HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

C. Rufus Rorem

C. RUFUS OREM

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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Taken in 1964 when Doctor Rorem was a special consultant to the Health and Hospital Review and Planning Council in New York City.

CHRONOLOGY

1894	born: Radcliffe, Iowa
1916	Oberlin College, A.B., cum laude
1916-1917	Goodyear Tire and Rubber Co.
1917-1918	U.S. Army, private to 2nd Lieutenant
1919	Mason City (Iowa) Globe Gazette, reporter
1919-1922	Goodyear Tire and Rubber Co.
1922-1924	Earlham College, Assistant Professor of Economics and Dean of Men
1923	CPA (State of Indiana)
1924-1927	University of Chicago, Instructor in Accounting
1925	University of Chicago, A.M.
1925-1928	University of Chicago, Assistant to the Dean, School of Commerce and Administration
1928-1929	University of Chicago, Assistant Dean, School of Commerce and Administration
1928	University of Chicago, Assistant Professor
1929	University of Chicago, Associate Professor
1929	University of Chicago, Ph.D.
1929-1936	Julius Rosenwald Fund, Associate Director of Medical Services
1935	LL.D., Yankton College
1937-1946	Hospital Services Plan Commission, AHA, Director Committee on Hospital Service, AHA, director Blue Cross Commission, and later, consultant
1947-1960	Hospital Council of Philadelphia, Executive Director

1960-1964	Hospital Planning Association of Allegheny County, Pittsburgh, Executive Director
1964-1969	Hospital Review and Planning Council of Southern New York, special consultant
1969-1974	Blue Cross Association Consultant

MEMBERSHIPS AND AFFILIATIONS

American Academy of Political and Social Sciences

Member

American Accounting Association

Member

American Association of Hospital Consultants

Member

American Association of Hospital Planning

Member

American Economic Association

Member

American Hospital Association

Life Member

American Institute of Accountants

Fellow

American Public Welfare Association

Chairman of Committee on Public Welfare Accounting

Dictionary of American Scholars

Listing

Hospital Association of Pennsylvania

Chairman of Accounting and Statistics Committee

Phi Beta Kappa

Member

Social Security Administration

Chairman of Committee on Classification of Public Assistance Costs

Who's Who in America

Listing 1930-1967

Who's Who in the East

Listing since 1967

AWARDS

1955	American Hospital Association Award on the 25th Anniversary of Blue Cross
1960	American Hospital Association Justin Ford Kimball Award
1969	American Association for Hospital Planning Special Award
1972	Hospital Financial Management Association Board of Directors' Award
1977	American Institute of Certified Public Accountants Honorary Membership Award
1979	Blue Cross and Blue Shield Associations Pioneer Prepayment Award
1982	American Public Health Association Sedgwick Memorial Medal

BOOKS

Accounting Method. Chicago: University of Chicago Press, 1928, 1930.
New York: McGraw-Hill, 1942.

The Public's Investment in Hospitals. Chicago: The University of Chicago Press, 1930.

Private Group Clinics. Chicago: The University of Chicago Press, 1931.
New York: Milbank Memorial Fund, 1971.

The Municipal Doctor Systems in Rural Saskatchewan. Chicago: The University of Chicago Press, 1931.

The Crisis in Hospital Finance (with Michael M. Davis). Chicago: The University of Chicago Press, 1932.

The Costs of Medicines (with Robert P. Fischelis). Chicago: The University of Chicago Press, 1932.

The Costs of Medical Care (with Isadore S. Falk and Martha D. Ring).
Chicago: The University of Chicago Press, 1933.

BOOKS

(Continued)

A Quest for Certainty. Ann Arbor: Health Administration Press, 1982.

ROREM:

I was born in the village of Radcliffe, Iowa November 17, 1894. My father was a merchant and also engaged in the sale and purchase of farms, building them up for resale. At the age of 15 in the spring of 1910, my family moved to Mason City, Iowa where I graduated from high school in the spring of 1911.

We lived on a farm near Mason City owned by my father. I worked there halfheartedly until the autumn of 1912.

My mother died when I was five years old. My first and only memory of her is the date of her death, and particularly an episode at the home when relatives were grouped around her bedside weeping. After some moments I decided to join in the weeping and was immediately shushed, or told to keep quiet, which seemed totally unfair and gave me a permanent bias concerning the perception of adults.

After the year on the farm I decided I should go to college. Two sisters and a brother had done so. When I proposed this to my father, he merely said, "I wondered when you were going to get out of here."

I thought of going to a Methodist college in Sioux City, Iowa--Morningside College--where my elder siblings had graduated. My brother, who had finished there, said, "Don't waste your time, go to a good school where there are standards."

I said: "What would you suggest?"

"Well," He said, " I think there are only two you should bother with. One is Princeton University, the other would be Oberlin College."

"Oberlin," I said, "is a girls' school for musicians!" My sister had gone there.

"Oh, no. It's a regular college."

I left Mason City in the autumn of 1912 with travel and tuition money in my pocket, a certificate of high school graduation, a note from the principal, and appeared at Oberlin on registration day. Things were simpler in those days, so I was accepted with some reluctance on the part of the registrar's office.

There was little choice in the curriculum. One modern language and one laboratory science were required. I elected German and chemistry. To my surprise in the first semester I found myself on the honor roll with high grades in both these subjects, particularly in chemistry. Up to the first one and one-half years I had thought I might major in chemistry but I lost personal interest in the subject during the long spring afternoons, and then shifted to social science. From then on I majored in political science and graduated with honors in that field, and was elected to the scholastic society of Phi Beta Kappa.

In my entire college career I took no business courses of any kind, and only an elementary one year course in economics. However, I assumed I would go into business after four years of college. In fact, I hardly knew that there existed such activity as graduate study.

Immediately on graduation from Oberlin I obtained a job at the home office of the Goodyear Tire and Rubber Company as an apprentice in the department of manufacturers' sales. Manufacturers' sales meant the sales of new tires to manufacturers of automobiles. My contacts were with manufacturers of automobiles and trucks. Correspondence and sales promotion were directed to the Ford Motor Company, Buick, Cadillac, etc. (The General Motors Corporation had not yet been formed.)

I observed one thing at this time which I have always remembered. In order to introduce a product effectively, it is necessary to persuade people to try it. Our way was to influence manufacturers of automobiles to place Goodyear tires on their products as original equipment so that when car owners asked for replacements they would naturally ask for the product originally on the automobile.

I also worked as an assistant to the Goodyear chief cost accountant, because the automobile companies purchased tires from Goodyear on a "cost" basis. This cost was not determined by Goodyear but by auditors for the automobile companies, which kept their experts at our plant at all times. Our objective, of course, was to get a large proportion of the new equipment business. Goodyear started at least 10 years ahead of their competitors in this field, which accounted for their being the leader in the sale of pneumatic tires in the United States at the time.

After one year with the company, World War I broke out. During the summer of 1917 I joined the Army YMCA and worked for several months at Camp Sherman at Chillicothe, Ohio. This work involved providing and designing recreation for enlisted men. I also tutored soldiers in elementary French, as I had a facility for languages and had some interest in that subject.

After about six months I joined the Army Ordnance Corps, and, following a short course at the University of Chicago, worked for a year and a half in various army camps and at the U.S. Armory in Springfield, Massachusetts. I was commissioned as second lieutenant.

Leaving the military service in the spring of 1919, I went back to Akron, Ohio. I asked for re-employment at Goodyear. Previously, as mentioned, my work had involved only office activity and correspondence. I asked that I be recruited as a salesman in some territory, because I felt I needed some "outside" experience. With some reluctance they informed me that they didn't feel I was the salesman type and should stick to office work.

My response was simple: "I know I am not the salesman type, but I want to get out of here before too many people find it out."

So I went back to Mason City, Iowa looking for some other kind of job. I worked for several months with the Mason City Globe Gazette as a reporter. This paid, as I remember it, about a hundred dollars a month, possibly less.

By chance I dropped into the Sioux City, Iowa office of Goodyear and found that they needed a salesman in one of their territories. On looking up my record they found no demerits and enlisted me as a salesman in the territory surrounding Yankton, South Dakota. An aspect of the new job appeared first in my life that was to recur several times afterward. I took this job without knowing exactly what I was supposed to do, what the exact character and details of my product were, who my prospective customers were, or how to get from place to place.

This new assignment worked out all right. I received promotions, moving from the Yankton territory later to Sioux Falls, South Dakota with a service area much larger than I started with. Since that time in the seven or eight jobs I have held, I have never had a predecessor. I have always been the first person to take each particular job, with no one to "break me in" or instruct me as to where the emphasis should be placed. That has continued up to the present day.

After three years of traveling and lonesome nights in hotels (having been married in the summer of 1920), I decided to leave the field of business enterprise and seek a career in some sort of academic or intellectual work. I applied for a position as teacher of political science in high schools. I also offered to teach German, or mathematics, or any subject, or to be an assistant coach. I was rebuffed everywhere, because I had completed no college courses in Education. So I decided I would apply for a position with a college.

After a series of applications, I was interviewed for the position of Assistant Professor of Economics at Earlham College at Richmond, Indiana, a Quaker school with about 500 students. The position would involve the teaching of business subjects, which were very popular after World War I. The subjects would be elementary economics, marketing, business experience. I was presumed to be qualified to teach business subjects. I informed the president of the college that I could teach all the subjects except accounting.

"Well," he said, "unless you agree to teach accounting, the interview is over."

