the thing to do, but you really have to get back to how that doctor practices versus the other doctors in that particular department for whatever you are measuring. They can't do that by law. They can't measure the doctor under present regulations -- they can measure it, but they can't publicize it. But they can publicize the hospital.

Now the interesting thing is this last mortality data that came out has not caused too much flack from hospitals, mostly because they've got a chance to answer or come back with why they have exceeded the limits of the mortality rate. The problem still is that it is too difficult to explain to the public. No way you can do that.

WEEKS:

We have medical audits for as many years as I can remember in this business, but we still don't know what...

OWEN:

The medical audit from inside can be very useful because there you've got a chance to look through each case and go through it and say you did this, you did this, you didn't do that. But just to publish whether a person died or

not is not going to tell whether it's good quality of care.

WEEKS:

No. Because how are you going to take in all the genetic influence in spite of everything else.

I think we had better go to your service in Washington.

OWEN:

All right.

WEEKS:

I have been trying to come up with the origin of the Washington Service Bureau. I can remember talking to Jim Hamilton about when he went there in 1943. I think that's the year he was what we would call now the chairman of AHA. It was wartime and the hospitals of this country needed a procurement office in Washington just to get items that were scarce and items for which you had to have special permission.

OWEN:

OPA, the work order. Right.

WEEKS:

I remember hearing that Hamilton hired somebody from Long Island, somebody who was, I think, a journalist. He hired him to go around in Washington and get acquainted. I don't know whether there was an actual office that was opened or whether he was just trying to find somebody who could open doors and get things done. What is your opinion of the origin?

OWEN:

I don't know. Here is what I have always been led to believe, but I don't have any facts to prove it, and that is that during the war, as you say, the Office of Price Administration was one of the offices that needed to be

monitored. Hospitals were having trouble getting some necessary equipment and supplies and making sure that they got their rations. So there was some work there, but I don't think there was an office opened at that point in time. I think it was after that. My first recollection of an office was in 1948, or thereabouts, when Hill-Burton started. That was really the beginning of more interest being taken. I don't know when Kenny started in Washington.

WEEKS:

I'm not sure either.

OWEN:

I think it was the fifties, if I remember right.

WEEKS:

In 1943, Jim Hamilton became president. Just previous to his actually taking office he had pushed through a membership dues increase -- quadrupled it. One of the purposes of that extra money was to open an office in Washington.

OWEN:

That's what I understand. I know that the office became more important to the Association during the time of Hill-Burton. Then it gradually grew in importance as Kerr-Mills and then Medicare and Medicaid came into being. So, you've got to remember that there was no Department of Health, Education and Welfare, HEW, until the Eisenhower years. That was about 195Ø, somewhere around there.

WEEKS:

Eisenhower took office in 1953.

OWEN:

So that was about when it became important that AHA have an office in

Washington. My own understanding is that Kenny was probably the first full-time Washington person.

WEEKS:

That probably is a good way to leave it. He was supposed to have been close to Senator Hill and, of course, Wilbur Cohen.

OWEN:

Yes. Wilbur Cohen, Paul Rogers -- he was pretty good friends with those fellows.

WEEKS:

I don't know much about Lee Gehrig who followed Williamson, didn't he?

OWEN:

Yes, that's correct. Lee worked for Kenny. Lee came out of the Public Health Service and was a -- I hate to use the word "bureaucrat" -- an administration official for many years and kind of came out of that mold.

WEEKS:

I never met Al Manzano.

OWEN:

Al Manzano was an interesting person. He probably never should have been offered the job in Washington, really was not of the right temperament to take that kind of a job.

WEEKS:

Did he have a Latin temper?

OWEN:

He was Filipino. He did not add a great deal of credibility to the AHA in the course of time he was there.

WEEKS:

I found that there are different ways that you heads of that office have operated. I find that much of this is, in my opinion, is due to the chief executive -- what type of person that chief executive is and what that person feels he or she should do as far as being in Washington or as far as representing the hospital association.

Could we start off with talking about your organization? Who you have working for you and what they do?

