

HOSPITAL
ADMINISTRATION
ORAL HISTORY
COLLECTION

Robert M. Sigmond

Part 2



ROBERT M. SIGMOND
In First Person: An Oral History
Part 2

American Hospital Association
Center for Hospital and Healthcare Administration History
and
Health Research & Educational Trust

2009

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

ROBERT M. SIGMOND

**In First Person: An Oral History
Part 2**

**Interviewed by Kim M. Garber
On August 8, 2008**

Edited by Kim M. Garber

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CHRONOLOGY

- 1920 Born June 18, Seattle, WA
- 1941 Pennsylvania State College, State College, PA
BA degree
- 1941 Married June 29 to Barbara Cohen of Chester, PA
Children: Alison (1947), Laurence (1951)
- 1942 Pennsylvania State College, State College, PA
MA degree
- 1942-1945 US Air Forces, War Department, and the War Labor Board
Various civilian wartime assignments
- 1945-1946 Governor's Commission on Hospital Facilities, Standards, and
Organizations, Philadelphia, PA
Research Associate
- 1946-1950 Hospital Council of Philadelphia, PA
Research Associate
- 1950-1955 Albert Einstein Medical Center, Philadelphia, PA
Assistant to the Executive Vice President and Medical Director
Also Assistant Director and Acting Director of the Center's Northern
Division
- 1952-1954 National Commission on Financing of Hospital Care, Chicago, IL
Director of Fiscal Studies
- 1955-1964 Hospital Council of Western Pennsylvania, Pittsburgh, PA
Executive Director
- 1955-1968 University of Pittsburgh, Graduate School of Public Health, Pittsburgh, PA
Adjunct Professor
- 1964-1968 Hospital Planning Association of Allegheny County, Pittsburgh, PA
Executive Director
- 1968-1975 Albert Einstein Medical Center, Philadelphia, PA
1968-1970 Executive Vice President for Planning
1971-1975 Executive Vice President
- 1968-1976 Temple University, Philadelphia, PA
Adjunct Professor of Health Administration
- 1976-1977 Blue Cross Association and Blue Cross of Greater Philadelphia, PA
Consultant

CHRONOLOGY (continued)

- 1977-1996 Blue Cross and Blue Shield Association, Chicago, IL
Advisor on Hospital Affairs
- 1981-1985 Community Programs for Affordable Health Care, Chicago, IL
Director
- 1985-1987 Temple University, School of Business Administration, Department of
Health Administration, Philadelphia, PA
Scholar in Residence
- 1989-1994 New York University, Robert F. Wagner Graduate School of Public Service,
New York, NY
Adjunct Professor
- 2001-2004 Drexel University, School of Public Health, Philadelphia, PA
Senior Advisor to the Dean
- 2004-present Thomas Jefferson University, College of Graduate Studies, Master of Public
Health Program, Philadelphia, PA
Inaugural Senior Scholar
- 2005-2007 City of Philadelphia, PA
Senior Advisor to the Health Commissioner
- 2005-present Health Research & Educational Trust, Chicago, IL
Walter J. McNerney Fellow

MEMBERSHIPS AND AFFILIATIONS

Academy for Health Services Research and Health Policy
Member

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

American Association for Health Planning
Secretary-Treasurer and Member, Board of Directors

American College of Healthcare Executives
Life Fellow

American Hospital Association
Chairman, Committee on Areawide Planning Agencies
Chairman, Council on Research and Development
Honorary member
Life member
Member, Council on Blue Cross, Financing and Prepayment
Member, General Council

American Public Health Association
Fellow
Member, Committee on Racial Discrimination
Member, Subcommittee on Community Planning

Appalachian Regional Commission
Member, Health Advisory Committee

Association of American Medical Colleges
Member, General Assembly

Association of Areawide Health Planning Agencies
Member, Board of Directors

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

Blue Cross of Western Pennsylvania
Member, Board of Directors

City of Philadelphia
Member, Nonprofit Contributions Advisory Board

Coalition for Nonprofit Health Care
Member, Research Advisory Council

MEMBERSHIPS AND AFFILIATIONS (continued)

Community Hospital-Medical Staff Group Practice Program
Chairman, National Advisory Committee

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

Delaware Valley Hospital Council
Member, Executive Committee of the Forum

Dorothy Ridcr Pool Health Care Trust, Allentown, PA
Trustee

Group Health Planning, Inc.
Member, Board of Directors

Health Issues Policy Group
Member

Health Research & Educational Trust
Chairman, Hospital Advisory Committee
Member, National Steering Committee, Community Care Network Project

Health Services Research
Member, Editorial Board

Health Systems Agency of Southeastern Pennsylvania
Member, North Philadelphia Sub-Area Council

Holy Redeemer Hospital and Medical Center, Meadowbrook, PA
Director and Member, Executive Committee

Hospital Association of Pennsylvania
Chairman, Council on Administrative Practice
Member, Council on Planning
Member

Hospital Council of Western Pennsylvania
Public Representative

Indian Health Service
Member, Health Programs Systems Center Advisory Committee

Inquiry
Editorial Board

Integrated Mental Health, Inc.
Member, Board of Directors

MEMBERSHIPS AND AFFILIATIONS (continued)

Journal of the American Public Health Association

Editorial Board

Medical Care

Editorial Board

Mercy Health Corporation of Southeastern Pennsylvania

Trustee

Milbank Memorial Fund

Technical Board

National Center for Health Statistics

Member, Panel of Advisors

National Commission on Community Services

Member, Advisory Committee on Community Action Studies

National Committee on Vital Statistics

Member, Subcommittee on Epidemiological Uses of Hospital Data

National Institutes of Health

Member, Initial Review Committee, Division of Regional Medical Programs

New York University

Chairman, National Advisory Committee, Hospital Community Benefit Standards Project

Northland Health Group, South Portland, ME

Member, Board of Directors

Pennsylvania Mental Health Association

Member, Committee on Development

Member, Committee on Insurance

Pennsylvania Public Health Association

Member, Executive Committee, Medical Care Section

Philadelphia Health Access Network

Member

Philadelphia Health Management Corporation

Chairman, Goals and Priorities Committee

Member, Board of Directors

Member, HMO Management Council

MEMBERSHIPS AND AFFILIATIONS (continued)

Philadelphia Neighborhood Network
Member

The Philadelphia Plan
Member, Board of Directors

Philadelphia Unemployment Project
Member

Physicians for Social Responsibility
Member

Pittsburgh Public Schools
Member, Health Advisory Committee

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

Sisters of Mercy Health Corporation
Trustee

South Philadelphia Health Action
Vice Chairman

University of Pennsylvania
Member, National Advisory Committee of the Leonard Davis Institute on Health
Economics of the Wharton School

Urban League of Pittsburgh, Inc.
Member, Health Committee

Western Pennsylvania Comprehensive Health Planning Group
Member, Steering Committee

Western Pennsylvania Regional Medical Program
Member, Steering Committee and Advisory Committee

AWARDS AND HONORS

- 1969 The Dean Conley Award of the American College of Hospital Administrators for the best paper in the hospital literature
- 1975 Trustees Medal, Albert Einstein Medical Center, Philadelphia, PA
- 1976 Edwin L. Crosby Fellow to the Nuffield Provincial Hospitals Trust, London, England
- 1981 Corning Award for Exceptional Contributions to Hospital Planning by the Society for Hospital Planning
- 1981 The William B. Woods Memorial Lecture, Park Ridge Hospital, Rochester, NY, and again in 1991 and 2001
- 1984 Award of Merit, American Association for Hospital Planning
- 1985 The Michael M. Davis Lecture, University of Chicago, Chicago, IL
- 1985 The C. Rufus Rorem Health Service Award
- 1986 Clifford C. Thorne Lecture, State University of New York, Albany, NY
- 1992 Robert Tonks Lecture, Northeast Canadian American Health Council, Portland, ME
- 1993 Distinguished Service Award, Hospital Association of Pennsylvania
- 1995 Distinguished Service Award, Ohio State University
- 1996 The Andrew Pattullo Lecture, Association of University Programs in Health Administration
- 1996 Self-Actualization Award of Merit, Health Policy Issues Group
- 2001 Inducted into the Health Care Hall of Fame
- 2002 Golden Apple Award for Teaching Excellence, Drexel University School of Public Health
- 2008 Self-Actualization Award of Merit, Health Policy Issues Group (second time recipient)

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- Sigmond, R.M. The notion of hospital incentives. In: *Health Services Management Readings and Commentary*. Ann Arbor, MI: Health Administration Press, 1978.
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- Unger, W.J. Can new capitation experiment cut hospital costs? [Interview of Robert M. Sigmond]. *Hospital Financial Management*. 10(12):22-26, Dec. 1980.
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- Sigmond, R.M. Is there anything unique about planning by hospitals as public service organizations? In: *Future of Health Planning: Report of a National Invitational Conference*. Chicago: American Hospital Association, 1981.
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- Sigmond, R.M. Cooperation, competition, regulation: health care system's balancing act. *Hospital Progress*. 62(3):32-35, 62, Mar. 1981.
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- Sigmond, R.M. Free care – who pays? In: *Proceedings of the Trustee Institute of the Council on Continuing Education*. Alexandria: NACHRI, 1983.
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- Sigmond, R.M. Health care of the poor: on reshaping the marketplace. *Health Progress*. 67(10):96, Dec. 1986.
- Sigmond, R.M. *Testimony to Blue Ribbon Panel on Physician Involvement in Governance and Management*. Farmington Hills, MI: Sisters of Mercy Health Corporation, 1987.
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- Sigmond, R.M. New guidance on hospital ethics policy. *Trustee*. 41(9):24, Sept. 1988.
- Sigmond, R.M. C. Rufus Rorem obituary. *Journal of the American Medical Association*. Nov. 1988.
- Sigmond, R.M. The future of community benefit standards for hospitals. In: *Proceedings of the Thirty-First Annual George Bugbee Symposium on Hospital Affairs*. Chicago: University of Chicago, 1989.
- Seay, J.D., and Sigmond, R.M. Community benefit standards for hospitals: perceptions and performance, the future of tax-exempt status for hospitals. *Frontiers of Health Services Management*. 5(3):3-39, Spring 1989.
- Seay, J.D., and Sigmond, R.M. Hospital governance and the need for community benefit standards. *Trustee*. 42(12):6-7, Dec. 1989.
- Sigmond, R.M. A catalyst for change. *Health Progress*. 70(10):40-42, Dec. 1989.
- Sigmond, R.M. Hospital governance and healthcare reform, parts I and II. *The Governance One Hundred*. Winter, 1991 and Spring, 1992.