I agreed to teach accounting and left my Goodyear job the summer of 1922 to enroll for graduate study at the University of Chicago. I studied elementary and advanced courses in accounting concurrently in order to teach that fall at Earlham.

I stayed at Earlham College two years. Because of my youth and the dismissal of the former Dean of Men, I was given his responsibility for a year and a half. Originally I thought this would be an ideal life--to be an adviser to undergraduates--but I found that (as Dean) I really was a proctor of the residence hall rather than a consultant for student careers.

While teaching business subjects in college, I also taught in night school in the public school system of Richmond, Indiana, particularly in the field of accounting. Then (as often later) I taught subjects which I had never previously studied in class. I organized a class in auditing, and gave a course in cost accounting for people who were full-time practitioners in the field. I used existing textbooks and expounded the subject matter from notes I prepared. People seemed to be satisfied and happy with their instructor.

After two years I decided I would like to earn a master's degree, and applied for graduate study at various places including the University of Michigan. Professor William A. Paton at Michigan offered me a fellowship to cover tuition for graduate study, which I decided to postpone, because by this time we had two young children.

The University of Chicago surprised me in the spring of 1924 by offering me a full-time instructorship in accounting. I was one of very few holders of the CPA certificate available for their faculty.

I might say I had always been good at examinations in any subject, and willing to express myself on any topic, knowing I had a 50 percent chance of being right or wrong. The state of Indiana had no residence requirement for eligibility to write the CPA examination and they allowed me to substitute my graduate work at Chicago and my instruction at Earlham College as being private practice "on my own account." To make a long story short, I passed the examination on the first attempt and from 1923 found openings were available, which I had not expected.

I stayed five years at the University of Chicago where I taught courses in accounting, cost accounting, and income tax procedures. I served successively as Instructor to Associate Professor, also as Assistant to the Dean (later Assistant Dean) of the School of Commerce and Business Administration during a period of five years.

At the end of the first year of teaching and part-time study, I obtained a master's degree, and presented a thesis on the branch office management of the Goodyear Tire and Rubber Company. At the end of four more years, in 1929, I received a Ph.D. with a thesis titled Business Value which was a comparison of "value" as applied in business practice with that expounded in economic theory. I came to the conclusion that the value of a commodity or service was what one could receive for it immediately or ultimately. Elaborations are essentially commentaries on this fact both in the market place, and in academic considerations.

In December 1928 during my last year of teaching as Assistant Professor of Accounting, when I was working also as assistant to the Dean as sort of an adviser to students, I was called upon by Michael M. Davis, Ph.D. He was a

medical economist who had just become Director of Medical Services of the Julius Rosenwald Fund in Chicago. He also was a member of the executive committee of the Committee on the Cost of Medical Care (CCMC). This committee had been organized in 1927 to study the cost of medical care from the standpoint of the general public, the individual patient, the institution, and the professional personnel.

The CCMC had been gathering statistical data and general facts about the organization and administration and resources for health care. They were beginning to explore the financial aspects of hospitals and wished to add to staff a person familiar with accounting and administration particularly with respect to capital investment and costs of maintenance.

Dr. Davis asked me to recommend someone with competence in the field of social statistics. After some discussion he offered me a temporary part-time appointment with the Committee, which I accepted, to work with him at the offices of the Rosenwald Fund in Chicago. He informed me I would not be a regular member of the staff but would work on a specific study, for which money was available from the Rockefeller Foundation. The study would be of the amount and nature of the capital investment in the hospitals of the United States. No such study had ever been made, no such estimate had ever been compiled, and no specific information was available in the libraries. If I were to accept this assignment, I would perform the task in my own way and find out whatever was available.

The opportunity appealed to me as I had been active in some aspects of public finance and nonprofit corporations. Under my direction several master's degree students had prepared theses on trade associations. I had

also served on a federal committee to develop uniform statistical terms and definitions for various units of social service such as clinic visits, patient days, and "free" service at health agencies.

The Committee was composed primarily of sociologists, business men, and physicians. I agreed to take the job at the end of the academic year, meanwhile working on a part-time basis through the summer of 1929. I went on the full-time payroll of the Committee on the Cost of Medical Care January 1930 and moved to Washington, D.C.

My first study of the cost of medical care, financed by the Rockefeller Foundation, was published in November 1930 by the University of Chicago Press with the title, The Public's Investment in Hospitals. This title was used because the preliminary findings showed that hospital capital had come from public sources (rather than from private investors) which expected neither repayment of the original capital nor a return in the form of interest.

Investor-owned hospitals at that time represented about 10 percent of the national total, as the estimates were finally developed--a percentage that still remains. The money invested in the hospitals in the United States has increased twentyfold, but the ratio of investor-owned hospital remains the same--about 10 percent of the national total. The capital of the other 90 percent at the time of the study was equally divided between philanthropy and taxation.

The Committee on the Cost of Medical Care conducted a program with many subdivisions. My own studies were limited to business operations, or to the fiscal and administrative side of medical care production. Consequently after

I was nicely started on the effects of hospital capital and its relations to hospital costs, I conducted a study of group practice among private physicians, a trend which had been developing for at least 40 years--having its roots in the Mayo Clinic of Rochester, Minnesota.

The first study, The Public's Investment in Hospitals, was issued in November 1930 by the University of Chicago Press, which was the official publisher of the Committee on the Costs of Medical Care. A second study, Private Group Clinics, was published February 1931.

Some broad conclusions came to my attention at that time which appeared to be important. The primary problem facing society in providing medical care was the effective utilization of capital investments in facilities and personnel. At that time the average hospital had an investment of about a million dollars. The average public investment in a physician was approximately $10,000. The average investment in a nurse was zero, since she worked her way through nursing school, making a personal investment from the day she entered the institution's premises.

An interesting part of the capital investment study was that many facts and data were obtained by personal visits to institutions. I would ask each hospital for a copy of its financial statement. During the winter of 1928-1929 the first hospital I visited was the Huggins Memorial Hospital in Wolfeboro, New Hampshire which had 24 beds, and second was the Massachusetts General Hospital in Boston which had 24 operating rooms. At neither place was there any record of capital investment. For purposes of insurance, some records were maintained, but neither hospital kept a plant ledger, and management was surprised that anyone should ask for such information.

After a few weeks, and after visiting a dozen more institutions, I found that instead of asking questions I was answering questions. This was a field in which I knew very little, but in which the hospital representatives knew nothing. Within a month I became an expert on capital investments in hospitals and began writing on the subject. There was no literature. If I wanted to read something about capital investment, I had to write it myself.

An illustration of how little I knew about hospitals was that I did not know that attending physicians at hospitals were private practitioners using the institutions to carry on their practice. I did not know that very few deans of medical schools in the country received cash salaries for their work. They donated their services for the most part, and made their living from serving private patients in their spare time.

For example, a statement from the Presbyterian Hospital in Chicago, the teaching institution for Rush Medical College, revealed that the medical school paid $500 for the services of Dean of the medical school, Dr. S. E. Irons, who later became President of the American Medical Association.

I said to him, "I find everything in the statement but your salary."

"That's it."

"That $500? You can't live on that."

"Of course I can't. That's just for office expenses."

"Well," I asked, "how do you make your living?"

"I have a private practice on the side."

The Committee on the Cost of Medical Care was disbanded during the summer of 1933. Meanwhile (1931) I had moved to Chicago to work on a full-time basis with the Julius Rosenwald Fund, acting as Associate Director of Medical Services under Michael M. Davis.

Although the Rosenwald Fund paid my salary and expenses, I still remained a member of the staff of the Committee on the Cost of Medical Care. I was one of the three joint authors of the final report of the Committee called The Costs of Medical Care. The authors were Isidore S. Falk, Ph.D., C. Rufus Rorem, Ph.D., C.P.A., and Martha D. Ring. Dr. Falk was the primary author; I wrote the section dealing with financial and organizational matters; and Miss Ring served as editor and coordinator of the volume as a whole.

During the latter years of the work of the Committee I was the author of a volume titled The Municipal Doctor System in Saskatchewan. I also was co-author with Robert P. Fischelis, D. Pharm. of The Costs of Medicine, dealing with the pharmaceutical industry and the use of prescription drugs and over-the-counter products.

The Committee on the Costs of Medical Care was the first public body to approach the entire problem of producing, delivering, and financing health services to the American people. The project began during a time of high wages and low prices. The Committee concerned itself with prevention, treatment and financing phases of personal care and public health. The study cost a million dollars, which was spent over a period of five years. Since that time many millions of dollars have been spent annually to discover and rediscover some generally known facts including the following:

(1) No one can tell when he will be sick or injured, or what his care will cost.

(2) The total costs of medical care needed by a group of individuals during a period of time can be estimated with reasonable accuracy.

(3) During any given time period some individuals will require no health care, some will require a great deal.

(4) It isn't the cost, it's the uncertainty that gives rise to most criticism of health service.

(5) Prevention is cheaper than cure--and less exciting.

(6) Some accidents will happen that require health service.

(7) Man's best friend is himself. Most of his health service consists of following a doctor's advice.

(8) Many of the best things of life are free--moderation, rest, etc.

(9) Elderly people have more sickness and less money than others.

(10) Present methods of producing and financing health care tend to increase the total and per capita expenditures for all groups of the population.

(11) Medical practitioners and institutions can provide better and more service through cooperation than in competition.

(12) Medical practitioners and institutions have a vested interest in maximizing health services and stressing their complexity and mystery.