OWEN:

I have the Association really broken down into three major areas in Washington -- I'm talking about the Washington office now. The first area is the legislative and regulatory area. This is headed by Rick Pallock. He is really my vice president, the second in command. He is responsible primarily for the regulatory and legislative activities. Break that down in this fashion: legislative, we divide legislative representatives or directors who work on the Hill in dealing with Congress. We assign them committees like the Senate Finance, House Ways and Means, and so forth. Two to each one of the committees, one on the Republican and one on the Democratic side. The person who works on the Republican side, say in the Senate Finance, would work on the Democratic side in House Ways and Means. So they are not identified as Republican or Democrat from our standpoint. The assignment by committees has worked very well from the standpoint that when I really want to know what a vote count is, which is important, I need to know from these people how they feel that their people are going to vote in that particular committee.

Before a couple of years ago, people were assigned regions of the country primarily so that if somebody was a legislative representative, they would

represent Region IX, which is California and so forth. That was good, but then we had Pete Stark on the subcommittee on health on the House Ways and Means and you've got Rangel from New York on it. The person who knows California doesn't know Charlie Rangel. So I needed to go with somebody who knows Charlie Rangel, Pete Stark and everybody in between. That has worked out pretty well. Their job primarily is to keep track of what is happening in those committees and as bills move from one committee to another and other committees pick it up. The second thing is that they are still assigned to a region as far as working with state hospital associations. So that if we have a problem with, let's say Idaho or Utah, then whoever is responsible for that area usually works with them as they come into town and arrange meetings for their administrators. That's the legislative side.

On the regulatory side we have three or four people and they work primarily with Bill Roper's staff over in HCFA and with PROPAC. Their job is to make sure that regulations coming out we know about and, if possible, we can make some changes before they come out. Their job is to make sure that we get that input to it. It works sometimes, sometimes it doesn't. When it doesn't work it is usually because HCFA says that they don't want any input until after it's been published. We say if you do it before it's published you will save yourself a lot of grief.

The second major group division I have is what they call our relations with state and allied hospital associations, constituency centers and what-have-you. We have a partnership for action program in which we work with the states so that we get grass-roots support. We ask each state to have a contact so that we can get hold of them, for instance Spence Johnson here in Michigan. When we want to get ahold of Dingell or VanderJagt he tells us who

we can contact, whether it is a hospital association person or a trustee or whomever it might be. This is our partnership for action. The constituency centers, which is relatively new, is broken down into rural hospitals, metropolitan hospitals, multi-hospital systems, and they want representation in Washington. We have a staff person assigned to them who also works in coordination with legislative staff. Then we have a PAC group to raise money for the candidates. That is part of this what we call association relationship. Jim Doherty is our vice president who runs that. Chris McEntee who came to us from AARP heads up the constituency center and works primarily with that whole area. Most of the people on my staff have worked for a congressman in one way or another.

A third area is the communications departments. We did have a Washington memo that we sent out once a week on what was happening in Washington. That has since been replaced with a The Week which is a newspaper that the AHA is publishing in Chicago. We have a deadline at Thursday noon and get almost everything in that that we want. We also have a weekly letter that I send to the allied hospital associations in which I inform them of our activities, for instance -- "I met with Rostenkowski today and here is what he thinks, but it's not for publication." Mostly to keep them aware of what is going on. They seem to like that. It is sort of an insiders letter. Although once in a while it gets me into trouble if somebody gives it to one of the congressmen.

Our organization is communication, it's legislation and regulation, and it's relationships with other groups. We do a lot of things that fall in between that. For instance, once a month I have a breakfast meeting in Washington for all of the other associations in town, seventeen of them, and we invite over a congressman from the Hill. We are right close to the Hill,

which is great. We have had Pete Stark and we've had just about everybody on the House Ways and Means subcommittee on health. We'll start to work on the Senate now. They come in and have breakfast for about half an hour and then they'll take about 15 minutes to tell us what is on their mind. We open it up and each representative can ask one question. What is pressing on their agenda. Bill Gray, for instance, when the budget was coming up, what did he see in the budget. That kind of question and answer period. What I am trying to do is keep my flow of information up to date to know what the Catholics are going to do and the Protestants. Unlike Mike Bromberg at the Federation, I'm still trying to pull this whole thing together in conceptual form. I know darn well that there are certain things we can do together. We can say let's get as much money in the budget as possible for health. Everybody agrees to that. We can say this is what we want to do at the capitol. We want to continue to pass capital through. You get into the question of do you want one national rate; do you want a national hospital or regional rates, do big cities want more; do rural hospitals want more; do the rural referral centers want more; the public hospitals are claiming they have got to have a disproportionate share. We'll all get together for the big push, but from then on it's a cat and dog fight. It's very difficult to sit in a spot for the national association and try to make heads or tails out of it.