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- Sigmond, R.M. Community care networks and health care reform. *The Journal of Health Administration Education*. 12(3):353-371, Summer 1994.
- Sigmond, R.M. From charity care to community benefit. *Hospitals & Health Services Administration*. 39(2):141-142, Summer 1994.
- Sigmond, R.M., and Seay, D.J. In health care reform, who cares for the community? *Journal of Health Administration Education*. 12(3):259-268, Summer 1994.
- Sigmond, R.M. Capitation: it's older than you think. *Trustee*. 47(8):16-17, Aug. 1994.
- Sigmond, R.M. Who gets it? The grand designers face off against the incrementalists. *Hospitals and Health Networks*. 68(15):78, 80, Aug. 5, 1994.
- Sigmond, R.M. Back to the future: partnerships and coordination for community health. *Frontiers of Health Services Management*. 11(4):5-38, Summer 1995.
- Sigmond, R.M. Why aren't CEO salaries going down? *Trustee*. 48(9):24, Oct. 1995.
- Sigmond, R.M. Learning from the ghost of healthcare past. *Healthcare Forum Journal*. 38(6):14-19, Nov/Dec. 1995.
- Sigmond, R.M. Community assessment or action? From conflict to synergy. *Health Progress*. 77(2):64, Mar/Apr 1996.
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- Sigmond, R.M. 1996 Andrew Pattullo lecture: a vision of the role of health administration education in the transformation of the American health system. *Journal of Health Administration Education*. 15(1):43-69, Winter 1997.
- Sigmond, R.M. Making a real difference: beyond community service to community benefit. *Michigan Health & Hospitals*. 33(4):8-10, July/Aug. 1997.
- Sigmond, R.M. Beyond good intentions: accountability for community benefits. *Michigan Health & Hospitals*. 34(4):14-15, July/Aug. 1998.
- Sigmond, R.M. Community benefits are key: a common link for effective integration. *Michigan Health & Hospitals*. 34(5):42-43, Sept./Oct. 1998.
- Sigmond, R.M. Community benefit planning: the missing link in community health models. *Michigan Health & Hospitals*. 34(6):22-23, Nov./Dec. 1998.

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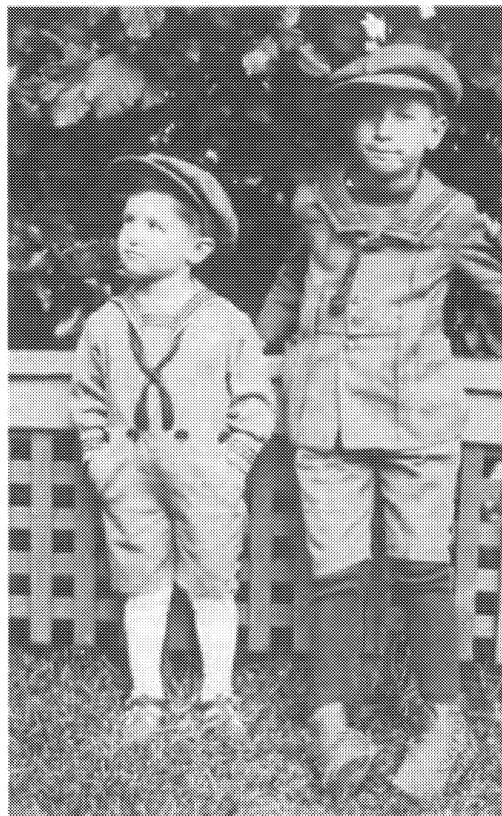
Sigmond, R. Why health system CEOs should support single payer. *HealthLeaders Media*, Dec. 17, 2007.

EDITED TRANSCRIPT

KIM GARBER: Today is August 8, 2008. I'll be interviewing Robert M. Sigmond as a follow-up to his earlier oral history interview conducted in 1980¹. While a student, Bob Sigmond became interested in economics and in local community affairs. His study of these subjects at Penn State soon led to a career dedicated to the health care field. Mr. Sigmond has served as the chief executive of Albert Einstein Medical Center in Philadelphia, as the executive director of three associations, as a senior advisor to the Blue Cross Association and as a university faculty member, among other positions. He is a prolific author. He has known many of the key figures in health care administration and policy since the Second World War. To set the stage, could you tell us what hospitals were like at the beginning of the 20th century?

ROBERT SIGMOND: Before I talk about that, let me point out that today, as you said, is the eighth day of the eighth month of the eighth year in the 21st century, so this a big "8" day. I'm doing this shortly after my "double-eight" birthday.

I wasn't actually there at the beginning of the 20th century but I was born in a hospital a few years later. At the time, only about half the people in this country were born in hospitals, in comparison with today when almost everybody is. The reason is that hospitals in the early part of the 20th century were making a significant transition in gaining the trust of physicians and their private patients. Until the invention of the steam sterilizer, which happened at the end of the 19th century, most people who could afford to pay for a physician would not go to a hospital because it was a very unsafe place. The hospital was essentially only for charity patients. There was a general feeling that I can remember as a child that if somebody was going to a hospital, they were probably going to die. Hospitals in the early part of the 20th century were transitioning because of the marked reduction of infections



Bob (left) and his brother Irwin. Photo courtesy Robert M. Sigmond.

due to the new emphasis on sterilized supplies and hand washing. The hospital was becoming the doctor's workshop instead of the home – where the surgeon operated on the kitchen table. Doctors were having their private patients come to the hospital, where they could provide services much more effectively than in the home.

¹ Weeks, L.E., editor. *Robert M. Sigmond in First Person: An Oral History*. Chicago: American Hospital Association and Hospital Research and Educational Trust, 1983. This document is in the collection of the Center for Hospital and Healthcare Administration History located at the American Hospital Association Resource Center.

That meant a real transition in financing, because up to that point few patients paid for their care, which took place in large ward accommodations. The hospitals, which were much smaller than they are today, were mostly financed by philanthropy, especially from board members who would contribute to keep their hospitals open. So in the early part of the 20th century, there was a transition to paying patients receiving more customer-sensitive private care, most frequently in semi-private rooms.

The whole field was expanding very rapidly and seemed to be in very good shape when the Great Depression began in 1929. Hospitals were in great trouble because they had grown to the point that now they were requiring significant money beyond philanthropy. Just prior to the Depression, as many as 60 percent of the patients were paying and the costs were rising rapidly. Suddenly that changed as middle class patients did not have the ability to pay. Most of the hospitals survived the Great Depression because their communities rallied around. Physicians closed up their offices when they couldn't afford to pay the rent and moved their practices into empty bedrooms in hospitals.

There was a need at that time for some more systematic approach to the financing of hospital care, as well as the financing of physician services. Both had been moving from the basic 19th century approach of paying for care when you got it, or contributing a couple of chickens or something. Financing was just beginning to move toward post-payment, which meant that the physicians and hospitals had to set up billing systems, a whole new development. But more important, there were the beginnings of prepayment, where the hospitals and physicians arranged for people to pay a small monthly amount while they were well, so that the money would be available to pay the hospital at the time of service.

GARBER: These early prepayment plans evolved into the Blue Cross concept?

SIGMOND: That's exactly right. The most important development beyond the steam sterilizer in the history of hospitals and medical care in this country was the formation in 1927 of the Committee on the Costs of Medical Care (CCMC). Blue Cross evolved from the work of the CCMC. This was formed because in the absence of prepayment arrangements, the costs of medical care were becoming extremely burdensome not just on poor people but on the middle class as well. So, the major national philanthropic foundations, except the Commonwealth Fund, funded the Committee on the Costs of Medical Care that spent five years studying the situation, finding out what were the possibilities for improving the health system and improving the financing. The foundation that didn't participate said they didn't need a study – they already knew what had to be done.

The Committee on the Costs of Medical Care, which started in prosperous times in 1927, ended in 1932 when times had totally changed, in the very depths of the Depression. They made five recommendations which shaped hospital and health care policy in the United States for decades:

- First, services should be paid for through some form of group prepayment.
- Second, so the services would be provided with high accountability for quality and least cost, they should be provided not only by physicians in individual practice but

primarily by organized groups of physicians associated with hospital medical staffs who would work together and who could employ and use subsidiary help so that a person could get effective, coordinated service as medical care was becoming more and more specialized and fragmented. So group payment and group practice – the CCMC staff discovered group practice, a unique American invention, out at the Mayo Clinic and some other places—were the two major recommendations.

- Third, they recommended expansion of educational programs not only for physicians and nurses but for subsidiary help who could more efficiently do a lot of the work that nurses and doctors were doing.
- Fourth, they recommended a vast expansion in public health, because they felt that a lot of the medical care would not be necessary with effective public health agencies helping people to lead a healthier life and creating healthier communities.
- Finally, they felt that every community should have some kind of a coordinating body so that the various independent hospitals and doctors, and other health care entities could be working together on a voluntary basis, and not be duplicating services unnecessarily.²

The major innovation, however, was the emphasis on group prepayment. Rufus Rorem³, along with Michael Davis⁴, were key CCMC staff people who discovered community-based prepayment plans springing up and visualized a network of such plans as a solution to the nation's crisis in financing a growing health care system. People were solving the problem in their own communities. Leaders realized that it was a lot easier for people to pay fifty cents or a dollar a month and not have to pay anything when they were sick, because payment of a bill of even a few hundred dollars was a major problem.

So Rufus Rorem took the lead in creating the Hospital Services Plan Commission at the American Hospital Association. Dr. Rorem became the first chief executive of what was to become the Blue Cross Commission. He helped to start almost all of the earliest Blue Cross plans.

² The Committee on the Costs of Medical Care published 28 reports in the period 1928 to 1933. The Committee's recommendations were published in: *Medical Care for the American People: The Final Report of the Committee on the Costs of Medical Care*. Chicago: University of Chicago Press, Nov. 1932 (reprinted in 1970 by the US Government Printing Office at the behest of the Department of Health, Education, and Welfare). The 1932 final report is in the collection of the Center for Hospital and Healthcare Administration History located at the American Hospital Association Resource Center. The recommendations can also be found in secondary sources such as: Weeks, L.E., and Berman, H.J.: *Shapers of American Health Care Policy: An Oral History*. Ann Arbor, MI: Health Administration Press, 1985, Appendix B.

³ While he was the Director of the Commission on Hospital Service at the American Hospital Association, C. Rufus Rorem, Ph.D. (1894-1988) wrote a short treatise describing the concept of group hospitalization: *Non-Profit Hospital Service Plans*. Chicago: American Hospital Association, January 1940. A few years later, Dr. Rorem revised this work as a second edition entitled: *Blue Cross Hospital Service Plans*. Chicago: American Hospital Association, Mar. 1944. Decades later, Dr. Rorem was interviewed for the *Hospital Administration Oral History Collection*. The transcription of his oral history and both of the Rorem reports can be found in the collection of the Center for Hospital and Healthcare Administration History located at the American Hospital Association Resource Center.