(13) Many doctors "overwork" themselves by performing services and giving advice which can be equally well provided by nurses and supervised assistants.

(14) Hypochondriacs often request, and receive, care which health practitioners consider unnecessary. A patient would often be better served if a doctor were paid to refuse services or drugs which a patient thinks he needs.

(15) It has been suggested that an insurance plan should require patients to pay deductibles or partial fees, thus to reduce the amount of unneeded care. This would constitute the practice of medicine by arithmetic rather than by professional judgment.

(16) The average individual American is not capable of dealing with his own economic problems of health care. Legislators have recently discovered what had long been obvious to the average American.

(17) Most of present research and experimentation is unnecessary to accomplish the avowed purposes, namely: (a) to determine whether any specific method of delivering service would be cost effective; and (b) to determine whether a new method of financing health care would be more equitable to individuals who require service.

As I said, in 1931, after two years with the Committee on the Costs of Medical Care, I returned to Chicago to work as an Associate for Medical Services of the Julius Rosenwald Fund. I remained with the Julius Rosenwald Fund until December 1936 when the trustees of the Fund liquidated the program in medical economics. During the five year period I worked in Chicago, I conducted some research but most of my time was devoted to the promotion of uniform accounting among hospitals, the development of group practice by physicians and at hospitals, and the development of "group hospitalization"--which was the name originally given to the Blue Cross movement for the group payment of hospital and medical services.

During this time "organized medicine" was reluctant to accept group hospitalization on the general principle that it was socialized medicine and would remove medical practice from control by the doctors. The first formal recognition by a medical group came from the American College of Surgeons, whose members performed services almost exclusively in hospitals. They saw in the Blue Cross movement a device by which they could collect either larger surgeon's fees, or find it easier to collect all fees because there was no hospital expenditure to take precedence over the doctor's charge.

My first interest in the economics of health care had centered upon the production of service. The main unsolved problem was (and still is) effective utilization of the huge social investment in facilities and personnel.

I had prepared my three extensive publications (Capital Investments in Hospitals; Private Group Clinics; and The Municipal Doctor System in Rural Saskatchewan) before I gave much attention to group payment, that is, health insurance.

Health care insurance, taxation, or some form of group payment appeared necessary to achieve equity of the financial burden and appropriate distribution of care.

Hospital care insurance originated as a device by which an individual hospital would be guaranteed specified revenue, and would assume responsibility for specific services for groups of people who paid money to the institution. They were eligible to receive specified care at that institution without extra cost at the time of illness.

The most publicized health insurance program was one initiated in Dallas, Texas by the Baylor University Hospital. It enrolled members of the Beneficial Association of School Teachers at the city of Dallas in a program by which each one would contribute 50¢ a month regularly. For this amount each individual was entitled, if necessary, to 21 days of hospitalization each year.

The program was initiated by Justin Ford Kimball, D.D., who was Vice President of Baylor University and administrative officer of the medical school, dental school, and other health-related professional activities in

Dallas. He persuaded approximately 1,600 of the 2,000 teachers, many of them Baptists, to join the program and pay the money into Baylor University Hospital.

Many individually sponsored health programs had been established before. The Baylor program was the first institution to start a program of health service benefits, as opposed to cash indemnities toward the hospital bill. The service benefit principle is the feature, and probably the only distinctive characteristic, which explains the rapid growth of the insurance principle in paying hospital bills.

One weakness of the Baylor Hospital plan was that the benefits were available in only one hospital, a Baptist hospital, therefore the plan was not widely acceptable to people of other religious beliefs.

During the time that Baylor Hospital was expanding its coverage from approximately 1,600 to 6,000 beneficiaries in the city of Dallas, two other hospitals established similar and competing programs. One was a Catholic hospital, the other a Methodist institution. Both of these hospitals ultimately enrolled approximately 5,000 beneficiaries who paid 75¢ a month through a promoter for exactly the same benefits as at Baylor. Each hospital received 50¢ a month for each person enrolled by the promoter. The enrollment in the Methodist and Catholic programs was not deterred by the fact that their fee was $9.00 a year while the Baylor program was available at only $6.00 per year. Any reluctance to participate arose from disbelief in the programs in their entirety.

I found out later when interviewing business executives about enrollment of employees that none of them objected on the grounds that family coverage was not worth $24.00 a year. They doubted whether the contract was worth anything. They just did not believe in the program at all.

Originally people were required to choose one hospital at the time they joined the plan. It soon became apparent it was necessary to allow people to choose their hospital at the time of illness rather than at the time of enrollment. This meant, of course, that effective group insurance for health care should allow free choice among several alternative institutions. Dallas and the state of Texas were among the last areas of the country to have a free choice, areawide plan. Ultimately the single hospital plans which had been formed at Dallas, Houston, and Fort Worth were merged into one plan, the Hospital Services Association of Texas. Except for the principle of providing hospital service benefits, Dallas (and the Baylor Hospital) cannot be considered the instigator of communitywide health services prepayment.

The earliest plan to provide service benefits in several institutions appeared in the city of New Orleans where the Baptist Memorial Hospital joined with the Jewish hospital, Touro Infirmary, in establishing a citywide program with service benefits at the two institutions and modest cash benefits elsewhere.

The first full-blown, communitywide, free choice hospital service organization--still group hospitalization--was at Newark, N.J. It was introduced in 1933 by Frank Van Dyk, who later moved to New York (1935) to become director of the New York City plan. In Newark the areawide plan covered approximately one dozen hospitals, each of which agreed to provide stated benefits for a stated amount expressed in terms of dollars per day.

Another important and early plan of citywide group hospitalization developed in 1934 in St. Paul, Minnesota where Mr. E. A. van Steenwyk, a 29 year old former real estate operator, conceived the ideal of free choice benefits among all the institutions in St. Paul. He also introduced for the first time the principle of dependents' benefits. Other programs had been for employed persons only with no coverage for wives or children of the employed individuals. The Minnesota dependents' coverage did not start as a full-benefit program. For an additional 25 percent of the $1.00 per month charge to employed individuals, coverage would be allowed for dependents.

For some time in the United States it was customary to charge an additional amount for each dependent. Within a few years the law of averages indicated that it would be practicable from a statistical point of view to have a standard family rate regardless of the size of the family. In other words, one uniform rate for a one-person family, male or female, and a uniform rate for a family of two or more persons regardless of number of dependents.

It became my responsibility while working for the Rosenwald Fund to visit, upon request, many areas throughout the country. In the course of several years I visited at least 40 of the areas where plans were established. In several of these I had the pleasure of being able to recommend individuals to serve as the original executive directors of plans. These directors were recruited from many fields: finance, industry, accounting, sales, hospital administration, social work, and education.

The Rosenwald Fund decided in 1936 to discontinue its program in medical economics, although there was widespread interest among the general public. (Julius Rosenwald had died in 1932.) Some board members of the Fund were

embarrassed by personal criticisms from their family physicians who objected to change in medical service organization. As a result, early in the year of 1936 the medical economics section of the Julius Rosenwald Fund was voted to be discontinued at the end of the year. (Certain other work in Negro public health and education continued for some time longer.)

The Rosenwald Fund faced the problem of what should become of the medical economics staff, Michael M. Davis, and C. Rufus Rorem. Separate amounts were voted: a total of $150,000 for Davis, and $100,000 for Rorem, to be paid in four years of equal installments. The problem then arose as to what agency should sponsor their activities, since the Fund was required to restrict its donations to nonprofit organizations eligible to receive grants.

Michael M. Davis decided to move to New York City to establish a nonprofit corporation called the Committee for Research in Medical Economics. It was headquartered in New York City for several years until he moved to Washington, D.C. to continue his interest in health economics on a personal basis.

My grant was offered to several agencies. My first suggestion was that the money be granted to the Twentieth Century Fund, which had been interested in medical economics, particularly group practice. The Twentieth Century Fund decided not to accept the grant, since it would mean the addition of a stranger to their division of medical economics, and might embarrass their present staff.

I then made the suggestion that the National Association of Community Chests might consider a program of this type. The director of that organization considered this program as outside its sphere of interest, which was charity and public services to be financed by donations from individuals

and groups. He recognized that group hospitalization was a way by which people collected their own money for services for themselves--an organization to administer funds as though it were an insurance company. Furthermore, he foresaw that such programs could become areawide or even statewide, and would not fit into the programs of local community chests and their charitable activities.

The third offer was made to the American Hospital Association, which promptly accepted the grant with the understanding that I (Rorem) would become a part of their staff but be paid from the money granted by the Rosenwald Fund.

Beginning January 1, 1937 I organized the Committee on Hospital Service of the American Hospital Association and I moved my offices from the Julius Rosenwald Fund to 18 E. Division Street in Chicago where I became the third male employee of the American Hospital Association. The others were Dr. Bert W. Caldwell, Executive Secretary of the Association, and an individual who served as janitor. By the vote of the Trustees I was given the title of Associate Secretary of the American Hospital Association, and Executive Secretary of the Committee on Hospital Service of the American Hospital Association.

I assumed no duties or responsibilities for the activities of the Association as a whole, was not invited to the meetings of the Board of Trustees, and was not dependent on the Association for travel expenses or any other costs of the Committee on Hospital Services.

Two primary objectives comprised the program of the Committee: (1) improvement of hospitals through the development of uniform accounting according to a standard program which had been developed in 1933-1935 under my

chairmanship while still in the employ of the Julius Rosenwald Fund; and (2) development of group hospital insurance for the payment of hospital bills on a community, state, and national basis.