WEEKS:

I think you are wise though in talking to all of these people regularly and trying to work with them. Because you are going to take the temper off their feeling that they have to have their own representative and they can't use your services anymore. Now, even if they have their own representative, they also have your input.

OWEN:

Yes. Well, they have their own representative in most all cases. The real problem is to try to get them to look at the bigger picture. If we can get more money into the pot, how it is divided after that becomes less of a problem -- they are all members of ours anyway. Somebody is going to do well. On a budget neutral position you have a no win situation, because if we give more to the rural the rurals are happy but all the city hospitals are unhappy. If you give more to the city hospitals then the city hospitals are happy. The problem with a national rate is it splits the states. We had a question this year, as a good example, cost of doing business. Should that be a separate kind of calculation? Well, we couldn't come up with a good cost of doing business formula, nothing that anybody would buy -- at least any of the hospital people. California, Illinois, Michigan and Massachusetts said they were going to go on their own and try and get it. They couldn't convince Congress that there was any sense to what they were talking about, but they did convince Congressman Rostenkowski from Chicago that he should give a percent more to cities over a million and do a cost of doing business on a labor index. If you lose on labor under the present formula you are going to lose double under their plan because you lose on labor and you lose on the cost of doing business. What it has a tendency to do is just shift money. Take it away from Georgia, give it to Illinois or Michigan. We are going to switch to a national rate so they will take money away from Michigan and Illinois and give it back to Georgia.

You begin to wonder whether a national association can do anything with the situation.

WEEKS:

You mentioned before that there is a time comes when you can do something. I think if you keep talking until that time comes...

OWEN:

You know that door will open. Right.

WEEKS:

Maybe that day will come when you can do something.

Your regional staff members don't necessarily have to be from that region then, do they?

OWEN:

No, no.

WEEKS:

Are they mostly Washington people?

OWEN:

Well, they are Washington people who are just assigned to a region.

WEEKS:

Because you want people who know their way around.

Where does the president come in now? I know that George Bugbee was distastefully occupied in lobbying for Hill-Burton. He tells everybody he was not a lobbyist, although he had to register as one. But at heart he was not a lobbyist. Crosby didn't like to appear in Washington either, did he?

OWEN:

No, he did not. That's correct. Alex did.

WEEKS:

Alex loved it, didn't he? In fact he lived there part-time.

OWEN:

He lived there part-time, that's right. It was a good thing for him to do because Kenny had been fired, so to speak, and Lee, who knew his way around but did not like being a good front man for the Washington office. Alex was ideal for that. So Alex, by being down there, was very helpful in that period of time. When he had a Washington staff who was not happy at testifying he did a great job.

WEEKS:

Covering all the territory.

When did McMahon appear? I mean how often does somebody have to appear before a committee?

OWEN:

It depends on the time of the year. I have testified as many as three times in a week. Budget, Committee on Health, AIDS, OSHA, you name it. I, probably in the spring and in the fall, would average once a week. When I came to Washington, Alex asked me to testify. Alex, I think, had been doing it for five years or six and decided that was enough. He had had it. It's fun at first, but it can be old stuff.

WEEKS:

He did do less after you came then?

OWEN:

If I saw Alex once a month in the Washington office it was the exception, but that was part of the deal that we had. When I came to AHA, one of the big questions in my mind was, I had been running the New Jersey Hospital Association for nineteen years, I reported to a lot of boards, but, strictly responsible to only boards of trustees. To give that up and go back and

report to somebody, work for somebody again, I didn't know whether my ego could take it very honestly. So I had a long talk with Alex. That was the second time he had asked me to come to Washington. He had asked me to come when Lee left. I said no, because the kids were still in high school. The second time I told him okay, but I've got to know how we work. He said, "Look, you run Washington. That's your job, your baby, you do it."