⁴ Michael M. Davis, Ph.D. (1879-1971)

Another great man named van Steenwyk⁵, who created the plan in Minnesota, also thought of calling the new national movement Blue Cross. He wanted a symbol that would combine medicine and religion and patriotism. He first thought of Red Cross, but that was taken, and then he thought of White Cross, but that was a shoe company. So that's how we got to Blue Cross, which was the only patriotic color left. As soon as Mr. van Steenwyk developed the Blue Cross plan in Minnesota, Dr. Rorem copyrighted "Blue Cross" in the name of the American Hospital Association. This gave the American Hospital Association control of the Blue Cross symbol, and of the standards which Dr. Rorem developed and managed.

GARBER: What were some of the problems that the early plans helped solve?

SIGMOND: I've mentioned the two major problems. One was that the hospitals needed money and they could not get enough money from philanthropy and patients to survive during the Depression. But they could get money from a third party that collected 50 cents a month from individuals and a dollar a month from families. Blue Cross provided a practical community approach to solving the financial problems of hospitals when the commercial marketplace and the government were not able to do so.

Second, many of the people who were now using hospitals during the Depression were not used to getting charity. They wanted to pay. But they didn't have enough money. So Blue Cross not only enabled hospitals to get paid, but also enabled people to avoid paying for care when sick.

GARBER: We've seen a decrease in the number of Blue Cross plans over the years. What caused that to happen?

SIGMOND: It was caused by the merger of plans – the merger of Blue Cross and Blue Shield plans and also mergers of plans in different communities and even states. These mergers were designed to take advantage of economies of scale and to deal more easily with national employers who eventually were paying the premiums on behalf of their employees, encouraged to do so by favorable income tax incentives. Rufus Rorem was opposed to geographic consolidation. For example, he thought that Michigan ought to have three Blue Cross plans: one for the Detroit area, because the way health care is organized in Detroit is much different from the northern region and the communities in central Michigan. He felt it very important that each Blue Cross plan reflect the culture of the community it served. He believed that community forces were very important not only in how health care is organized but in how people manage their health. So he was concerned that a Blue Cross plan covering multi-states, or even covering the whole state of Michigan, would get too much involved in the marketing and payment and not sufficiently involved in making sure that the plan and the financing that it provides was influencing how health care is organized. Based on his work with the CCMC, he visualized group *payment* and group *practice*, working together in the community interest. Working together in Detroit and working together in Muskegon are two quite different things, so he favored community control of community-based plans.

⁵ Elmer A. Van Steenwyk (1905-1962)

Over the years, the need to be competing with commercial insurance and the need to be dealing effectively with large corporations has led to mergers, which were supposed to have two benefits. One was economy of scale, but my own sense is that there's no great economy of scale by merging. For instance, in Pennsylvania the Pittsburgh plan and the Philadelphia plan are trying to get state approval to merge. Each is a multi-billion-dollar not-for-profit corporation now. To date there's been little evidence of economies of scale presented at public hearings.

The other reason for the mergers was that supposedly it was going to make it easier for the plans to tap into the capital markets. But again, that case has never been made to my satisfaction. Frequently, the merger movement was closely linked with another development that Dr. Rorem would have opposed – the shift from the Blue Cross plans all being not-for-profit organizations to a number becoming profit-making commercial organizations. For many of the chief executives of the plans, merging usually resulted in great advantage in terms of personal net worth in the distribution of the new company's stock. Nevertheless, with the reduction in the number of plans, there is still a Blue Cross or a Blue Cross-Blue Shield plan covering every inch of territory of the United States. Enrollment is at an all-time high.

GARBER: Would you discuss the relationship between Blue Cross plans and hospitals and how that relationship evolved over time?

SIGMOND: It started with a very close relationship. It had to be a close relationship since the insurance commissioners thought about Blue Cross as a form of insurance, and none of the plans had any reserves, a basic requirement of commercial insurance organizations to protect the subscribers. With all of the early plans, with no reserves, the hospitals guaranteed to provide the contracted services to subscribers, whether or not the plans had the money to pay. Now, the Blue Cross leaders and the hospitals who started these plans didn't think in terms of commercial insurance, they thought of it as *social insurance*. Social insurance is designed to cover bad risks. Insurance companies try to avoid bad risks.

What Blue Cross was all about was enabling people to be able to get hospital care without having to pay a bill at the time of illness. That included people who were high risks. In fact, because Blue Cross executives saw the plans as a community mechanism to connect people to needed care, many supplied hospital admitting offices with enrollment forms, allowing patients to join at the time of their hospitalization – an early example of open enrollment! By the end of World War II, Blue Cross was so successful that commercial insurance companies became competitors for carefully selected employed groups with lesser risks and therefore with lower premiums. Blue Cross was finding itself at a competitive disadvantage because their premiums reflected having the bad risks along with good risks, for Dr. Rorem insisted that premiums be set on a community basis.

That was a fundamental notion of Blue Cross at the beginning – that you don't set up a plan for a particular group of people who, because of their age or gender or other characteristics, you could make money with a lower premium than for the community as a whole. So, Blue Cross found that it was facing anti-social competition. If they kept losing the good risks, they would have to keep raising their premium, exposing more good risks to

loss, and on and on. Eventually many of the Blue Cross plans began to adopt variations of commercial insurance practices to protect their financial stability.

GARBER: Let's move to your experiences as an advisor to the Blue Cross Association. You sometimes referred to your desire to help Walter McNerney⁶, who was the head of the Blue Cross Association, save Blue Cross from itself. What did you mean by that, and were you successful?

SIGMOND: I think in my last comment you get a hint of what I meant by saving Blue Cross from itself – that some of the plans were becoming so divorced from the basic Blue Cross concept that it looked like the concept was being undermined by the plans. To respond to your question, I think it would be worthwhile if I go back to talk about my interest in Blue Cross, which actually goes back to the 1940s when I went to work for Rufus Rorem, who had just left the Blue Cross Commission. By that time, Blue Cross had 20 percent of the population signed up. It was the biggest membership group in the nation. In ten years, he had brought it to that state. He decided to move on because he was no longer the leader of a social movement. He felt that he was heading up a trade association of Blue Cross plans, many of which were really much more interested in their own financial stability than the basic value of the concept.



Bob and Babs Sigmond in college. Photo courtesy Robert M. Sigmond

So Dr. Rorem eventually left the Blue Cross Commission and went to his second love which was coordinated planning at the community level. You remember that was one of the other CCMC recommendations. So he came to Philadelphia to head up the Hospital Council, with the idea that he was going to demonstrate the feasibility of some of the CCMC recommendations in Philadelphia, and I went to work for him.

By that time, most of the Blue Cross plans had had enough of the stubborn leadership of Rufus Rorem. Although he was a Quaker, he was really quite vigorous in his own way. He was succeeded by leaders of the national organization who were not very aggressive or innovative. So, when any of the plans got into some kind of a problem and got little help from the national organization, they called Philadelphia. If they had an interesting problem, Rufus Rorem and I were on the next train out, because he didn't fly.

⁶ Walter J. McNerney (1925-2005) was interviewed for the Hospital Administration Oral History Collection in 1979 and 1980. The transcript of these interviews, entitled: *Walter J. McNerney in First Person: An Oral History*. Chicago: American Hospital Association and Hospital Research and Educational Trust, 1983, can be found in the collection of the Center for Hospital and Healthcare Administration History located at the American Hospital Association Resource Center. The complete archival *Papers of Walter J. McNerney* are also located at the Center for Hospital and Healthcare Administration History.

You might wonder—why did the Hospital Council people let us spend all that time out of town? The reason was that our Hospital Council was not a trade association. It was a tax exempt subsidiary of the Community Chest that had brought Dr. Rorem in to try to improve the efficiency of the hospitals so they wouldn't be such a drain on the Community Chest. You can imagine that many of the hospital administrators preferred that we were out of town!

GARBER: How did you become involved with Walter McNerney?

SIGMOND: Initially, I became one of Walt's mentors, after he contacted me while he was an administrative resident with O.G. Pratt⁷ at Rhode Island Hospital. Subsequently, I was involved with him while he was in Pittsburgh and later on when he set up the graduate program at the University of Michigan. At Michigan, I participated every year in a summer program that he organized for future chief executive officers of Blue Cross plans. The participants from the different Blue Cross plans were sent to Michigan for a month to be exposed to McNerney, me, and others who grew up with the CCMC. Largely because of this exposure, when Blue Cross was searching for someone to bring new vitality at the national level, McNerney got the job. From that point on, whatever else I was doing, I was reflecting my addiction to Blue Cross by beating on McNerney on every occasion to make sure that he was saving Blue Cross from itself. By that, I meant encouraging the presidents of the plans to focus on the fundamental goal of their organization, which was financing decent health care for the total population, not simply on improving their bottom lines and market share.

Eventually McNerney said, "Look, if you're that interested, why don't you quit your job as head of the Albert Einstein Medical Center and come work for me? And what I want you to do is start out by making a detailed study of the relationship between the plans and the hospitals, and come up with some useful recommendations." At that time, some of the plans were beginning to treat the hospitals as the enemy because the hospitals were requiring more and more money with little concern about cost containment. On the other hand, some of the plans really were still working too closely with the hospitals. There were other problems in terms of relationship with the hospitals, especially in the marketing efforts.

So I quit my job at Einstein. I didn't become a Blue Cross Association employee, but served as a paid advisor on hospital affairs for the Blue Cross Association, a position that I held for many years, with my office next door to his. I took with me a former student, Tom Kinser⁸, who was working with me at Einstein, and who subsequently became a top Blue Cross executive. We spent six months visiting a good many of the plans, quizzing them about their hospital relations. In 1976, the Blue Cross Association published what I like to call the Kinser-Sigmond Report, and other people call the Sigmond-Kinser Report⁹. Tom Kinser was very important in preparing that report.

⁷ Oliver G. Pratt

⁸ Thomas A. Kinser

⁹ Sigmond, R.M., and Kinser, T. *The Hospital-Blue Cross Plan Relationship*. Blue Cross Association, 1976.

The report described three kinds of relationships between the hospitals and Blue Cross plans. One was totally adversarial with Blue Cross wanting to pay as little as possible, the hospital wanting as much as possible – almost like a nasty labor-management situation. We called that the adversarial relationship. Then we found other plans in which there still was a very close relationship centering around how Blue Cross got started and not thinking entirely of Blue Cross as a source of money but understanding health service and financing as two sides of the same coin, a favorite McNerney expression. That was at the other extreme, which we called the interdependent relationship. In between, we found plans that really had what we called a straight business relationship, nothing adversarial, nothing special, just two organizations trading money for service.