I want to mention at this point in our discussion of the Committee on Hospital Services that I took part in the activities at the annual conventions of the AHA during those years following 1929, and that many of those activities had some bearing on the development of group hospitalization.

Programs of the annual conventions of the American Hospital Association (in 1929 at Atlantic City, and in 1930 at New Orleans) included references to my forthcoming book, The Public's Investment in Hospitals. The first mention was in 1929 by Winfred H. Smith, M.D., a member of the Committee on the Cost of Medical Care and superintendent of the Johns Hopkins Hospital, Baltimore. The mention in 1930 at New Orleans was by Julius Rosenwald, who quoted widely from the galley proofs of the forthcoming book.

At the 1931 annual convention of the American Hospital Association in Toronto, a paper on "Group Hospitalization" by Dr. Justin Ford Kimball was presented in absentia, by an unidentified volunteer. The paper described a contributory insurance program for 1,500 Dallas, Texas school teachers who, for 50¢ per month were guaranteed 21 days of care (annually) at the Baylor Hospital of Baylor University. Dr. Kimball had been city superintendent of schools, and had become (about 1925) vice-president for medical affairs of Baylor University.

While the group hospitalization paper was being discussed, I was elsewhere in the convention. At one meeting I described the "Middle-Rate-Plan" for controlled physician fees for semiprivate patients at the Massachusetts

General Hospital in Boston. At another session I presented a formal paper advocating improved and uniform accounting entitled "Cost Analysis - An Aid to Hospital Financing."

Beginning with the Detroit 1932 convention, the developing voluntary hospital insurance was the subject of considerable discussion. The movement was called by various names, such as hospital insurance, group budgeting, prepayment plans, group purchase of hospital care, and group hospitalization. The Blue Cross symbol and name were not mentioned, inasmuch as they were developed two years later by Mr. E. A. van Steenwyk of St. Paul, Minnesota.

During the period 1932 to 1936 I had served as consultant to the American Hospital Association Council on Community Relations and Administrative Practice although my headquarters was located at the Rosenwald Fund. The Fund paid my salary and other expenses during the four year period.

It was customary to report to the annual convention of the American Hospital Convention. My first presentation to the national meeting in Milwaukee in 1933 included the following:

> As long as hospital bills are unpredictable as to amount, people will complain about them. It is impossible to silence a popular, present day criticism of hospitals by explaining that hospitals are efficiently managed, or that hospital bills are reasonable...
>
> The function of group hospitalization is not to make easier the problems of the superintendent, but to solve the problems of the individual and of the public who own the hospitals...
>
> Group hospitalization, by way of definition, is a device by which people pool their resources by fixed and equal periodic payments, the total being used for the payment of hospital services to members who require such care. Group hospitalization plans are not primarily for the benefits of hospitals...but for the benefit of people.
>
> The experience of the last several years...has demonstrated that the people can and will budget their hospital bills if given an opportunity...

The Council on Community Relations and Administrative Practice (following the action of the trustees endorsing the principle of group hospitalization) has specified certain characteristics (or criteria, or essentials, or points) which would characterize successful and ethical group hospitalization plans. Let us examine them now and test their validity, both by logic and experience.

The first principle was that a group hospitalization plan should place primary emphasis upon public benefit and secondary emphasis upon hospital finance...Group hospitalization is a method by which people pay their bills, not a product to be sold by a hospital executive, although the public will require the active cooperation of hospital directors in outlining the administering of their plans...

The second essential was that group hospitalization shall be limited to hospital services. The term "hospital service" was purposely not defined, but it means merely that the plan should include only those services which the hospital regularly provides...

As one man said to me in Boston: 'What is the objection to including the physician's bill?' I merely replied, 'I have no objection, and the public has no objection. Whenever physicians want medical bills included, some arrangement can be made.'

The third criterion was that it should involve participation by all hospitals of standing in the community. This policy avoids competition among individual hospitals.

The fourth point was that plans should be economically sound. The rates should be sufficient to cover the costs of services and payments to the hospitals, and payments to the hospitals should be sufficient to remunerate them for the care rendered on behalf of sponsorship.

The fifth point was that group hospitalization should have community sponsorship. A group hospitalization plan should be established for the people and by the people. The initiative may come from hospital superintendents, professional groups, industrialists, social workers, unions, or people in the various trades.

The sixth and last characteristic is that it should be promoted on a noncommercial basis. No intermediary group should be allowed to take the position of promoter or sponsor with the idea of a net profit or a net loss made from the success of this plan.

The foregoing criteria were ultimately developed into 14 standards which served as the basis for formal approval of Blue Cross Plans by the American Hospital Association.

I held the position at AHA for 10 years (January 1937 to December 1946) during which time the Committee on Hospital Service changed its character in several ways. During the second year (April 1938) an approval program of Blue Cross hospital plans was developed according to standards I had drafted, and which have been amended from time to time.

During the second year the name of the Committee was changed to The Hospital Service Plan Commission. After another year the term "Blue Cross" was introduced and the sponsoring group was known as the Blue Cross Plan Commission, which was the forerunner of the Blue Cross Association.

At this point mention may be made of the origin of the term "Blue Cross" which was used to identify nonprofit hospital service plans which had gained the approval of the American Hospital Association. The term "Blue Cross" was first introduced by Mr. E.A. van Steenwyk who used this title to identify his plan in St. Paul, both as a design on the literature and as a term to describe the organization which was registered by the State of Minnesota--not as an insurance organization, but as a hospital service plan association.

The Blue Cross was widely adopted, with or without permission, by various plans being formed throughout the United States. In the spring of 1939 a list of "approved" plans was issued. These plans were allowed to identify themselves by a Blue Cross on which the seal of the American Hospital Association was superimposed. This granting of the seal to indicate approval by AHA came about through formal action of the Association's Trustees, approved by the Association's House of Delegates and membership.

During several years of the period when I was serving with the Blue Cross Plan Commission, each approved plan paid annual dues to the Association based on the number of subscribers in the plan at the end of the calendar year. Each approved plan became an associate member of the Association. The greater portion of the dues was used for the activities and expenses of the Blue Cross Plan Commission.

Before the establishment of membership dues there had been other changes in the management of its successors, the Commission on Hospital Services, and the Blue Cross Plan Commission. One was the temporary election of six hospital administrators, chosen as "advisers" to the Plan Commission.

The original Committee on Hospital Service consisted of five persons with voting privileges and final authority over resources and program. They were appointed by the President of the American Hospital Association. The five persons were as follows: Basil C. MacLean, M.D., Superintendent of Strong Memorial Hospital in Rochester, NY., Chairman; S. S. Goldwater, M.D., Commissioner of Hospitals of New York City; Rev. Maurice F. Griffin, a Catholic clergyman of Cleveland, Ohio; Robin C. Buerki, M.D., administrator of the Wisconsin General Hospital, Madison, Wisconsin; and C. Rufus Rorem, Ph.D., C.P.A., Executive Secretary and voting member of the Committee.

As of January 1947 I resigned from the Blue Cross Plan Commission to accept the job of Executive Director of the Hospital Council of Greater Philadelphia, covering five counties in southeastern Pennsylvania and three across the river in New Jersey with a population of approximately five million people and a membership of about 60 hospitals.

Hospital representatives in the new Council (not to be confused with the Philadelphia Hospital Association) were all trustees of member hospitals. The representatives in the Council elected appropriate officers consisting of a chairman, vice chairman, treasurer, and secretary. The Council was financed partially by contributions from member hospitals based on the bed capacity at the time. The Council also received a substantial portion of its resources from the local community chest, the Community Fund of Philadelphia.

There was some confusion as to the program of the new Hospital Council. I conceived the purpose primarily to be areawide planning for comprehensive health service to the public. I felt our responsibilities should cover capital investment, financial operation, cooperation with the Community Chest, and negotiations with Blue Cross. There were also shared activities--joint activities--such as uniform accounting, and joint purchasing. I remained in this job for 13 years until my retirement at the statutory retirement age of 65 in December 1959.

Shortly after my announcement in September 1959 of resignation from the Hospital Council of Philadelphia, I accepted a job as Executive Director of the newly formed Hospital Planning Association of Allegheny County with headquarters in Pittsburgh.

This opportunity was very appealing to me as I had always felt that coordination of facilities and personnel was the proper major objective of community and professional leaders. The Pittsburgh situation was specially promising since my personal friend, Robert M. Sigmond, was the executive director of the association of hospitals in Allegheny County, and he was a leading figure in developing the planning agency.

The Hospital Planning Association was an organization of industrial and commercial leaders in Allegheny County, many of whom were trustees of hospitals in the area. No hospitals held membership in the Association as operating institutions, nor did they make any contributions. All financial support came from industry and commerce based on recommendations of a committee of civic leaders. The annual contributions ranged from a high of $25,000 down to a low of $1,000 from individual leaders and smaller enterprises. The three largest contributions were: United States Steel, $25,000; Westinghouse, $10,000; and Alcoa, $10,000. I recall that there were 35 or 40 contributors. The original operating budget was approximately $50,000 a year. During the four and a half years I remained there additional grants were received for special projects from the U.S. Department of Health, Education and Welfare. Two studies were completed and published. One was a study of a hospital as a medical service center, the other was a report on planning for hospital services in rural and suburban areas.

I accepted the Pittsburgh position with the idea of staying four or five years. In the middle of the fifth year I announced my intention of retiring permanently. I also let it be known that I intended to retire to the City of New York to be nearer our children and their families. A son lived in New York City, a daughter in Philadelphia.