I said, "Okay, as long as we've got some way that we keep track of one another, and I really don't want to run out to Chicago every week."

We had an extremely good working relationship. He would come to Washington occasionally, sometimes I wouldn't even see him. He would come in for other meetings in Washington, but it had nothing to do with his advocacy or the Hill. He would be there for a meeting with Jim Sammons or Department of Defense, or other national meetings.

WEEKS:

I'm glad you cleared that up.

OWEN:

In the four years that Alex and I worked together, I think he only testified once that I can remember.

WEEKS:

Is that right?

OWEN:

Yes. Once we appeared together and maybe that was the only time. I don't think he ever testified after I got there.

WEEKS:

Did you ever bring in anyone from a state association?

OWEN:

Yes, I would bring in people every once in a while, depending on what the subject was. Maybe a hospital administrator, maybe a trustee. For instance, a couple of months ago there was a hearing on unrelated business income tax and I brought a lawyer who was a trustee from Cleveland to come in and testify with me. We had one on AIDS here two or three weeks ago, we brought a nurse from Fairfax Hospital to come in and testify. They have a good program. We've brought in small hospital administrators from Alabama, from North Carolina. We've brought in teaching hospitals from around the country -- from Chicago, from California. I try to bring in people in addition to my own testimony.

WEEKS:

Doesn't this also strengthen your ties with the state associations?

OWEN:

The ties with the members more so than the state associations.

WEEKS:

Members see members doing something.

OWEN:

You have to be careful in doing it because they have a tendency to only know their own hospital. When Congress is looking for a big picture, one hospital isn't enough. So, you have to know what it is that the congressman is looking for. If he is looking for something that is going to be what is happening in the field in general, then that is usually where I play the role. If he wants two or three hospital people who know what is happening on the firing line, then we bring them in. I think it works out very well. We usually know the committee and we know the people on the staff.

WEEKS:

Did we say enough on the tax on unrelated income?

OWEN:

The tax on unrelated income I don't think is a big issue. The big issue, I think, is on the whole tax structure, the unrelated business income is being taxed in most cases in hospitals. But what Congress is facing right now is there are 834,000 non-profit organizations that pay no taxes and their income this past year was $359 billion, exclusive of hospitals. Now if Congress could get ten percent of that money they would have $35 billion more for debt reduction. I think pressure is going to be on our non-profit tax exemption and all other non-profits.

WEEKS:

There hasn't been anything done federally about taxing -- some of the employers, I believe, have a clause in their insurance programs whereby they pay to their employees some money if they don't use health services. The question has come up whether that should be taxable.

OWEN:

Yes. Is it income?

WEEKS:

Then also there has been, I think in two or three states, Blue Cross surplus, additions to surplus that is untaxable. Do you have any feeling that there is going to be a move on the feds in this direction?

OWEN:

Oh, yes. It has already started. Blue Cross now is taxed.

WEEKS:

Federally?

OWEN:

Yes. That just happened last year with the tax reform act. But there has already been a bill in to tax hospitals' interest income on endowment, for instance, and other savings. That was defeated. It is going to happen. The question is how long will we be able to withstand it. There is definitely a move to try and tax non-profits. That does not mean necessarily that they will take away the 501 (C)3. In other words, they may tax your income but may still let you receive gifts to a certain extent.

WEEKS:

I noticed last night when I watched Bush announce his candidacy he again made a statement, "I am not going to raise taxes."

OWEN:

That's right.

WEEKS:

But, of course, he may not have the decision.

OWEN:

That's part of it. They don't want to generally raise taxes. They see all that tax-free money out there and they would like to tap into it. But the biggest problem I think is going to come from the state legislatures. Utah has already passed a law to tack real estate taxes on non-profit hospitals that don't give a certain amount of free care. Minnesota defeated a bill just like it. Pennsylvania has an unrelated business income tax proposal that they are talking about. It is a big issue coming up.