We recommended that every plan be staffed effectively to have all three kinds of relationships at the same time. Ideally the plan would have an interdependent relationship with each hospital based on a shared vision and shared goals related to improving health services and the people's health. But you can't dance with somebody who doesn't want to dance. So we recommended that each plan should be staffed up and have programs to deal with hospitals depending on what the relationship was, but with the idea of always trying to move a hospital from an adversarial relationship to a business relationship and then on to an interdependent relationship whenever possible.

GARBER: What was the reaction to the Sigmond-Kinser Report?

SIGMOND: Very strange and unexpected. At that time, McNerney tended to be ahead of his Board of Directors on many issues. He was a real leader, maybe too much in this case, since he had never told the bosses that he had commissioned the study. When he published it as a Blue Cross Association document, much to his surprise and mine, there was an uproar. Key board members who were involved in adversarial hospital struggles about money interpreted our report as urging everyone to shift to an interdependent relationship with all of their hospitals as soon as possible. They insisted that the report be pulled back. Eventually the report was issued with a different cover, not identified with the Association. I actually have copies of the two covers in my files. That was one of the most traumatic times in my career. Some of the Plan executives really believed that the only way to deal with the hospitals was as an adversary, but McNerney and I went on to promote the broader concept in the report throughout plan land.

This was only one example of the tensions between McNerney and the plan executives that resulted in McNerney leaving BCA in 1981. McNerney's promotion of health maintenance organizations operated by the plans was another example. So, I had only a limited period of time, between '76 and '81 to be working so closely with McNerney.

GARBER: At the time that Walter McNerney did leave the Blue Cross Association, there was also a leadership change at the American Hospital Association.

SIGMOND: Yes. The head of the American Hospital Association at the time that McNerney came to Chicago to head up the Blue Cross Association was a very great man, Ed

Crosby¹⁰, a physician/administrator from Johns Hopkins who originally came to Chicago to head up the Joint Commission on Accreditation of Hospitals. Crosby and McNerney formed a very close relationship because they knew that there had to be some major national legislation about financing of health services at a time when Congress and the federal government were not ready for it and the American Medical Association seemed to be opposed to any change at all.

Crosby and McNerney recognized that the existing finance system could not support the requirements of the hospitals. There were just too many people that were too poor to be able to afford even a monthly premium from the competing Blue Cross Plans and commercial insurance. In addition, there was the increasing number of aged people who were insurance bad risks. Commercial insurance avoided the aged and McNerney's initiative to keep the Blue Cross Plans struggling to serve them was insufficient. Increasingly, older people supported by Social Security were having as much trouble paying for hospital care as the disadvantaged. The hospital system was at risk because the combination of patient payments, prepayment, insurance and philanthropy could not keep up with the demands on the system from two costly trends:

- The growing number of patients to be served who could not pay
- The growing cost of the new necessary services coming out of the research laboratories every year.

Without the leadership of the Crosby/McNerney partnership, I believe that Medicare and Medicaid would have been delayed for some years.

One of the important things that McNerney and Crosby worked on was the actual separation of Blue Cross from the American Hospital Association, where it had been located organizationally from the very beginning. You might ask why they would separate if they were working closer and closer together. Because both Crosby and McNerney felt that the image of Blue Cross being a part of the AHA just confused everyone in terms of how the financing system worked. It seemed more logical for them to be independent and then be able to more clearly define the kind of interrelationships that were in the public interest. Unfortunately, as the relationship between the two entities was being redefined, Ed Crosby suddenly passed away. There was some confusion as many did not understand that the separation was designed to strengthen the working relationships nationally as well as locally.

In any case, the relationship between the American Hospital Association and the Blue Cross Association remained very solid through the passage of Medicare. Nevertheless, the AHA Board of Directors rejected the recommendation from the search committee that McNerney succeed Crosby. Instead, they selected Alex McMahon¹¹, a leading Blue Cross Plan CEO whom McNerney had been grooming to succeed him at BCA.

¹⁰ Edwin L. Crosby, M.D. (1908-1972) was Executive President of the American Hospital Association from 1954 to 1972.

¹¹ John Alexander McMahon (1921-2008) was President of the American Hospital Association from 1972 to 1986. His oral history, Weeks, L.E., editor. *John Alexander McMahon in First Person: An Oral History*. Chicago, IL: American Hospital Association and Hospital Research and Educational Trust, 1987, is in the collection of the Center for Hospital and Healthcare Administration History, located at the American Hospital Association Resource Center.

In the process of developing the Medicare and Medicaid legislation, McNerney had promoted the innovative notion that Medicare would be administered for the government by competing intermediaries selected by each hospital. Because of the close relationship between Crosby and McNerney, 96 percent of the hospitals selected Blue Cross as the intermediary.

In more recent years, the relationship has again become more distant, mainly because of the growth of commercial insurance and the fact that the hospitals were entering into contractual relationships with some commercial insurance companies. Eventually, the federal government abandoned the intermediary relationship.

GARBER: Around this time, in the early '80s, was the time of the Voluntary Effort and that was something that you worked on.

SIGMOND: Yes. When Jimmy Carter was president, health care costs were going up at a very rapid rate and he felt that the hospitals were not taking sufficient leadership in keeping costs under control. He proposed price controls for hospitals. By this time, Alex McMahon was heading up the American Hospital Association. Alex McMahon took the initiative of bringing together the American Hospital Association, Blue Cross-Blue Shield, the American Medical Association, and national business and labor organizations in what was a voluntary effort among those organizations to attempt to contain the rise in health care costs sufficiently so that Carter's proposed legislative initiative for price control would become unnecessary.

Walter McNerney felt that it was very important to bring Blue Cross back into a more effective relationship with the hospitals. He assigned me full time to work with the Voluntary Effort, which then was headed up by a capable AHA executive, Paul Earle. I became his assistant and spent almost all of my time representing the Blue Cross Association with the Voluntary Effort, rather than on other Blue Cross affairs. The Voluntary Effort had a measurable impact on the rise in hospital costs.

GARBER: Was the Voluntary Effort successful?

SIGMOND: The Voluntary Effort was successful from one perspective, in that President Carter abandoned price controls on hospitals. It never even came to a vote and became a non-issue. So against my advice, the leaders of the Voluntary Effort declared victory and disbanded. This was not what either I or McNerney wanted to happen. We felt that the Voluntary Effort was an important beginning at getting the elements of the health system working together at the community level. We were just getting someplace when the leadership, not including McNerney, decided—well, we've done it; the legislative threat is gone. But McNerney and I saw the Voluntary Effort as the beginning, not the end of, something. But that was the end of the Voluntary Effort.

At that point, we got together with the Robert Wood Johnson Foundation, which wanted to support the continuation of the development of collaborative cost-containment initiatives at the community level. We put together a proposal for what became known as Community Programs for Affordable Health Care (CPAHC), a \$16.5 million program of the

Robert Wood Johnson Foundation. The co-sponsors were the American Hospital Association and the Blue Cross Association and I became the executive director of this initiative.

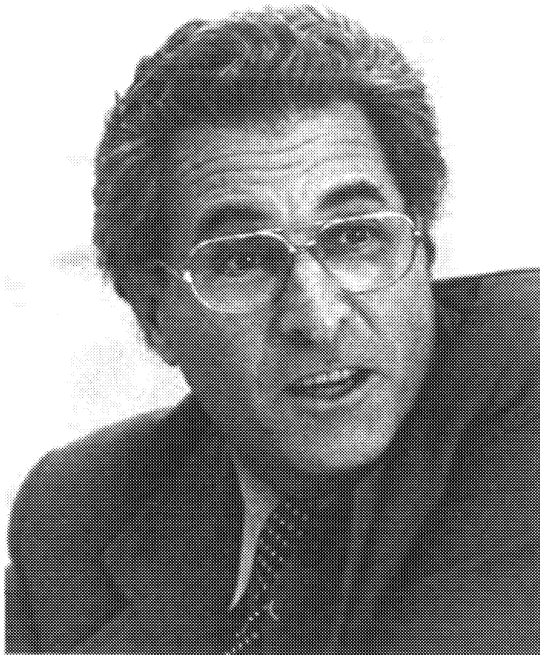
The brochure announcing the program states that: "The share of personal health care expenditures for the average family in 1980 was \$2,850 and following current trends it could be almost \$5,000 by 1985 and more than \$8,000 by 1990. So announcing a grant program to help hospitals, health insurance, business and labor wanting to join together to slow this rate of increase in their community..."

The program was divided into two stages: small initial planning grants which would serve as the basis for selecting the communities to receive million dollar grants for the second stage – implementation. The program attracted a great deal of attention and we were able to fund as many initial planning grants as we could afford, and encouraged others to proceed with local funding.

As we moved ahead with decisions about the implementation grants, we ran into some problems that we had not adequately anticipated. The applicant communities weren't as interested in the goal of creating community collaboratives to deal with cost containment as having a million dollars to carry out some very specific project with long term outcome goals. We had great difficulty in selecting promising applicants for implementation grants.

As a result, selected grantees weren't making measurable progress in the short run.

The Foundation began to wonder if this was a worthwhile project to continue to support. They had it evaluated by academicians who looked for and did not find significant impact on costs within a four-year period. There was lack of understanding that we were attempting to fund new collaborative relationships that would not show quantitative results for a decade or more.



The Foundation eventually decided to phase the program out. They were kind enough to fund me as a scholar-in-residence at Temple University. There have been a number of published articles about this program. I never wrote an article defending it, but John Dunlop, who was the chairman of the advisory committee, did.

That was a very interesting period in the history of health policy, when the whole notion of community collaboration was being tested in a time when things were becoming increasingly market-driven, increasingly bottom-line oriented, with many hospitals more concerned with preserving a positive bottom line than preserving their mission. Emphasis

on cost containment shifted to the potential of the competitive marketplace, with community collaboration hampered by a new emphasis in the courts on anti-trust violation.

GARBER: How did your work at Temple lead to your involvement in the issue of tax exemption for voluntary hospitals that was based on charity care or on community benefits?

SIGMOND: With my grant from the Robert Wood Johnson Foundation, which was to look into the future of voluntary hospitals, I began to write a number of papers emphasizing the long history of the social commitment of hospitals reflected in the guidelines for ethical conduct of health care institutions of the American Hospital Association.¹² These guidelines set out the ethical community role of the hospital.

Probably my most influential paper was the Michael Davis Lecture “Re-examining the Role of the Community Hospital in a Competitive Environment” that I gave at the University of Chicago.¹³ But in the course of trying to revive interest in the hospital as basically a public health institution, it became clear that increasingly, hospitals were becoming more and more obsessed with acute inpatient care, rather than a broader perspective with emphasis on preventative services to patients who do not stay overnight, primary care, and care of the chronically ill. Although the most dramatic things hospitals do are inpatient services, increasingly hospitals were actually providing more ambulatory services than inpatient services and were also involved in a great many less organized community activities. Today, by the way, most hospitals’ budgets involve more income from ambulatory services than inpatient services but there still is this obsession with the hospital bed.