Upon hearing that I was moving to New York, the Hospital Review and Planning Council of Southern New York inquired if I was willing to join their group as a special consultant. My answer was in the affirmative. I also gave the hint that if they wished me to come sooner, I would resign somewhat

sooner. As a result I resigned July 1, 1964 and became a special consultant to the Hospital Review and Planning Council for approximately five years, retiring finally in March 1969.

After that I worked as a special consultant to the President of the Blue Cross Association on a strictly part-time basis, to be paid $5,000 a year for a period of five years in semi-annual installments of $2,500 each. My duties were not specified, but it was understood that I would be available for consultation with the President from time to time. I also was invited to attend any committee meetings that were of interest to me, and also to be present at meetings of the Board of Directors from time to time.

As a matter of fact, I regarded my reimbursement primarily as an honorarium for past services rendered, in as much as no retirement program had been developed during my time. I continued in this position until June 30, 1974, and have continued to live in New York City in Greenwich Village.

* * *

I have given a chronological account of my life up to 1979. Now I should like to elaborate a little about some of the ideas, events, and persons I have already discussed somewhat. These remarks will not be necessarily in time sequence, but as they occur to me as I talk.

WEEKS:

Before you begin, let me interrupt. The other day I noticed your name as an author of a piece in Encyclopaedia Brittanica.

ROREM:

In the year 1957 and again in 1971 I was asked by Encyclopaedia Brittanica to prepare an article on "Hospital" for their books on the subject. The article was expected to cover all aspects of the subject throughout the world and since the dawn of civilization. To my suprise, I could find no definition, good or bad, to use as the basis for introducing the subject. Accordingly I created a definition in 1957 which has served as the topic sentence of the opening of the articles on "Hospital" for that year on. The sentence was, "Hospital, a place equipped and staffed for diagnosis and treatment where sick or injured persons receive medical care of such nature that some patients are required to utilize a bed during part or all of their stay."

Of particular interest to me was the concept that a hospital was a place where people received appropriate health services, and that only some of them utilized a bed during all or part of their stay. The article consisted of approximately 4,000 words of history and prophecy.

WEEKS:

Will you comment on third party reimbursement, and possibly about its effect on the operation of hospitals?

ROREM:

It has been said that reimbursement through third parties caused hospitals to set up good accounting systems. I don't think third parties were conscious of making it necessary, although it likely had that effect. I was interested in uniform accounting long before third party payments were a consideration. At first the third parties merely provided cash to the institutions through contracts that paid identical per diem amounts to all hospitals (with high

costs or with low costs). The idea of basing payments on "cost" didn't develop until the payments became a larger part of the total revenue of the institution.

In fact, in the early days the rates were not negotiated. In the single hospital plans, as Baylor University, the money was paid over to the hospital as collected from the membership. When multiple hospital plans were developed, each hospital was paid for days of service provided, at the same per diem rate for each institution. The reason this was satisfactory was that it was considered "found" money. Hospitals received that much more than nothing.

Baylor University kept the money in a separate bank account. It was paid over to the operating account as fast as it was earned. The institution provided specific services as needed. As far as the differences in costs among hospitals are concerned, they were not taken into consideration until later. Then bit by bit the inequity of paying the same to hospitals with high or low per diem costs became apparent, and an attempt was made to reverse it.

One of the first attempts to adjust Blue Cross payments to hospitals was related to the length of stay. The idea was that each hospital would receive double rate for a one day stay, triple rate for a two day stay, and then level off. The actual difference in payment among institutions because of the differences in their expenditures on behalf of patients was a much later development.

I have always supported cost analysis as a method for comparison of operating costs: (1) to measure experience during one period with that of another; and (2) to determine whether the various departments are efficiently operated.

Cost accounting for the various departments may be useful in controlling total expenses, but "costing" the various products of a hospital (lab tests, operations, patient day, etc.) has never really served as a basis for pricing health care at hospitals.

One main problem in computing unit costs of health care at hospitals is the allocation of overhead items (dietary, housekeeping, etc.) to the revenue producing items. Alternative methods of allocation are the so-called direct and step-down systems. By the latter system the indirect expenses are allocated among each other before being charged against the end product services (inpatient, outpatient, etc.).

In my opinion, the simplest method is the one most helpful to administration. Refined mathematical procedures often give the impression of precision and accuracy, and, therefore, of significance. More than likely such calculations are irrelevant to decision making in the pricing and financing of health care at hospitals.

The term flat rate, or inclusive rate, per day was originally used to designate a composite of services available to a hospital inpatient whether he used all or merely some of them during his stay. Until third party agencies were developed, the inclusive rate system was found in very few institutions. The flat or inclusive rate was actually an application of a health care insurance principle. It assured a patient that his total bill would not exceed the rate per day times the number of days of inpatient care.

Blue Cross and other third parties originally paid the providers identical inclusive rates for services listed in the subscriber contracts. Later the system was amended to recognize differences in length of stay and institutional costs.

WEEKS:

Would you comment on allowable costs in figuring third party reimbursements. I am thinking particularly of depreciation allowance.

ROREM:

One of the most controversial elements in hospital reimbursement is whether and how an allowance for depreciation should be included in the amounts paid to institutions. The main controversy centers on whether such allowance should be related to original cost of construction or purchase, or on the probable costs of replacement. Hospitals in "new" buildings favor actual cost as the basis. Hospitals using old buildings prefer replacement cost.

In such discussions I have suggested that an allowance for replacement is the sounder public policy. However, I disapprove of paying any depreciation allowances directly to the institutions on a current basis. Such payments should be placed in a community or regional fund for use from time to time when a particular hospital needs to make a capital investment for expansion, remodeling, or change of program.

It is essential that each community or region have the necessary resources to provide good care for its members. However, it is not necessary that each hospital be guaranteed perpetual existence. Hospital capital belongs to the community, for the larger part has been furnished by taxation or philanthropy. The important thing is the common funding for the community or region.

Some person might reason that some hospitals that receive depreciation allowances don't fund them. That the allowances get lost somewhere. So, if you put the allowance into a community fund, the money would be available when it was needed to build. You could say that, but that is not the reason. The reason they should not get the money is that the money does not belong to the hospital. It belongs to the community. The people paid the money. The hospital is comprised of a certain amount of social capital.

If you have time to glance through my book, The Public's Investment in Hospitals, you will find that I said that it would probably never be possible for hospital reimbursements to include substantial allowances for depreciation. But I was wrong on that. They have been paid that depreciation. If I had known that might happen, I would have said it was against the public interest for an individual hospital to establish a separate fund for depreciation and replacement. If the public decides to change a hospital into a nursing home, it can do so from the common fund.

Am I talking regional control? Yes, indeed. If you start with the theory that an institution that takes the trouble to get itself started has a right to do everything it can to keep itself going, then you are in trouble.

There would be agreement that it is necessary to provide necessary obstetrical services to the community, but this should not mean that every hospital have or expand its OB facilities.

It was in 1966 as a member of the staff of a New York planning agency that I was a joint author of an article, "Does Every Hospital Need an OB Service?" Of course, every hospital doesn't need an OB service. I stated the standards

I had set up 15 years before saying that unless a hospital can serve 2,000 births a year, it ought not to have an OB department, because it won't be able to maintain a good service.

At the time I wrote the article they would ask: "You mean a hospital should not be allowed to have a department or to expand even if it does have to money to pay for it?"

That was the question to stop all questions.

I said, "Yes, of course I do."

I didn't think it would ever happen, but now certificates of need are required for much of the new construction. In the sense of regulation, the government bodies are leading the voluntary agencies in planning for a community's health care.

WEEKS:

It has been said that construction costs, capital costs, are rising so fast they are becoming a major factor in the high cost per patient day. Would you care to comment?

ROREM:

Some of the new construction of hospitals is running $100,000, $150,000, or even more, a bed. Many are becoming alarmed at the thought of the third parties including the depreciation of that amount of capital cost in the reimbursement schemes.

I used to say that a certain amount--$15,000 a bed--was terrible, was frightening. Now I say that $150,000 a bed is ridiculous.

Instead of worrying about how to raise the money to build such a hospital, it is better to worry about how to avoid the whole project.

If you ever were in Chicago in the old days, you'd pass a clothing store called Foreman & Clark which sold men's suits at a bargain. They had all second floor salesrooms. They said, "Walk upstairs and save $10!" I framed a paraphrase for that: "Walk right on and save $50!"

In line with that I say: Instead of going into a hospital and incurring a bill of $1,000 for two days, stay home and keep the money. Physicians would agree in private that many patients could stay home. Patients could come to his office at the hospital, and go home the same day. There could be a minimum charge. They might agree, for example, not to provide any care for less than $50--even if it were to take a speck out of your eye. In the same manner, if it were a very important laboratory test, the price would be $50, or any other figure. The idea of using an average figure for everything is a good one. It's not a wild idea.

WEEKS:

Have you anything to say about today's view of Blue Cross?

ROREM

Sometimes people will ask if Blue Cross has created a monster. I ask if it's the physical structure, or the point of view that Blue Cross created.

As a physical structure, it obviously has helped create hospitals. I said in an article in 1954 that even if hospitals were planned on a community basis we might still have too many. This might not be all bad, because some could be used for other things--used for nursing homes (before they started, for old folks homes)--used for outpatient facilities. I am a great person for remodeling rather than rebuilding.