WEEKS:

So expect some taxes even if they aren't new -- untaxed monies are now being taxed.

Have you had a chance to work with Carol McCarthy yet in this job?

OWEN:

Yes. She has been with AHA two years.

WEEKS:

Has it been two years?

OWEN:

She took over in June 1986, so it has been one year and a half.

WEEKS:

I was wondering if she is indicating any desire to appear in Washington herself.

OWEN:

She appeared once for a committee hearing. It was an unfortunate experience, not her testimony, but the chairman, Mr. Stark from California, got a little bit upset at her and created somewhat of a problem by saying the testimony was useless and was worth nothing. That created somewhat of a disturbance. What I am hoping is that we can find a House committee or Senate committee to get her back on a more positive note. She is certainly not pressing to take over testifying in my place, but I would have no problem if she did. The advantage is if you are there all the time, you get to know the people, you know what it is they are looking for -- you can kid with them or you know when they don't like to joke, you know what they like to hear, you know what their favorite topic is and when you know that you can kind of lead them. The kind of thing that Ed Crosby didn't like to do.

WEEKS:

Sometimes we hear criticism of AHA in general, it's not the Washington office particularly but that AHA as an organization reacts more than it acts.

Would you call that fair?

OWEN:

Yes, I think that is probably true. The problem is when you act you run the risk of losing half your members because you are out in front. As an example, where should the AHA be in the whole matter of testing for AIDS? Should we be out in front and leading the pack saying that all patients should be tested for AIDS? Surgeons would love that. On the other hand, if we wait and react to the field it will probably take us another year to decide whether we believe in testing or not. So I think it is a gamble we have to make. But you are always going to have a third of your hospitals who aren't going to like what you do if you get out in front of them. You are going to have two-thirds who are not going to like it if you stay too far behind.

WEEKS:

In other words, you are gathering information before you make the decision. So you are in the process until you see the right point to make a decision.

OWEN:

The Washington office is always in the unenviable position of having to make policy sometimes very quickly, sometimes sitting in a congressman's office when he says this is what he wants to do, will you go this way or that way? You haven't had a chance to go back and test it out in the field, so you say go this way. And you hope you are right. That's the risk you take. That, to me, is not reacting. That's acting.

The argument came up about capital. I said to a number of hospitals, "How do you want to go on capital?" Nobody could agree, so they said, "Do the best you can, Jack." I know that whatever comes out they are going to

ask, "Is that the best you could do?"

WEEKS:

In the meantime, when you are making a snap decision like that you are drawing on all these thirty-one years of experience too. It isn't as though you were just approaching it.

OWEN:

And you know pretty much in the long run what is going to be best for the institution.

WEEKS:

I would like to touch a second or two on some personalities. A man I never met, and who is now dead, Vane Hoge. He was in your office, I believe.

OWEN:

Yes, he was a very good friend of Ken Williamson's. Vane also came out of the public health system. A very, very nice man. Quiet, laid back, but very effective. Especially in the area of Medicare and the start of what was happening in regards to how the Medicare and Medicaid programs were going. He was a good friend of Wilbur Cohen. Along with Alanson Willcox, who was at the AHA Washington office the same time as Kenny, and Vane Hoge.

WEEKS:

The first time I have reference to him was Hill-Burton, when he was sent by the Public Health Service, I believe, to the University of Chicago to take the course in hospital administration so he could be a good advisor when they were developing Hill-Burton -- to the different commissions and things that preceded Hill-Burton.

I have heard George speak very kindly of Michael Lesparre.

OWEN:

Yes. Mike is free-lancing now. He took early retirement. He made Washington Memo into what I considered to be a first class publication in the Washington area. Mike was with the AHA for over thirty years.

WEEKS:

George spoke very highly of him. He said he didn't want to live in Chicago.

OWEN:

That's correct.

WEEKS:

That's why he was always out East.

OWEN:

He didn't want to leave New York, but Kenny finally talked him into coming to Washington in charge of the publications for us.

WEEKS:

You just mentioned that Mike Lesparre came back to New York.