In the course of attempting to focus on the hospital as an organization with broader goals than pure inpatient care and a commitment to community and charity, I became aware of growing skepticism by governments at all levels on tax exemption of hospitals. Until the ‘60s the tax exemption for hospitals was based on charity care.

At that time, the Internal Revenue Service, which administered the program and decided which hospitals were tax exempt or not, was concerned that with the enactment of Medicare and Medicaid there soon wouldn’t be any more hospital charity – that it wouldn’t be long before the people that weren’t poor and the people that weren’t old were going to say, “Well, why are they getting financing from the federal government? What about us?” The IRS anticipated that universal health insurance was going to follow within a few years, which would be the end of their role in regulating hospitals.

At that time, the American Hospital Association failed in its effort to create a new basis for tax exemption – namely, simply an exemption for *being* a health institution, the way educational institutions are exempt without a commitment to charity. They failed. But the

¹² *Ethical Conduct for Health Care Institutions: Management Advisory*. Chicago: American Hospital Association, 1990. This document is available in the collection of the American Hospital Association Resource Center.

¹³ Sigmond, R.M. *Re-examining the Role of the Community Hospital in a Competitive Environment: The 1985 Michael M. Davis Lecture*. Chicago: University of Chicago, 1985.

IRS discovered that if you go back into the true meaning of charity in old English common law, any activity that benefits the community as a whole can be classified as charity. So they expanded the definition of charity by administrative action, not by a Congressional action, that charity was to include not only charity care but also community benefit.

After having done that, the next step for the IRS was to develop regulations that would clearly define community benefit. They went to work on that and I helped a little bit. But when they brought this to the attention of the head of the IRS, he said, "Wait a second. I don't think we're going to have universal health insurance in a hurry. I don't think we need to get involved in defining community benefit." He was right, as we are still looking forward to legislation for universal health care.

So the IRS has never formally defined community benefit. The only guidance until this year has been to examine how they have handled certain cases. But it became pretty clear to me over 20 years ago that the hospitals and the hospital association should define community benefit standards for the hospitals. With the then-chairman of the board of the American Hospital Association I brought this idea to the Kellogg Foundation and they gave us a million dollars to develop standards for community benefit.

GARBER: The AHA chairman that you refer to was Ed Connors¹⁴?

SIGMOND: It was Ed Connors, whom I had become very close to when I was serving on his board of directors when he headed up one of the Mercy hospital systems. We intended that this million dollars would go to the Trust of the American Hospital Association – the Health Research & Educational Trust (HRET) – and would be carried out there. But it turned out by this time, Alex McMahon had retired and we had a head of the American Hospital Association who felt that getting the Association too involved with creating community benefit standards would create some member tensions. The investor-owned hospitals were becoming more important. Much to our surprise, HRET declined the million dollars and so the project was set up at New York University, staffed by Tony Kovner¹⁵ and Paul Hattis¹⁶, who now is at Tufts University.

Our goal was to develop and test standards that could be adopted by the Joint Commission on Accreditation. We worked with an outstanding national advisory committee and others, helping us to develop a set of standards that was written in that very strange language that JCAHO uses. We called it "JCAHO-ese."

Then we put out a brochure to the field and announced that we were looking for hospitals that wanted to test whether these standards would work and would be helpful to them in developing a systematic community benefit program. We made a very special point, having learned from our experience with CPAHC, that we didn't offer them a dime. We offered them the prestige of being part of our program and what they would learn not only from the staff but from each other. Some people thought that was bizarre. But hundreds of

¹⁴ Edward J. Connors was Chairman of the Board of Trustees of the American Hospital Association in 1989.

¹⁵ Anthony R. Kovner, Ph.D.

¹⁶ Paul Hattis, MD, JD

hospital representatives showed up for meetings for potential participants. We actually got 135 applications from hospitals wanting to test these standards.

In developing standards for hospital community benefit programs, we made a distinction between a hospital's service area and its communities. Most hospitals define their service area as the geography from which they draw patients. Obviously, they wanted that to be as large as possible. We emphasized: If you really want to do something in terms of benefiting a community and have measurable results – which was key to our standards, that there be measurable results – you're better off to target the smallest possible community and probably target more than one community, because each community has its own culture. A community is not just a population with some common interest or characteristics. We defined a community as: "all the people and all the organizations in a reasonably circumscribed geographic area with a sense of interdependence and belonging. Initiatives by hospitals to benefit a community necessarily have to reflect the targeted community's shared values." These standards called for the hospital to develop a systematic program consisting of various activities and projects designed to give more explicit shape and identity to what the hospital is doing to fulfill its community commitment. The standards called for changes in how the hospital's community service activities are governed, planned, organized, managed, reported and evaluated to demonstrate real value to targeted communities. For each target community, projects are to be designed to improve health status, or to address health problems of underserved populations, or to contain the growth of community health care costs. The standards also call for activities to promote collaboration with other organizations in each targeted community, and activities to assure that the community benefit program is fully integrated with the hospital's more traditional activities and not viewed as an isolated "add on" by the medical and nursing staffs, other professionals and the management team.

GARBER: Do you feel that the Kellogg initiative that you've been describing has had an ongoing impact?

SIGMOND: My own impression is that it had a significant initial impact, despite the fact that we did not focus on developing a community benefit program to meet the requirements of the IRS. We were attempting to develop a community benefit program that was consistent with the AHA ethical standards and the mission and vision of hospitals. Some other hospital organizations developed standards that weren't quite as demanding as ours because they were focusing on meeting IRS requirements. We had stronger standards. Our major impact is reflected in the increasing number of hospitals with community benefit departments, not simply organized data collection of community benefit activities.

To our disappointment, when we offered to turn the standards over to the Joint Commission we ran into insurmountable obstacles. We dealt with a great person, who's still there, Dr. Paul Schyve.¹⁷ He was very empathetic with what we were trying to do, but he also told us that the Joint Commission had a lot of other initiatives on its agenda having to do with issues of quality, and other things that related to increasing pressure on the Joint Commission to be a stronger force in raising hospital performance with respect to patient care. So he told us that he couldn't assure us that the Joint Commission would nurture our

¹⁷ Paul M. Schyve, MD

new baby the way we would like. We wanted to team up with the Joint Commission possibly serving as an advisory committee, but he said the Joint Commission had had bad experiences with other groups along that line and wouldn't do that again. We never did reach an agreement with the Joint Commission. The Kellogg Foundation then gave some money to the Health Research & Educational Trust to carry on, but the Trust staff went in a different direction.

GARBER: Let's talk about your most recent activities. In 2005 you were named the McNerney Fellow of the Health Research & Educational Trust. What is the McNerney Fellowship? Were you the first Fellow?



SIGMOND: I was not the first Fellow. In the beginning, I was involved in helping to raise the money that created the Fellowship. There were five Fellows before me. The Fellowship was created mainly by friends and admirers of Walter McNerney after he had a series of strokes that left him unable to speak or write. His head was clear and he kept in touch with developments in the health field, but quite suddenly, he was not the major force in health policy that he had been for decades. After some years, we created the Fellowship to support a Fellow each year as part of the educational activities of HRET. The Fellow was to be an established health leader who would take some time and reflect on the perspective of Walter McNerney.

I believe that something in the neighborhood of a half million dollars was raised. The Fellows continued in their jobs although some were in the process of retiring. Among others, we had such wonderful people as Gail Warden¹⁸ and Howard Berman¹⁹ who had been graduate students under McNerney at Michigan. Then one day I heard that they had run out of money to appoint a new Fellow. By this time, McNerney had been out of the picture for almost a decade, and they had decided to close down the Fellowship.

I got in touch with the Health Research & Educational Trust, where I had earlier served as the Edwin L. Crosby Fellow, and offered to be the next McNerney Fellow with no pay, if they wanted to keep it alive. My primary goal would be to get the Fellowship endowed, which was my original concept.

In 2005 I became the Fellow, and I'm still the Fellow, promoting the values of

¹⁸ Gail L. Warden

¹⁹ Howard J. Berman

McNerney's perspective for the 21st century along with raising the money for an endowment. Although close to a half million dollars has been raised, due to some unusual circumstances none of that money has been turned over to HRET as yet.

The problem that I ran into, which I did not anticipate, was that the people that I was approaching to re-fund the Fellowship—and they were quite interested again because right at that point Mr. McNerney had passed away – told me they were not interested in having it funded at the Trust because they were concerned about how the original money had been managed. I went into a series of negotiations with the Trust to provide an active advisory group to help in the HRET Board's decisions about the Fellowship. Those negotiations never came to fruition so eventually, with agreement of the Trust, we created a new 501(c)(3) organization called the McNerney Endowment. The Endowment now has a website, with many of McNerney's most recent papers and his oral history, in which, interestingly enough I participated in asking the questions. I am actively continuing to raise money for the Endowment. I was involved in that actively as recently as yesterday.

GARBER: You've also become involved again with your early love of local health politics. What have you been doing?

SIGMOND: I could easily spend an hour telling you about that. Let me just say briefly that in Philadelphia a few years ago, a group of community activists, of which I was not a part—I'm a little more withdrawn than a genuine community activist but I'm always ready to help them to be effective – did something that everybody told them they couldn't possibly do. That was to get enough signatures to put an initiative on the ballot, which had never been done before in Philadelphia. The community activists were trying to turn Philadelphia into California, where there are ballot initiatives all the time.

To make a really long story short, the vast majority of the voters approved an amendment to the city charter requiring the Health Department to develop and maintain a plan for "decent health care for all Philadelphians." *Decent health care* is a McNerney expression. Usually when you're hearing talk about health care, you'll hear about *highest quality care for everybody*. In fact, there are a lot of reasons why most people wouldn't want highest quality care like the President gets, and there's no way you could have highest quality care for everybody all the time.

So McNerney suggested a more realistic modest goal. He defined *decent health care* as the kind of care you'd want for your family. Everybody should have that kind of care. With that amendment to the Philadelphia city charter, the Health Commissioner had to find a way to develop a plan for universal decent health care. He had to do it with very little money for that purpose, because the mayor was not enthusiastic about supporting follow-up to ballot initiatives. The mayor allocated only \$25,000 for development of the plan, not enough to attract professional proposals.

We did get a group of graduate students from Princeton University to take the money and develop a plan for us, which would meet their thesis requirements for graduation, so it didn't seem like a little bit of money to them. I became their advisor. They developed an excellent plan, which was put on hold as we got involved in a mayoral election. I supported a reform mayor who was elected, much to the surprise of the pundits. He has

continued to put the implementation of the decent health care plan on the back burner until he solves some of the more critical problems in our city, like safety on the streets and getting a public school system that works. I believe he knows that before he gets around to a second term, he's got to turn his attention to decent health care.