Now to get back to the other aspect that Blue Cross may have helped create a point of view that drugs and lancets could accomplish everything. I believe we probably are having too much medical care. I say this in the sense that we seek services of physicians too often. If we think of patients' care of themselves as medical care, then we don't have too much. I think the solution to any so-called shortage of hospitals, for example, is to stay out of the hospital. The way to give a doctor the chance to lengthen his life, which he might shorten from overwork, is to stay away from him and have permission to talk with his nurse.

"Why don't you go home and rest?" she might ask. Or she might say, "Everything considered, you should stay right here, the doctor will see you."

A nurse ought to be rated on the number of people she can keep away from the doctor. That, of course, is heresy and practicing medicine without a license on my part, but I can't be sued for it.

WEEKS:

You were one of the first medical economists and always had practical outlook on things. Any comments on the present scene?

ROREM:

Some persons point to the economics of medicine and ask if that's what may be keeping the doctor seeing as many people as he can. That's where it all starts. The doctor is practicing medicine to yield the greatest possible return. It's amazing when you consider what society has done to itself. We give physicians the legal authority to keep others from competing with them, legal authority to serve anybody they wish to, legal authority to charge whatever the traffic will bear, and legal authority to refuse to serve any

patient they choose to turn away. You add all that together and it's a wonder that a physician is honest at all. All these factors tend to make him do what is best for him economically, rather than what is best for the patient hygienically.

One of the most debated features of the economics is the way the doctor gets paid. Most of them work on the fee-for-service plan rather than on a salary. The fee-for-service system is all right in a delicatessen. If you don't want the commodity the store sells (if the price of peanut butter goes up from 50¢ to a dollar a pound), you just don't buy it, or you eat less of it. You can't do that with medical care. That's where we came in. The economic differences between medical care or health services and ordinary commodities are legion.

We'll all accept the fact that a person is entitled to health care if he needs it, without regard to his ability to pay. Second, we believe a person should keep as healthy as possible, be careful, and eat properly. We know that two people with the same amount of money may require health services that vary in magnitude of 100 to 1. One person may need nothing in a particular period; the other will need more than he can pay for in a lifetime.

However, buyer and seller are not on equal terms. The physician may know what's wrong with you, but it's obvious the patient doesn't know what's wrong. So they are not on equal terms. It's not a situation with an informed buyer and an informed seller where you safely can let the buyer beware. Add all those things together and you'll find that the fee-for-service ideal is pretty ridiculous.

You may ask: How do you work on that? Not, in my opinion, by putting "caps" of costs of things and services. There is need to change the method of reimbursement. I think a doctor of medicine should be paid by as professional a method of compensation as a clergyman or a teacher. He obviously should make a good salary. I wouldn't make it too small. I would say a top specialist should have a salary the same as a United States Senator. When the Senate salary reaches $100,000 that becomes the rate for the doctor. It should go to the man the public thinks is entitled to it, not to the man with the best sales personality.

The real problem is that you can't protect yourself as a patient. You don't know what illness you've got. You don't know what should be done for it. You have to trust somebody. Why not pay the person who represents mankind, and has your interest at heart? If the doctor gets the same fee when he sends you home with a smile and a pat on the back as when he writes a prescription or performs surgery, it would be different. There isn't any doubt in my mind that the fee-for-service system interferes with the quality of medicine.

Of course, it's always a matter of dollars. Probably most of the physicians would not be prepared to settle for a United States Senator's salary.

About the second week after I began a study of capital investment I developed a one sentence questionnaire which I put to every doctor I met, wherever I was--at a party, in business, in a hall, on the street, accidentally. I asked the same question: "Doctor, what do you think of the idea of physicians working on salaries?"

They all gave the same answer: "What salary did you have in mind?"

They always said that, never a flareup as to it being undignified, improper, or a trend toward Communism. A simple, practical answer: "What salary did you have in mind?"

That was at a time, 1929, when the average income of the American holder of the M.D. degree was $5,000 a year and when 40 percent of them made $2,000 or less. There were some who made $1,000 and some who made $100,000.

At that time, when the average doctor's income was $5,000, I suggested that intern's get full room and board and a $100 a month for incidental expenses. The second year I'd like to have it go up to $200 a month, the third up to $500 a month until a person was certified, then have it go up until it was up to $10,000 in a couple of years, and after the adjustments to tenure with a salary of $15,000. Anything beyond $15,000 would be only for special items, for rare specialties, or for research, or something equally important.

Some said: "Well, if that's what you have in mind, I think it would be all right." Not $100,000, I stopped at $15,000.

They said it was fine. You understand with this plan a person is going to get his salary no matter how hard he works--or he can loaf. One might say that if you pay all doctors the same, everybody will want to go to the best doctor. That's what patients want to do now, anyway. Each physician gives you the impression he is the best doctor for you. Naturally, he can still do this, but, if money is not the object at the time, and he is going to be paid a salary anyway, he may say: "I don't like to operate more than three times a day." There isn't one surgeon in a hundred who operates three times a day every day.

I think salary reimbursement would save the lives of physicians, it would make them better tempered, it would give them some respect for humanity. Doctors have their respect for humanity challenged every time they meet a person or a patient who acts like a child. I think it's a wonderful thing that doctors are as honest as they are.

I have met some--they are not necessarily prosperous, they are doing well, they are in the Buick class. Did you ever see this magazine that came out of AMA, the AMA News I think it was? It was chit chat, about gossip--a weekly newspaper for physicians, at any rate. The General Motors Corporation bought a page ad captioned: "When You See A Buick at the Door, You Know the Doctor Has Arrived!" Why AMA didn't rebel at that, I don't know. I think they were proud of it. Now it would be another car. It would be a Cadillac or a white Lincoln.

WEEKS:

You have commented on several subjects but now I would like to hear your opinion on Blue Cross and hospital relations.

ROREM:

I'd like to comment on the criticism we often hear about the relationship between Blue Cross and the hospitals. In my opinion the most important thing that has happened in the relationships of the Blue Cross Association and the Blue Cross plans to the providers--hospitals and doctors--was the separation of Blue Cross from AHA. I think it was long overdue. The separation was a healthy thing. It wasn't a sign of anything bad. It wasn't going from bad to worse. I think they were recognizing human nature and the practice of medicine as it is. It is unreal to assume that a buyer and a seller can act as partners in a capitalistic society.

The role of a Blue Cross or a Blue Shield organization or an insurance company should be to represent the customer. Now those three do represent the customer, but the insurance company has to represent its stockholders as well.

WEEKS:

I have recently heard the term "medical care industry" used. What is your reaction to that?

ROREM:

When representatives of the hospitals and of the medical profession allow themselves to be thought of as the medical care "industry," they place themselves in a very poor bargaining position with politicians. If health care is a private industry and so affects the interest of the public, it needs control. If it's a public service, the control will move in anyway.

The practice of medicine has always been an investor-controlled industry. The doctor has invested himself; he has persuaded the taxpayers to invest a great deal more. When he starts practicing, he represents only himself.

The hospitals are now a 90 percent noninvestor industry. The other 10 percent, the proprietary hospitals are totally investor-owned. The proprietary hospitals know they are going to be thought of as an industry, and they would like to have the rules set up so they can play it that way. They know what to do. That is: be careful, be efficient, be economical, don't take customers who can't pay--find a place to send them somewhere else. If patients are difficult, send them over to the university medical center or to a public hospital.

The hospitals for a long time spoke of themselves as a public service industry. As I said, this position puts them at a disadvantage in dealing with politicians. I don't know just what the politicians think of hospitals, in fact I don't know what they think about their own Veterans Administration hospitals, or of state hospitals. I would say, however, that politicians don't know much about the concept of public service.

Speaking of VA hospitals: My first contact with the Veterans Administration was when I was with the Rosenwald Fund and I was a consultant to the American Hospital Association. This was about 1932, just when we were wending our way out of the Depression.

The question being considered was whether veterans should be taken care of in existing voluntary, county, and city hospitals, or whether we should build new ones for them. The American Hospital Association was against building new hospitals for the veterans. They wanted veterans to go to existing hospitals and pay regular rates. They would get regular doctors and pay them.

I was hired to look into this. I was introduced at a meeting by Paul Fesler, who said: "Rufus Rorem is going down to Washington to prove that it would be cheaper to take care of veterans in private hospitals than it would in government hospitals."

I had to stop him. "No, Paul, I am going down to see <u>whether</u> it's cheaper."

I got in to see Congressman Wright Patman. (He recently died. He was chairman of one of those important committees for a long time.) I told him what I was doing there.

He said: "What side are you on?"

"I am not on any side. I have come to find out whether in the public interest it is better to use the voluntary and local government hospitals or to have new ones built."

"I know. Which side? Do you want us to build them, or don't you?"

I said, " I am trying to find out which."

The conversation never passed that stage. He just couldn't believe anybody would come to see him who didn't either want to start something or stop something.

The interesting result of that investigation (to which nobody listened) was that I came to the conclusion that it would be much cheaper to build veterans hospitals in metropolitan areas--not in rural areas--with salaried doctors to be paid not $5,000 a year but $25,000 a year, than it would be to use nonfederal hospitals.

No one took the trouble to read the report.

It is sometimes stated by physicians that salaried staffs would loaf on the job if guaranteed a regular income regardless of the amount of work done on individual patients. This viewpoint is insulting to the many dedicated health workers in governmental institutions who work for salaries, and is not shared by the large numbers of satisfied patients who have received care in tax-supported facilities. Some day it may be considered as respectable to be born in a city hospital as it is to graduate from a state university.