OWEN:

Mike was in New York. He was running the office in New York and he did communications work for Hospitals magazine. Then Kenny wanted him to come to Washington to do the monthly communications in Washington. Mike really didn't want to come to Washington, but after he got down there he found he loved it very much. He has been a fine employee for the AHA over the years.

WEEKS:

We mentioned Alanson Willcox before. I believe he has passed away, hasn't he?

OWEN:

Yes, I think Alanson is gone. He and Wilbur Cohen were responsible for the writing of the Medicare act. Certainly Alanson Wilcox was involved in a lot of the regulations that came out of Medicare. He worked for the AHA for a while as well. He left again when the administration changed after Medicare was in and Nixon came in.

WEEKS:

I come across the name Anna Rosenberg many times. In fact, I tried to set up an interview with her about a week or two before she died, maybe a month. I was asked to call back. They said she wasn't feeling well. She died shortly after that. She was an advisor to Crosby and McNerney.

OWEN:

She was PR, public relations advisor and she was well known in Washington circles -- especially with President Roosevelt.

WEEKS:

She had a subordinate cabinet post with him.

OWEN:

That's right. Ed Crosby was very impressed with her. Walt McNerney and Ed both used her as the AHA and Blue Cross Association public relations person.

WEEKS:

I'll just go quickly over some of these things.

Alphonse Schwitalla of the Catholic Hospital Association. I never met him, but he was a very strong character apparently. He made a statement one time that he was against the Washington office. He thought the Catholic Hospital Association representative in Washington should be sufficient. That

the AHA didn't need their own office.

OWEN:

I don't know him.

WEEKS:

Miles Hardie.

OWEN:

Miles Hardie of the International Hospital Federation?

WEEKS:

Yes.

OWEN:

Miles is a very likable, kind person.

WEEKS:

I interviewed him when he was here about two months ago. Somewhere I have a note that your office had some special duty for the IHF.

OWEN:

Yes, that's correct. We are the Washington office of the International Hospital Federation. I am the director of the Washington office of the Federation -- for whatever that's worth.

WEEKS:

I think he has retired now.

OWEN:

Yes.

WEEKS:

He should have in the last few months.

You have done some teaching I see. Princeton, Rider, Rutgers.

OWEN:

Yes. Mostly lecturing.

WEEKS:

You are a member of the Robert Wood Johnson Foundation board. That foundation must be the biggest one in the field now, isn't it?

OWEN:

I think the Hughes Foundation may surpass it when they get it all straightened out, but it is the biggest one in the health care field at the present time. It is over a billion dollars.

WEEKS:

We talked about Stanley Nelson and Al Snoke. You mentioned Bob Cathcart. George Graham. I never have gotten to know George. I have talked to him on the phone.

OWEN:

George is a really fine fellow. Ellis Hospital in Schenectady for many, many years. Very active in the AHA. He was chairman of the personnel committee back many, many years ago when I was running that committee. He moved up through the chairs of the AHA, on the board, and then became president-elect.

WEEKS:

He still lives in Chicago?

OWEN:

No, he moved. He is back in Schenectady. Just within the past two or three months.

WEEKS:

Bob Sigmond of course you know.

Let's talk about the future. The role of the federal government.

OWEN:

Okay. There are some people who think the federal government is going to back out of health care and turn everything over to the market and competition. I am not one of those. I think the federal government is going to play a bigger and bigger role in what happens in health care. The dollars that are controlled under Medicare and Medicaid, which are almost fifty percent of hospital revenues today and are going to be bigger tomorrow, are just too great politically to let go. Congress isn't going to let go of them. I think we are headed, very honestly, toward some kind of a rate-making device that is going to be similar maybe to what New Jersey had, maybe it will be done state-by-state with each state getting a chunk of Medicare dollars and they are going to have to make it last within the state, both for doctors and hospitals. I don't see the federal government getting out of the picture at all.

WEEKS:

DRGs for all. Do you think this is coming?