GARBER: That must have been a particularly satisfying relationship working with the graduate students because you've enjoyed the mentor-mentee relationship over your entire career.

SIGMOND: That is absolutely the case. I think the most enjoyment I've had in our field is with the people that I've mentored during the past 50 years. I've always been involved with some graduate program, though I was never much involved with the faculty, just with the students. I have former students today who are so successful, heading up Blue Cross plans and health systems and consulting firms, that they're making more money this year than I made in my whole career.

I am in regular touch with former students, some in their sixties, and have attended a few retirement parties. I also have students in their early twenties. Mentoring is so important to me, because I was so well mentored by Rufus Rorem and others. Also, a number of the students that I started out mentoring become my mentors, keeping me busy and in touch with reality. Outstanding examples are Walter McNerney and Howard Berman.

GARBER: Let's turn to your thoughts and observations about the nature of the health care system and about how best to finance care. Do you think that the way that the health care system is structured today is the best way to deliver care?

SIGMOND: No, I do not. To help explain why, let me spend just a few minutes making it clear what the word "system" means to me because it has various meanings. As a result, frequently in conversations about the health care system, everybody's talking across each other. The essential definition of system that I think you'll find in the dictionary is—a system is all of the parts that make up a whole and their interrelationships.

Now, notice that definition does not require that a system have a purpose. Some systems have a single purpose and that's when system theory works best. Everyone agrees that there's a single purpose. Everything is focused on that single purpose and one can develop a very systematic approach, in which all the parts are related to each other in fulfilling that purpose. Subordinate goals that most people focus on can only be achieved within the context of the over reaching purpose.

An example of that would be a system to get a human being up to the moon and back. There are probably a lot of subsidiary purposes, but the main thing is to get that person back alive, so everything else is subordinate to that. Most systems have multiple purposes, and interestingly enough, you have systems with no known purpose. Let's take as a useful example: a mountain system. If a mountain system has a purpose, only God knows. But if you want to drill a tunnel most efficiently through a mountain for a railroad track starting from both sides, you better take a systematic approach or you will drill two tunnels. You better know all about the elements of that mountain and how those elements relate to

each other and let the issue of the purpose of the mountain be with God. You are not trying to change the mountain system, only trying to get through it efficiently and effectively.

Most systems, including the health system, have multiple purposes. Usually, different people identify with different ones of these multiple purposes as the purpose, leading to conflicting notions of how to navigate or even visualize a reformed system. But unless everybody agrees that some particular purpose is the purpose, system theory is not useful in determining the best reform strategy. Without commitment to an overriding purpose, it may be possible to navigate the system somewhat more effectively for some particular change, but any approach to real system-wide reform will inevitably run into unintended consequences and fail.

For example, when most independent medical practitioners think about the health care system, implicitly they are thinking about the problems of physicians in serving patients. Working in a public health department or hospital, they think about the system quite differently. But independent physicians and the hospital and the health department are all part of the health care system, which will not function effectively and smoothly unless everyone is able to subordinate and adapt individual special interests to the overriding purpose that will drive a reformed system. We are not close to being there yet. Many policy experts don't even consider the patients' families or Congressmen as key elements of the nation's health system.

As I see it, the CCMC recommendations, with the emphasis on an overriding purpose of continuous health improvement, point the way to reform the health care system. Of course, a focus on improving health is quite different—much broader—than a focus on disease and disability or a focus on the individual patient, as important as patients must be. If the fundamental focus is on health, you have an entirely different system than if the focus is only on sick patients.

Recently, there has been both increasing fragmentation of purpose among independent units of the health system, but also increasing recognition that health is much more than the absence of disease and disability, much more than hospitals and medical practitioners. There is also increasing understanding that many of the factors involved in better health and health care are currently not readily controlled by health professionals, or even by individuals acting alone. Collaboration is required. Unfortunately, in recent years, the health care system in this country has been moving away from focus on better health to focus on better bottom lines. The health care system would be much simpler and probably much less expensive and much more effective if everyone subscribed to the idea that the fundamental purpose of the health care system is to improve health of all the people, community by community. That's the context in which I want to address your question about the health system.

GARBER: Do you feel that it's incumbent on the hospital to take leadership in focusing on contributing to the health of the community?

SIGMOND: From my perspective, having grown up with the teachings of the CCMC and the perspective of the ethical standards and guidelines of the American Hospital Association and the American College of Healthcare Executives, a community hospital really

has no choice. The hospital board and top management should be clearly focused on a mission and a vision that places everything that the hospital is doing in the context of playing a significant role in improving the community as a healthy place in which to live or work.

Now, that does not mean that the hospital necessarily becomes the leader, ahead of all the other elements of the health system. To be effective, a leader must have followers and that requires collaboration with other leading organizations. Ideally, not only the hospitals but many other organizations can take the lead in carrying out a common overarching goal of the community health system. The hospital, of course, is in a unique position in any community because it is still its own important workshop for most physicians, and other health professionals. As such, it can promote a broader perspective of the role of that workshop among members of the medical staff and others. A committed Hospital Board of Directors can have great leverage with business and political groups, as well as the professionals.

Real leadership for health care reform requires coordination and collaboration among all the leading community organizations, free of concern about so-called *per se* anti-trust legal action. As I see it, that calls for renewed attention to the fifth CCMC recommendation: that every community have an organization to promote this aspect of any organization's planning and operations. Coordinated, collaborative planning in the use of limited resources is the essential missing element in the structure of the nation's health system today.

Actually, in the early 1960's, with leadership from Rufus Rorem, voluntary planning agencies were created in many urban areas, based on the CCMC model. The emphasis was on promoting much more comprehensive planning within hospitals that reflected the American Hospital Association's ethical institutional guidelines with respect to community service. At that time, no single hospital had anyone on the management team with the word *planning* in their title. Others joined Rorem and me in promoting the creation of voluntary agencies to encourage coordinated planning by the hospitals themselves, with major emphasis on collaboration among the different hospitals. The most influential people in this development were Sy Gottlieb²⁰, Marty Palin, Steve Sieverts, and George Bugbee. Planning by the hospitals themselves, following agreed upon principles and processes and evaluated by a coordinated planning agency, made a lot more sense than the earlier naive notion of community-based planning organizations developing "master plans" for the hospitals to follow. As a result, a new profession of hospital planners emerged, with thousands of planners now employed by hospitals throughout the country.

But today, there is not in any community, a respected, powerful planning agency to assist various organizations in doing their planning in collaboration with other organizations, all committed to an over-riding common goal, such as continuous improvement in health services. In my opinion, this is the only way we will eventually develop a health care system that provides decent health care for all the people.

GARBER: There was a planning structure set up in the United States in the late '60s and early '70s at the state and local level. A lot of that has been disbanded.

²⁰ Symond R.V. Gottlieb

SIGMOND: Right.

GARBER: What was the difference between that structure and what you're proposing?

SIGMOND: Unfortunately, in the late 1960's, the federal government developed a national pattern of support of planning agencies which were perceived to have had the power to disapprove or approve specific hospital plans, with little or no consideration of the institution's involvement with other organizations addressing the same community needs. The new planning structure was primarily interested in containing unnecessary expansion of acute inpatient care, with less emphasis on improving community health services and outcomes. Competition among institutions for approval of similar "certificates of need" seemed to offer more important incentives than voluntary collaborative planning outcomes. Eventually, these planning agencies were seen as obstacles to effective planning, and gave community-based planning a bad name before they disappeared from the scene. The courts contributed to the trend away from collaboration as they ruled that even voluntary collaboration for more effective community service was subject to the restrictions on "per se" anti-trust activities. I believe that the time is now ripe to re-establish community planning agencies with the function of assisting hospitals to plan collaboratively with the common goal of improving community health services.

GARBER: A major impetus for the development of certificate of need programs was to help to control rising health care costs.

SIGMOND: Right, primarily through control of increases in the supply of acute care beds.

GARBER: Let's talk a little bit about money. I understand that you don't like to talk to about hospital reimbursement – that you prefer another term.

SIGMOND: If you think about the concept of reimbursement and you say—"Do I ever get reimbursed as contrasted with getting paid for what was actually spent in providing the services listed on the patient's bill?" – I think right away you'll realize that the only time you are reimbursed is when you travel for business and you submit the bills and you get reimbursed. The basic notion of reimbursement is that you get paid for whatever you spent. That isn't the way anyone ever gets paid except for travel expenses. With the reimbursement mindset in the hospital field, I do believe that reimbursement has been a major contributor to rising hospital costs, even though hospitals have never actually been reimbursed. So, I think we ought to get realistic and start talking about other methods of payment.

I believe, for example, that the way the Veterans Administration pays its hospitals may be a model for the way we ought to be paying all hospitals. Each V.A. hospital submits a budget each year and there is negotiation about whether the budgets that are submitted are consistent with the overall goals of the Veterans Administration. When that discussion ends, the hospital is paid the amount that is agreed upon. This eliminates all the expense of rendering fee-for-service bills, patient by patient, which is about as microscopic an approach to controlling costs as you can imagine. But that's what we do in this country. The hospital

goes to the trouble of sending out a detailed bill for each patient, even though most public payment is made through contracts with third party payers like Blue Cross. I hope that we can get away from payment for each prescription and other specific services and move toward a payment system based on an approved budget that reflects an approved strategic plan for improving the health of our communities. That is the way most hospitals are paid all over the world.

The simplest way to move toward payment based on the budget rather than on service to individual patients would be for each hospital to contract out the entire billing and collection activities to a competitive third party payer which would guarantee to pay all the money in the approved hospital budget. This is a true single payer plan, as contrasted with other so-called single payer plans which are really single source of payment plans. In the complex financing world of hospitals these days, single payer at the end of the process is much more doable in our society than single payer at the beginning of the process. With a single payer chosen by each provider to take charge of getting the hospital paid, we can continue to exploit the advantages of multiple sources of payment, not just government sources. Furthermore, with the third party payer concentrating on ensuring better management of the hospital's strategic plan and budget, it will no longer have to be involved in certifying the effectiveness of clinical management on a case-by-case basis as is the common practice today.

GARBER: Is there a way to provide access to care for the uninsured and the underinsured?

SIGMOND: I believe so. The key is in better management by each hospital of the quality, costs and revenue associated with what is now identified as uncompensated care. When I started out in this field back in the 1940's, there was no question that anybody who needed care or even thought they needed care could go to the nearest hospital and get care. Access was not an issue, because all the hospitals in those days were providing not only emergency services but also charity care for the uninsured who could not afford care from private practitioners – and not just for inpatient care.