As to investor-owned (proprietary) hospitals and salaried physicians, those hospitals have not engaged any large proportion of salaried physicians to care for patients in their institutions. In my opinion they could make more money and give better care if they operated with full-time physicians

employed on an annual basis (surgeons, radiologists, pathologists, etc.). Proprietary hospitals have an excellent opportunity to thrive financially. They do not have to accept "charity" cases except in emergency. They can send difficult and expensive cases to a teaching center or a public hospital. As business institutions they have an incentive to do good work, but also to do good work that is unnecessary, although possibly harmless.

Henry Ford Hospital in Detroit has done well with their paid medical staff. The hospital was started in 1914, and it's interesting how it started.

Henry Ford was charged a big fee in some voluntary hospital. He paid the bill, but it made him so mad he said he was going to build a hospital of his own. He did. He put everybody on salary. There was no insurance program, but he put a limit on all fees. No surgical fee, no matter how difficult the operation, was to be more than $400. The interesting thing was that the hospital filled up immediately. It has been filled ever since. It has been taking in money, paying good salaries. As long ago as 25 years, the chiefs of departments earned $1,000 a week--25 years ago.

WEEKS:

May I remind you that you were going to say some more about uniform accounting?

ROREM:

I have mentioned that one of the two most important areas of interest to me in the early days was uniform accounting. (The other was prepayment for hospitals bills or insurance for hospital bills.) I was named chairman of the committee that developed the uniform classification of accounts for AHA that is now in effect. We reported in 1935.

We had a committee of five persons. I was the one person who didn't have a scheme of his own. John Mannix was from Cleveland which already had a classification of accounts. Graham Davis of Duke Endowment personally worked up a draft of uniform accounting categories and installed it in hospitals in North and South Carolina which the Endowment was supporting. Somebody was from the state of Pennsylvania which had its own system, and also there was a man from the United Hospital Fund. So we had four persons, each of whom said, "Just take ours." All the plans were different.

I finally said, "If any two of you will agree on anything, I'll agree with you." We never got two to agree. We tried several times.

In one case, not wisely in my opinion, one member talked the rest of us into not having expense accounts for specialized departments. Just payroll and general accounts. Then allocations should be made to departments--to x-ray and lab, for example.

I said, "I think there would be direct expenses. The cost of the full-time director of anesthesiology ought to be figured right in with the others in that department, with no monkey business. Your full-time operating help should go in, etc."

We were now back to what the minority group wanted. If I had been stubborn, I might have gotten my way. I was getting tired. I wasn't getting paid for it.

However it was a fine committee. Others besides the original members helped out. Particularly where was a Mr. Sands, a C.P.A. from New York. We had a Doctor Verreau from Canada, a priest. He came in to substitute. We had some changes, because some people died off. Graham Davis had a great influence on the committee.

WEEKS:

You have spoken of Graham Davis...

ROREM:

I should say a few words about Graham Davis. He later went from the Duke Endowment to work for the W.K. Kellogg Foundation in their hospital division. When the Commission on Financing Hospital Care was formed, Graham Davis was appointed as the first director. He died shortly afterward.

Bachmeyer took over after Davis' death and had Maurice J. Norby as his assistant. Norby was a workhorse. Then Bachmeyer died and Norby had to finish up the work.

Norby was born in 1908, so he is still young by my standards. He quit business at the age of 58. I remember, it was the spring of 1966. He got tired. He had saved some money. He had only one child, a girl who was married to a solvent business man. Maurice wasn't well in some ways--just quit. Incidentally, for four years he was my Assistant Director at the Blue Cross Plan Commission.

WEEKS:

You spoke of Norby getting tired. Who were some of the other people who worked with you at Blue Cross?

ROREM:

I can understand how Norby got tired--especially tired of traveling. That was one of the reasons I quit Blue Cross in 1946 to become Executive Director of the Hospital Council of Philadelphia. I wanted to travel less and to avoid the political forces that were appearing on the horizon.

I had had two assistants at Blue Cross. My first assistant was Dick Jones. He was a lot of fun, an awfully nice fellow. Essentially he was a public relations man, he didn't have much interest in operation. My second assistant was Antone Singsen, a journalist from an eastern newspaper. We discovered he had administrative ability. After I left he took over the office until they brought in Dr. Paul R. Hawley to coordinate things. Hawley had had a career in the military service, but little experience with community organization. He had also been with the American College of Surgeons and had helped raise standards there.

There were a bunch of executives that followed after Hawley at Blue Cross. Basil MacLean was the last to come from the field, but he was completely unsuited for association work. He was what I would call more or less a "philosopher king." He was honest. He was intelligent, but he was insistent. He didn't have any interest in adjusting, or moving things around, or in compromising.

I remember working with Basil MacLean back in the early days of the Committee on Hospital Service. He'd come to me and say: "Rufus, quit complaining, pull up your drawers"--not going into any problem with me. We were close personal friends. Basil was really a good, benevolent dictator. But association politics is different from institutional administration. I don't think he quite understood the difference. A politician doesn't have any authority, he has to manipulate. He has a job which a business executive, a private executive, doesn't have. He has to take into account completely opposite opinions advanced by equally respectable constituents. He can't sit

down and pick what's good. As George Bugbee once said, "Rufus, don't tell them an idea is crazy, tell them it's impossible." George helped me a lot, more than he realized.

WEEKS:

While you were at Blue Cross the question of national contracts came up, didn't it?

ROREM:

In the early days J. Douglas Colman and E.A. van Steenwyk and others wanted benefits for the subscriber wherever he went. At that time I wanted to keep it simple. I thought we might let reciprocity rest for a while and offer liberal out-of-town cash benefits. Such a policy would tend to make people stay at home or come home if possible. Reciprocal service benefits would only work and be equitable (so I thought at the time) if service benefits were the same in the different Blue Cross Plans. Service benefits weren't the same. That was one of the hardest situations to get through.

They did get national contracts shortly after I left Blue Cross. I was already in Philadelphia at that time. I remember when the United States Steel contract came through, and then Republic Steel. Some wonderful work was done there. I think what saved us was that big companies wanted uniform service benefits.

WEEKS:

How did the commercial insurance contracts differ?

ROREM:

I want to add a few words about commercial insurance companies. The commercial insurance companies have never been equipped to offer benefits other than money indemnities. I remember in 1931 having a long talk with Dr. Reinhold Hohaus an actuary for the Metropolitan Life Insurance Company. We were discussing the Blue Cross movement, which was then called group hospitalization.

He said: "You know, it's a good idea you have got going there. We sell health insurance, but we can't give people this sort of thing. That's what people want, they want service. We are only equipped to give dollars."

He continued: "I don't see how insurance companies could give service benefits unless they controlled the providers. I don't think insurance companies are about to get into the medical care business."

Hohaus was wrong. Now, in Pittsburgh, Metropolitan operates a health maintenance organization with five or ten million dollars of capital investment. I suspect the Pittsburgh HMO will just become one of the expensive boondoggles, which insurance carriers can afford.

About 1945 a vice president of Prudential Insurance Company came to see me about "service contracts" with hospitals. Blue Cross reimbursement of hospitals was based upon costs incurred by the hospitals not upon retail charges for board and room, laboratory, etc.

I said: "I'll help you get service contracts with the hospitals, if you want them. Of course, you understand that all carriers will have to offer the same subscriber benefits--because you can't expect a hospital to recognize a half dozen or a dozen different kinds of service contracts."

I added: "Could you get Metropolitan and Liberty Mutual of New York to go along with you?"

"I don't think so."

"Well then, I guess you must start all over again."

Then I realized what is still true: Little as the insurance companies care for Blue Cross, they care less for each other.

This man from Prudential had no intention of cooperating with the other insurance companies. Mutual and Prudential were just across the Hudson from Metropolitan and Equitable. They could cooperate if they wanted to. They don't want to.

I don't see any future for a national program for commercial health insurance. Further I don't see any future for Blue Cross in a federal national health program except as a fiscal agent--an intermediary. Blue Cross does a good job as an intermediary in Medicare because they understand the problems.

As far as the hospitals are concerned, they'll have to decide that they are in the public service business, not in competitive private industry.

The commercial insurance companies don't know what to do with health service benefits. They see no future in health insurance except as a loss-leader for selling something else. If they can get health care out of the way it is much easier to sell casualty, life, accident, and other kinds of insurance. Some of them are smart enough to see that. Aetna are the people to talk to. They know what's going to happen. I think it's a matter of principle. Aetna wants uniform fees, that's all. The doctors won't accept them--agree to uniform fees. There's going to have to be uniform fees for uniform services.

WEEKS:

Do you want to say more about the interactions among health groups?

ROREM:

I should say a little more about the relationships among AHA, Blue Cross, Blue Shield, and the AMA. Blue Cross was a kind of step-child of AHA for a long time. Blue Shield was a stepchild of AMA. A lot of people at AMA still don't like the idea of Blue Shield at all. I think the time finally arrived when Blue Cross and Blue Shield at the national level had to join with each other and be co-champions of mankind against the providers. So the farther Blue Sheld and Blue Cross get away from AMA and the AHA, the better they are. Then they are not fighting Papa, they are fighting some stranger. It was long overdue. If you ever get the buyer and seller on the same side of the same transaction, it's ridiculous.

The hospitals are uniting on the wrong issue. They claim to want fair "competition" among themselves. This is just pure nonsense. Instead the goal should be for "cooperation" among themselves to avoid being federalized. It wouldn't be hard to federalize the hospitals--much easier than it would be to federalize the physicians.