OWEN:

Yes, I do. I don't think the voucher system that everybody in this administration talked about is going to be the answer. I think we are going to have DRGs for a long time. They are going to get more sophisticated. They'll have a coefficient of variation, they'll have a severity index or they will have something. But the more sophisticated it becomes, the more necessary that you have a commission or an appeal mechanism because when it's gross, you can live with that gross figure if it is high enough and nobody cares about the fine points. But when you get down to refining it, and the

prices are so low then you have got to have some of the fine points. The only other thing that would change my thinking is if we said the DRG system is going to give hospitals a basic rate and they go to the patient for the difference above that basic rate. Logically it makes sense, if you had a catastrophic plan on top so that a patient only had to pay within a corridor. Have a basic rate, have a corridor of maybe two to five thousand dollars and above that get catastrophic coverage. Let hospitals compete within this two to five thousand dollar corridor. But I don't think politically you can sell it. That's the problem.

WEEKS:

The HMO picture. I wonder what's going to happen with mergers and closures and changes, and whether there ever will be one or more national networks.

OWEN:

One national network of HMOs? I don't think so. I think there will be lots of them.

WEEKS:

Blue Cross is trying, you know.

OWEN:

Oh, I know. The problem with HMOs is the problem with anything else. With the Part B portions of Medicare going up so high all of a sudden they are looking at it as hard as they look at Part A. It was only a question of time. You can't move everybody out of the hospital, take care of them outside the hospital and not expect the price to go up, because the one thing we know for sure is that the total dollars being spent on health care have not abated at all. It is still going up just like it always did. It's just that we keep

re-distributing it. The problem right now is that HMOs are having to raise prices -- you know HCFA has given them a thirteen percent increase this year, but a lot of HMOs are dropping out of the Medicare program. If they don't get a decent rate, more will continue to drop coverage.

WEEKS:

Technology enters into this money picture too. We are getting much more technology now for examination. If you go into an examination they give you more x-rays. Our son was in the hospital for a checkup after his operation. It was $600 for x-rays. Not any other kind of treatment. It seems to be a lot of money.

OWEN:

Just diagnosis. Yes.

WEEKS:

I don't know how we are going to handle technology.

OWEN:

I don't know. We've got a bigger problem and that is what is going to happen with AIDS. If what everybody says is true, it is going to grow geometrically. We are going to have practically all of the patients in our big city hospitals as AIDS patients. And with no hope of ever surviving beyond maybe getting out of the hospital.

WEEKS:

What is amazing to me is the evident size of the gay community. I had no idea that it was as prevalent.

OWEN:

They were all in Washington over the weekend. There were hundreds of thousands of them.

WEEKS:

I don't know why they would want to be so recognized. Just the recognition fact was being booted about even before AIDS became known, before we put the word in our vocabulary.

So you don't think national health insurance is coming?

OWEN:

Well, no, I don't think it's coming because we can't afford it. I think we'll get a different kind of universal coverage. We'll have mandated health insurance before we get national health insurance. Congress will force the private sector to become part of it. If you look at Senator Kennedy's bill for mandated health insurance you can see what I mean. What kind of position do we take on that? Logically, we want more money for indigents, we want all persons who work covered with health insurance. How can we be opposed to mandated health insurance? We've got to be for it. So, we are for mandated health insurance, but if you as an owner of a business must buy health insurance and it must be at a certain level and you think the hospitals are charging too much, you are going to want them controlled, aren't you? So we are saying...

WEEKS:

May be the back door to control.

OWEN:

That's right.

WEEKS:

Then another thing, there will be exemptions of employers of fifteen or less, or eighteen or less, so there are going to be still millions that won't be reached.

OWEN:

They are talking now about something like five or six, which gets in everyone except the mom and pop store. One way to do it would be through raising the minimum wage. If they would add forty cents an hour to the minimum wage and instead of adding the forty cents an hour to a pay check, buy health insurance with it, basic health insurance. That would cover it. Then you wouldn't have to worry, even the small employer would still be covered. So instead of five dollars an hour minimum wage you would have four dollar and fifty cents wage and forty cents of health insurance.

WEEKS:

But then we still have the big question of how we are going to compete against Asia -- Asian labor.