Like most hospitals, the Albert Einstein Medical Center where I worked had dozens of free clinics staffed by supervised, unpaid volunteer physicians practicing on these patients, which was the most common way of learning to become a board-certified specialist in those days before the rapid growth of residency programs. These hospital charity clinics closed down when Medicaid provided funding for serving these patients in the offices of private practitioners. The assumption was that everything was going to be reimbursed, but of course, it did not happen that way. With disappointing rates of payment instead of reimbursement, the private practitioners limited the number of Medicaid and other uninsured and underinsured patients in their private offices. As these patients flocked to hospital emergency departments for primary and specialty care, the hospitals recently have had to serve an increasing number of the uninsured and underinsured.

Currently, the nation's hospitals are spending in the neighborhood of 30 billion dollars annually on uncompensated care. Legally, hospitals are not allowed to turn away patients without at least providing emergency services and referral for follow-up care. For patients who do not have continuity of care through private practitioners, the best

emergency physicians will not only make an effective referral, but will follow up to make sure that the patient is actually seen and cared for after being discharged. Dedicated emergency physicians know that without arranging effectively for continuity of care, these patients will soon be back, again and again. But unfortunately, patients without private physician connections are usually discharged from the emergency departments of most hospitals without any systematic procedure to assure access for follow-up continuity of care.

So today, in a limited way and at great expense there is universal access to health care if only in terms of the initial contact in the hospital emergency room. The simplest way to provide universal access to care for the uninsured and the underinsured is by more comprehensive regulation of the discharge practices in hospital emergency departments to avoid discriminatory practices affecting patients without effective private practitioner connections. There could be new rules, consistent with best practice, to make sure that required follow-up care is effectively arranged either by referral elsewhere or provided by the hospital itself. This would avoid current practices in many hospitals which discriminate in terms of access to decent care by emergency patients who are not admitted and who do not have an effective connection with private practitioners.

I believe that the country and ethical hospitals are ready for a government initiative to end discrimination against the uninsured and underinsured in hospital emergency departments once and for all. This could take the same form as was so effective in doing away with other forms of discrimination in the past. At the time that Medicare was enacted, many of the hospitals, especially in the south, discriminated in the most outrageous way on the basis of the patient's race. Such discrimination was based on the fiction of separate but equal hospitals limited to serving racial groups. When the new Medicare law excluded hospitals which discriminated on the basis of race, overt racial discrimination by hospitals disappeared overnight, despite all the financial and other implications. The country was ready for the change, and the hospitals really had no choice. I was a member of one of the teams that the government assembled to assist community leadership in various southern cities in their efforts to deal with the impact of the change on the many hospitals that previously had served African-American patients.

The EMTALA [Emergency Medical Treatment and Active Labor Act] rules could be changed by legislation, so that if a hospital wants to participate in any federal government programs, any patient that comes to the emergency room must be assured of comprehensive follow-up care. That care could be provided by referral to a reliable source of care, or by the hospital itself. Of course, many hospitals might close their emergency departments, and that might not be a bad thing either. But the hospitals that wanted to keep the emergency rooms open would comply. You might say, "Well, how can you make them do something that's going to cost all that money?" The answer is with sensitive management of the new EMTALA regulations.

I'll give you another example of overcoming discrimination by sensitive regulation. About 25 years ago, when there was concern in this country about wheelchair access, legislation was passed requiring buildings to become wheelchair accessible. Regulations were developed and a federal department was created to administer and enforce those rules. That department didn't have any money to pay for the necessary adjustments that had to be made in buildings, some of which would cost millions of dollars. So the government entered into

consent decrees, some of them running over a period of 25 or 30 years. The consent decree required the building owner to have a plan, a reasonable plan for eventually becoming wheelchair accessible.

Today, you find that wheelchair accessibility is becoming universal and it didn't cost the government a dime beyond the cost of managing the programs. Did it cost a lot of money to those who own buildings? Of course it did. But then, building owners always need to spend money to keep their buildings up. So the same thing could be done with universal access to comprehensive care. There could be new rules that would be administered sensitively, allowing for incremental improvement in access but really requiring any hospital that wanted to be involved in any kind of federal program—Medicare, Medicaid, whatever—to be committed to continuous decent care for any patient that the hospital served.

Would it cost any more money? I'm not sure it would cost any more money in the long run. First of all, it's very clear that because of the way we are managing patients with the heavy focus on inpatient care and insufficient attention to continuity of care, we are spending almost twice as much money per capita than other developing countries and developed countries. We're spending too much money primarily because we are not focusing on decent health care for all. Of course, for the short run, some additional federal funds would help in the transition from episodic to continuous, comprehensive care.

GARBER: This is an election year and I wondered what you think the prospects are for comprehensive health care reform legislation.

SIGMOND: I think it is now generally understood by leaders in both political parties that our health care system does not work as effectively as in other countries. Some say it's broken. Clearly, new legislation that will help to reform our health care system is required. There's a lot of discussion about what such legislation would look like but there is no consensus about that, partly because almost everyone is focusing on insurance and money and not on health. But the situation is so bad in terms of quality, access and cost that within the next five or six years we probably will have major legislation focusing on health improvement.

It's very much like the situation that McNerney faced in the early '60s in getting something through Congress that became Medicare and Medicaid. Without consensus on what to do, there is no likelihood that there will be major legislation in the first term of our new president. There are just too many other pressing problems having to do with the economy, with the war, with the educational system. We will not have time, even if the new president wants to make it a top priority – and I don't think the new president will make it a top priority – to develop the kind of consensus about the nation's health system that will lead to major reform until the second term, maybe the second year of the second term of the new president.

But during that time, there will continue to be changes, community by community and state by state, wrestling with crisis conditions and frequently finding local solutions. The reform will emerge, five or six years from now, as the people and the politicians understand that the real reform has to take place at the local level. The national reform legislation will

provide positive and negative financial and regulatory incentives for communities to develop incremental, tested changes that will result in improved health.

That's going to be the history. The reform will not occur as a result of some major piece of insurance legislation. It will occur from successful, innovative developments in communities that will spread more rapidly with positive and negative incentives from the federal government.

In my opinion, the goal for real health care reform in terms of money will be to bring the level of health care expenditures per capita in this country closer to the international average without adverse effects on quality or access. It's going to take some years for somebody with more political skills than me to develop the best legislative approach to spending less money for better health. But there is no question that we spend too much money. We can do a lot more in health improvement with a lot less money. As one presidential candidate often says, "Yes, we can."

GARBER: In closing, as you reflect on your experiences in the health care field over many years, what do you feel are some of the key lessons that you've learned?

SIGMOND: That's a tough question. I'd say first of all, I learned that money is very important, but it also can bring out the worst as well as the best in people. The other lesson is that we have got to find ways, and it's difficult, to relate the goals of various elements of the health care system to a larger goal, such as the goal of decent health care for all, so that as people make their health-related decisions every day or every year, they're thinking at least in part—How does this relate to my playing a more significant role in decent health care for all the people?

I could think of a number of other lessons, but my focus has always been on making things better at the community level. You just can't have a decent health care system for an individual – it has to be for the whole community, where the key institution is the community hospital working closely with the public health department. I think if people think of me, it might be in terms of that kind of emphasis: decent health care requiring a total systems approach but basically focusing on the community and focusing on institutions, of which the community hospital can have the greatest potential.

GARBER: Do you have any regrets related to your professional career?

SIGMOND: I think that in an earlier part of my career, I just had a lot more patience with people that I was working with, and I think I made a lot more progress. At some point I began to get impatient that things weren't moving fast enough. I think that I became so impatient that I ended up losing what I think I had in the terms of a leadership role, because the key to leadership is followership, and you don't have a bunch of followers that you're impatient with. So I regret that I have, especially, in the last 25 years, been impatient and lost the ability to be a more effective leader.

GARBER: Related to legacy – you alluded to one or two things earlier, one being the nearly ubiquitous nature of planning departments or planning staff at hospitals all across the country. What other things do you think will be part of your legacy?

SIGMOND: I really think that one can get obsessed with things like legacy. Each of us has a short time on this earth and we should make the most of it while we're here. As I think about the problems I'm encountering trying to get people to think about the legacy of Walter McNerney or Rufus Rorem, I don't see much legacy for most people like me. My real legacy is a lot of former students around the country who, whether they would attribute it to me or not, tend to think about solving their problems in a larger perspective than if they hadn't been in touch with me. They know that improving health care services and community health is more important than improving the bottom line. They can't forget the CCMC, Rufus Rorem, and Walt McNerney and what they accomplished. So I am more interested in their legacy than mine.

You suggested another way to look at legacy: Is there anything you did that really changed the health care system? I do think of three times when I was in the right place at the right time to play a leadership role in a significant change.

One was the development of strategic planning within hospital organizations. As a second example, I was able to encourage the hospitals and physicians in the Pittsburgh area – I mean the county medical societies – to take the lead on attempting to control hospital inpatient utilization on a voluntary basis. Physicians on the hospital medical staffs did that work voluntarily because they thought it was the right thing to do, years before hardly anyone had ever heard of utilization review. They thought it was the right thing to do because they were afraid that if they didn't do it, group practice was going to come into the area stimulated by the steel companies and the unions. So their motives might have been partly self serving, but I was able to take physician after physician down to Washington during the time the Medicare legislation was being enacted, and we got utilization control into the Medicare legislation, which people said couldn't be done. I honestly don't think it would be in there if I wasn't dragging all those physicians down to Washington. Now, do I like the way utilization control has developed? Not entirely.

The third thing like that is the notion that hospital community benefits should be organized. I can tell you, to end this maybe on a humorous note, a couple of years ago, there was a big meeting on community benefit with a big roomful of people, and I was introduced as the father of community benefit, not as the godfather but as the father. I remember responding to that by saying: Who was the mother? Then I speculated on some people and hoped that their husbands wouldn't be too concerned.

GARBER: Within the past few weeks, you were awarded an unusual statue, and this is the second time that you've been so honored. Could you tell us about that?

SIGMOND: Well, yes I can. I'm a founding member of a group that some of us formed about 25 years ago to meet every summer and talk about how to make the health care system more effective, to think back to the CCMC days, and what we each should be doing in our various jobs around the country to move things in the right direction.

After the second year, somebody said, "We've got to give a name to this organization to include in our expense statements." We decided to call it the Health Policy Issues Group, because that's what we were talking about. Quickly, Health Policy Issues Group was

shortened down to HPIG. Shortly after that, we decided to award the HPIGer of the Year Award to one of our members who would be required to display the HPIG symbol, a statue of a pig, on his desk throughout the year and emphasize to everyone his commitment to the values of being the HPIGger of the Year. And so this has been awarded many, many times over the years, and I got it maybe in the third or fourth year.

Lo and behold, this year—maybe because it's my big eight year—they decided to award it to me a second time! So obviously I could not do this oral history without sharing the PIGgy with you. I'm only the second person to be so honored twice. I'm in the distinguished company of Howard Berman, who many of you know is the recently-retired chief executive of the Excellus Blue Cross plan in Rochester. If I read off the list of other names, you would be impressed that I am in very, very good company.

Now, what we HPIGers have been talking about just lately is: Can we be optimistic or pessimistic about how things are moving? There have been any number of years when we discussed this at our HPIG meetings that the pessimism outweighed the optimism. But I always had an unusual quality of being optimistic, no matter what. I find good reason to be optimistic about the values and ingenuity I always find in my contacts with health care practitioners at the community level. This year I am especially optimistic because of the current leadership at the American Hospital Association, both in its elected officers and of course in its chief executive officer, Richard Umbdenstock. They have developed a major focus, *the* major focus of the AHA beyond struggling with legislation. The emphasis is on "Health for Life." That's a lot different from simply taking care of disease and disability, and much different from a focus on the marketplace and the bottom line. The emphasis of the American Hospital Association is on "Building Community Momentum for Health Reform: A Hospital Guide for Community Action."

The American Hospital Association, which many people think of as simply a trade association, has always had a basic commitment to improve health services which sometimes they haven't been able to articulate for sometimes over-stressed members. But today, the Association is fully committed to "Health for Life," and better health care. I am extremely optimistic that this kind of leadership from this important organization is going to spread during the next five or six years and become the effective theme for the health reform legislation that it will require and will create.

GARBER: Thank you, Bob. It's been a privilege to speak with you.

AFTERWORD **By Robert M. Sigmund**

This oral history was recorded on August 8, 2008, some months before the collapse of the nation's financial system and the recent formal announcement by authoritative economists that the nation has been in a recession during the past year. Massive efforts, involving the appropriation of hundreds of billions of dollars, have not yet succeeded in getting things back on track. Economists do not agree on what our new President should do to avoid having the nation slip into a depression. There is talk of rescue and recovery programs costing up to two trillion dollars, but no agreement as yet as to whether this

initiative will work. Most important, as yet there is no discussion of the necessity of a rescue or recovery program for hospitals and other health care providers.

As a child of the Great Depression of the 1930's, I see a real crisis just ahead for hospitals and physicians and other providers of necessary health care. They are going to have to cope with rapidly increasing numbers of uninsured and underinsured patients for the next couple of years, hopefully with the next year being the worst. Many experts see a national health program involving universal insurance as an urgent requirement. I do not disagree, though I personally prefer the prepayment concept to protect consumers as contrasted with risk-averse insurance. My experience indicates that insurance is necessarily managed with more concern for protecting the insurer than the patient. As originally developed in the United States, prepayment involved risk sharing on the part of both the third party prepayment agency and also the contracting providers. The sooner we move from compulsory insurance to compulsory prepayment for comprehensive benefits, the better. With prepayment, the consumer, the third party payer and the provider have a common interest in the most value for the amount of money that has been prepaid by or on behalf of the consumer.

But more about prepayment and insurance later. Right now, there is no way that a new national comprehensive program of either prepayment or insurance can become operational for at least a year after agreement is reached on its essential working characteristics. During the critical period just ahead, hospitals are going to have to learn to survive with much less operating income.

Notice that I said *less operating income*, not simply a reduction in the rate of increase. Most chief financial officers or chief operating officers of hospitals or health systems in the past 60 years have had little experience in preparing and managing a budget with less income than in the previous year. The hospital finance literature does not include many articles or papers on that subject. Nevertheless, some consulting firms are quite expert in doing just that for a hospital client, though often with only modest attention to the basic mission spelled out in the hospital's articles of incorporation.

In the immediate period ahead, before a comprehensive financing program is operational, many hospitals and third party payers are going to be in critical condition, resulting in bankruptcies, forced mergers, and even closing down. What should hospitals do to prepare for this critical situation?

Those associated with hospitals that were in existence during the Great Depression are advised to dig out the old minute books and related files to learn how their hospital survived in a similar economic downturn, but without Medicare, Medicaid or even Blue Cross and insurance. Almost all of the proprietary hospitals — that's what the investor-owned hospitals were called in those days — disappeared but the not-for profit hospitals survived. The current economic downturn is not likely to be as severe as during the 1930's, but the impact on hospitals, as currently organized, financed and managed, may be much more painful and much more likely to be fatal.

The key to survival in the 1930's was the hospital commitment to and from all elements of the communities served. Suppliers continued to provide necessities even when

the hospitals could not make payments. There were payless paydays, and physicians moving into the hospital's empty rooms when they could not pay their rent. Many employees lived on the hospital grounds and worked for very little more than room and board and free health care. Most hospitals ran many free clinics for those who could not pay private practitioners, staffed by volunteer physicians trying to sharpen or maintain their specialty skills. Philanthropy on the part of loyal trustees and others with money often helped save the day. Eventually, hospitals joined with community leaders to invent and reinvent prepayment that guaranteed service even to those who fell behind in their prepayment obligations – the beginning of Blue Cross. Premiums of a dollar a month for families did not cover costs, but provided a lot more money than sick patients could find in their pockets or get from their closed banks. With the Federal Deposit Insurance Corporation not yet invented, banks were of little help to patients, though many often allowed hospitals to be overdrawn for extended periods.

The key to survival in this crisis just ahead is shifting focus as quickly as possible from competing in the failing marketplace to responding in every way possible to the most basic health requirements of the communities served. This calls for special emphasis on primary care, prevention, continuity of care of the chronically ill and much more humane management of the limited funds available for so-called uncompensated care in the often heartless competitive marketplace.

A good guideline in these troubled times is the vision and mission of the American Hospital Association: The vision is of "... healthy communities where all individuals reach their highest potential for health." The mission is "to advance the health of individuals and communities" by leading "hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement." Today, the vision and mission of the American Hospital Association are bundled in the new framework for change "Health for Life". That is the direction that hospitals should be moving toward as the competitive marketplace is clearly the wrong place to be in the troubled years ahead. For many hospitals, the shift to community accountability and commitment to community health improvement will be difficult, but will be a lot more exciting and satisfying. Two examples of hospitals showing the way are Holy Cross and Mount Sinai, both in Chicago.

The oft-quoted saying, "No margin, no mission" has to be changed to, "No mission, no future." Every year in this country, a significant proportion of hospitals not only have had no margin, they have had a deficit. Dedicated hospital leaders know how to operate with deficits, often for two or more consecutive years. Unlike state governments, hospital deficits are perfectly legal, and necessary when sufficient income is not available to maintain decent quality and access standards and community credibility. With an eye to the future, reaching out and joining with others to serve distressed communities is the essential way to provider survival, spending much less money for better purposes.

The time is now for not only the American Hospital Association but also other organizations to develop and promote programs and projects to assist and encourage hospitals and other providers to change direction, with priority emphasis in their strategic plans and reduced budgets on the most primary, basic needs of the individuals who live and work in their communities. With fundamental emphasis on community health improvement during the critical months before comprehensive finance reform can be a reality, everything

that hospitals are doing can be re-formulated in a community service context, involving a new perspective on getting more value for less money. This calls for a revived emphasis on collaboration: with families, community organizations, physicians and physician group practices, physician extenders, volunteers and other providers. A special focus on humane management of the resources for serving so-called uncompensated care patients may be the best place to start to provide more with less money.

Time is of the essence. Many experts believe that comprehensive reform can be designed to reduce national health care expenditures. Comprehensive reform may be postponed until the hospitals have demonstrated that they can provide leadership in doing more and better with less money.

The American Hospital Association can also support federal legislation to help fund the necessary transition of carefully selected hospitals, like Holy Cross and Mount Sinai, which are attempting to make the shift from the competitive marketplace to a new emphasis on health improvement for individuals and their communities. In addition, the American Hospital Association can promote community collaboration for better health by sponsoring legislation to provide exemption for hospitals from per se violation of anti-trust laws.

The Great Depression gave birth to prepayment, health maintenance organizations, graduate programs in health administration and other important innovations catalogued by the Committee on the Costs of Medical Care in 1933. I anticipate that the upcoming economic crisis will be a similar period of innovation in the organization and management of hospitals and all other elements of the nation's health care system. It will be fun for me to watch this all develop, with many of my former students providing the essential leadership.

But now, let's get back to the fundamental difference between insurance and what I refer to as prepayment. The insurance concept is designed to protect the beneficiary from financial loss whenever the beneficiary is expected to pay a bill for services rendered. This is most common with various forms of property damage. We buy insurance so that when our car crashes or our home burns, we do not personally have to bear all of the losses. This is the most common way of looking at health coverage today. In the United States, any of us could be ruined if we become ill or injured and are expected to pay for the necessary care. Today, when a day in the ER can generate invoices totaling more than the average family's income, insurance is seen as an imperative.

By contrast, the prepayment concept is designed to completely eliminate the necessity for a patient to be at all concerned about paying for covered services. This is because with a prepayment plan, contracting providers have agreed in advance not to charge the patient anything for necessary covered services. By prepaying to a third party agency for covered services, so that the financial aspects of any care received is between the provider and the prepayment agency, the patient and the patient's family do not have to be involved. Prepayment is most commonly through taxes, but is also the financial mechanism of choice by subscribers, and their employers, to most not-for-profit group practice plans, as well as during the history of all of the Blue Cross plans.

Throughout the world, most patients leave the hospital without any bill to pay because of prepayment, primarily through government budgets or a not-for-profit plan. This is clearly the way to go in the United States in any new comprehensive government program to provide coverage for decent health care for all. With prepayment, marketplace competition is limited to the prepayment agencies, while the providers compete only with respect to access and quality rather than with price. With prepayment dominant in most countries except for the United States and China, insurance has the relatively limited role of protecting the pocketbooks of the well-to-do who seek services not covered by prepayment or who prefer providers not involved with the prepayment agencies.

With universal prepayment rather than universal insurance, the nation's comprehensive reform plan could be designed to enable each provider to select a single, preferred prepayment agency each year from among those competing in the marketplace, as was the case originally in the way Medicare paid for all covered hospital services.



Bob Sigmond (left) with Rufus Rorem.
Photo courtesy Highmark, Inc.

framework for agreement on and commitment to common efforts to organize services to make the most effective use of the limited funds available for health services – limited now and even more so in the future.

Today, most people will recognize prepayment if their so-called health insurance involves service benefits; in other words, benefits expressed in services rather than in the price of the services. Service benefits almost always involve contracts with providers in which the providers guarantee to provide those services, irrespective of the price, and with little, if any, balance billing to the patient. These prepayment contracts have the effect of joining the prepayment agency and the providers in sharing all of the risk associated with financing the covered health services.

Prepayment can be so much more important than insurance in any health reform for two reasons. First, it provides so much greater protection for the consumers. Possibly more important, prepayment contracts with the providers can become the

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