OWEN:

That's right. But you are going to pay out five dollars in minimum wage anyway. The employer is going to lose five bucks. The question is: do you want to lose five just in cash or lose four-fifty in cash and fifty cents for health insurance. And, if you are already buying health insurance then you've got to say I'll stay at the four-fifty because I am already providing health insurance.

WEEKS:

I wonder what is going to happen when both the husband and wife are working and...

OWEN:

Coordination of benefits. American Airlines and Chrysler have endorsed mandated health insurance. The Washington Post Sunday paper quoted American Airlines as saying we are tired of subsidizing Continental Airlines employees

in the hospital, and letting them beat us on the price of tickets because they don't have to pay for health insurance. Chrysler says we are tired of paying for other people's coverage too. Somebody has to pay for it.

WEEKS:

Do you see any way that the old aged and the indigent and the disabled can receive good care for the rest of their lives? We have been talking about the aged, over sixty-five, but there are a lot of disabled people out there that need long-term care too. I don't know if Medicare is taking care of all the indigent. I don't suppose it is.

OWEN:

The mandated health insurance program is not a bad idea in the long run, from a standpoint of the person, patients, involved. In addition to that we need some kind of catastrophic, not catastrophic inpatient, but catastrophic nursing home or home health care. That's really where the drain is going to be as we get older. It's the drain that comes over a period of time. The only way we are going to do that is to start now and to build up some kind of health insurance policy that a young person will pay for, very minimal because if you start paying when you are twenty the premium is small. The problem is nobody wants to start buying this insurance until they are sixty-five. That's too late.

WEEKS:

I answered an ad and got the rates on it. It was quite high. I have forgotten, but it was seven or eight hundred dollars a year. It has a limited coverage. I mean even if you went on paying this seven or eight hundred dollars a year, the company would never get any profit out of the deal. It has to begin, as you say, almost at birth.

OWEN:

But why not think about doing that as part of the mandated health insurance package. If you put it in for somebody who is twenty years old, just going into the market place, and say you are going to need this when you are seventy. He's not going to buy it. I could say it to my son, "You had better start saving for the time you are seventy." He would say, "You've got to be kidding." But if it were part of his life insurance or pension plan he wouldn't even miss it.

WEEKS:

When you get to be eighty like I am and you find people are holding your arm and watching the traffic for you. If that age is mentioned to a young person of twenty, we'll say, it doesn't seem possible that you are still alive and kicking.

Is there anything that you would like to add to this interview? Some wisdom that you haven't already

OWEN:

I think we have pretty well covered it. I think the real problems that national associations are going to have, not only the American Hospital Association but all of them, is that we have had a tendency to group ourselves around lesser than national organizations -- we have our own interests. National magazines have been suffering. Everything national has been suffering. So I think we've got a real problem at the AHA to maintain our membership. If we can take the high ground and only look at conceptual issues like what is it we want to see in catastrophic health coverage and other such issues, then I think we've got a chance of keeping people together. Once that conceptual dream is realized it will probably be broken up and it's going to

be done by the small groups.

WEEKS:

I have noticed with interest the change in Hospitals magazine over the past few years. There are no longer any how to do it articles in there.

OWEN:

That's right.

WEEKS:

I guess they are getting more towards either conceptual or news, or both.

OWEN:

Hospitals are so much more sophisticated. It used to be that you could hire somebody who is better than anybody in the hospital as a professional. That's not true any more. An association can't even afford to pay them what the hospital does.

WEEKS:

When you stop to think of how many graduates we are turning out of graduate programs every year, two or three thousand it must be. I am beginning to wonder are we going to be able to place all of these people. I was told by somebody on one of the faculties, "We don't even bother to place them any more. That's up to them." At Michigan, when I was still there, we felt good when we got everybody in the class placed. Everybody had a job. Then we also had an informal employment office. Anybody who was a graduate from our school, no matter how many years later, if he wanted to make a change he would call up and talk with John Griffith or somebody in the office and we would start looking around for him.

OWEN:

It's what we talked about earlier today, Ray Brown calling and saying

come down here and interview. I can't imagine that happening at this stage in the game.

WEEKS:

It's been a pleasure talking with you.

Interview with Jack W. Owen

Ann Arbor, October 13, 1987

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