WEEKS:

When you were at Blue Cross you studied the English system, didn't you?

ROREM:

When the idea of federalizing the health system is mentioned, usually sooner or later the conversation turns to the situation in England. The history of the English program is quite different from the history in America. The precursor, as far as time is concerned, of the Blue Cross in

America was the so-called penny in the pound scheme in England. Under the penny in the pound plan people earning less than so much a year could join the scheme in which a penny of each pound of their earnings, about 1/2 of 1% at that time, would go into a common fund. Money from the fund would be paid to a voluntary hospital when a member was admitted for care. The member's contribution to the penny in the pound scheme did not pay costs of care. The penny in the pound plan enabled one to get free service in a voluntary hospital without a means test at time of admittance. It was: You pay the penny in the pound and we won't ask you any questions. Of course, as mentioned, a person could not join the penny in the pound scheme if above a certain income level.

At that time (early 1940s) if you were above the income limit, you could go to a nursing home (private hospital) and pay your own bill.

One fact surprised me when I was in England in 1936 studying the situation. Side by side with the voluntary hospital system (voluntary merely meaning a nonprofit organization to which a person could make a voluntary contribution if he could afford it) there were many institutions called County Council Hospitals just like the New York City or State of Michigan hospitals. Anybody could be admitted if he was willing to accept what the hospital had to offer. He could not choose a private room, for none existed. A patient could not choose his own doctor, one would be assigned to him. He was expected to pay if he could. If he couldn't pay, he received care free. But he was requested to pay the cost as computed by the local government officials.

The County Council institutions were as big a system as the voluntary hospital group. The doctors who worked there were salaried.

The doctors who worked in the voluntary hospitals were presumably the cream of the crop, but they could not collect from patients for their services. Private pay patients were taken to privately owned "nursing homes" for care. These "homes" were run for profit. The situation I have just described in England was before the advent of the National Health Service which came into existence July 4, 1948.

In the United States the hospital insurance program started at the top and worked its way down. It started at the top providing benefits in semiprivate accommodations. In England it started at the bottom and worked up. They were already taking care of the people at the bottom in England before the National Health Service was established.

In the United States group hospitalization policy holders can be members of a lodge, they can be members of any group. They pay their sickness bills as a group--it's group payment. It's broad enough to be called insurance. We often call it prepayment, a coined word that some well-intentioned people developed to prove it wasn't legally insurance.

WEEKS:

We haven't talked much about the AMA...

ROREM:

I want to add some thoughts about the AMA. As far as the AMA is concerned I would say this: I think the AMA is about where it was 50 years ago in its attitude toward change in the health economic system--only a little farther to the right--except they are more intelligent now, more plausible now.

Fifty years ago the AMA attitude was: "We are not bad people. Why are you picking on us?"

When they finally discovered they were not being picked on, they said: "Well, at any rate why are you all worked up about a problem that doesn't exist? Everybody is getting good care. We don't see anyone who is not getting good medical care. Who are they? Send them to us. We'll take care of them."

Doctors by definition don't see the people who need medical care and don't get it. The fact that patients are in their presence indicates they are getting care, probably very adequate care. It's only the successful doctor who talks this way. He probably is a good one.

"Much medical care (say some doctors) is caused from smoking, drinking, speeding, or gormandizing. That is not our fault."

The doctors are right. It wasn't a doctor who pushed me off the curb when I broke my leg. People tried to help me. If they had left me alone, I would have been all right. I had participated in athletics and I can "roll." (I could be running at full speed and roll.) But somebody caught me and I dropped the last two inches and cracked the bone.

WEEKS:

Is a fee-for-service payment plan for medical care a practical way for paying physicians under a national system?

ROREM:

Doctors do not welcome change, and politicians are afraid of them. That's why I don't think a national health insurance based on fee-for-service plan will work--not if the fees are to be established by the providers. There would be no sense to it. Better to have cash indemnities than a sliding scale

of fees for services rendered. If there is more money available, doctors merely raise their prices higher. No matter what cash indemnities were given, doctors would request more.

My case may be an example. When I fell from the curb, I sustained a fracture near the hip. The doctor raised the rate on me over the Medicare schedule for fixing my hairline fracture. The doctor's fee was $2,000. I am a little different from some. I asked the doctor in advance if he would accept the Medicare fee schedule. He knew me. He suspected I might gossip--which I might. He said he would accept.

I don't know how long the operation lasted--how long I was on the table. He inserted a splint--they call it a "pin" now. The bill went to Medicare, which paid the doctor $1,500. I didn't pay the extra $500, so his secretary billed me for it. I went to see her. I said that I understood the doctor was going to accept the Medicare payment.

She said, "Just a minute, I'll go ask."

She came back. "That's right," she said.

There is no moral to the story, just an experience to relate.

WEEKS:

Back a ways I interrupted you when you were going to say something about national health care.

ROREM:

It is difficult to put this whole question of national health care in perspective unless the historical aspects and past experiences are taken into consideration. For example, under a nationalized system proprietary hospitals would still play some part. I think we might have two kinds of institutions.

We might have the nationalized group and the proprietary group. The proprietaries will profit immensely. They will still just take the easy cases at cost with allowances for capital investment. The good voluntary hospitals will probably be put under state or federal control. They are asking for it.

If we are going to benefit from past experience in our planning for the future, we should remember one thing: When hospitals started allowing doctors to admit private patients, they involved doctors in hospital finances. The doctors decided who would come, what they would be charged, when they would be discharged, and what to order the hospital to spend on their behalf. The hospitals are still beholden to the doctors.

WEEKS:

When you were at Blue Cross you did a lot of traveling and speaking...

ROREM:

I used to make a lot of speeches. I tried to anticipate whether I would get a laugh. Even doctors will laugh at themselves once in a while.

I remember once I was talking about Blue Cross. The AMA never liked Blue Cross because it was "inching in" on the doctors' business. You shouldn't mess in doctors' business. First the AMA decided Blue Cross was unethical, then they decided it was undignified, then they decided it was illegal, then they decided it was impossible-always moving farther back. They finally just didn't like it. It's unfair (they'd cry) taking bread out of the doctor's mouth. Actually it was stuffing their mouths until they could hardly move, making them rich. Blue Cross salvaged private medicine in America for 50 years--at least.

Some of the doctors said Blue Cross drove them into Blue Shield.

George Bugbee quoted Olin West as saying: "Blue Cross will lead us into socialized medicine."

It's only a question of what door you go through, that's all.

WEEKS:

You didn't say a great deal about the Committee on the Cost of Medical Care. Would you talk about that project a bit more?

ROREM:

I would like to say a few more words about the Committee on the Cost of Medical Care. It was initiated and started by a small executive committee which included: Michael M. Davis, a free lance medical economist; Ray Lyman Wilbur, M.D., who at that time had been President of Stanford University and later became Secretary of Interior under Hoover; Dr. Charles E. A. Winslow, who was head of the School of Public Health at Yale; Winthrop W. Aldrich, Chairman of the Chase National Bank; and one more, Dr. Haven Emerson, practicing physician and public health expert in New York City.

The Committee employed as their first director a man named Harry H. Moore who had just received his Ph.D. from the American University with a thesis titled, "Medical Care for Tomorrow." He was about 50 years of age.

The research program was directed by I.S. Falk, Ph.D., a biologist. He was a very intelligent person, very sure of himself, and nearly always right. He loved to expound and he did a good job of it. He loved to write and he did a good job it. He's five years younger than I am. Three of us wrote the 700 page report on the Committee's findings; then Falk wrote the final report, about 250 pages long.

The Committee on the Cost of Medical Care was financed by a group of foundations. The largest contributor was the Rockefeller Foundation. Another supporter was the Rosenwald Fund. The total amount of support money over five years was about a million dollars. The Twentieth Century Fund put up some money, also the Russell Sage Foundation, the New York Foundation and others.

Two important foundations contributed nothing. One was the Filene Foundation of Boston, the other was the Commonwealth Fund of New York City. For what reason? They argued that we already knew all the things we were going to discover. They offered to support an organizaton to promote some of the necessary changes, but not to study what was going on.

Some day I may write as essay to demonstrate that the collection of masses of numerical data is often unnecessary or irrelevant. Do we know what to do in case of sickness? Yes, go to bed or visit a doctor. Are some doctors inefficient? Probably. Should certain procedures be permitted only by certified, licensed professionals? Yes. We don't need statistics to tell us that sort of thing.

The findings of the Committee undoubtedly stimulated many of the attempts to make good health care more acceptable to the average person. The recommendations may be stated very simply as follows:

1. Groupings and coordination of health services organized around hospitals which provide complete ambulatory and inpatient care.

2. Expansion of all basic public health services to include both prevention and rehabilitation.

3. Financing of health service by insurance and/or taxation to enable placing family care in the family budget along with other necessities.

4. Areawide planning for health care delivery and financing.

5. Improved education and training of health care practitioners.

These recommendations were sufficiently inclusive to stimulate many experiments as to serve as the basis for local and national legislation.

* * *

I should say one more thing about the Commonwealth Fund. A fellow by the name of Barry Smith was the head of it. Published a very good work about 40 years ago called The Community Hospital. They were the first ones to emphasize the fact that medical care is one entity. You don't have a doctor's care over here, the hospital's care over there, and a the nursing and dentistry elsewhere--and quackery everywhere. It's all one. The main point is to make medical care available.

Macro-economic studies may tell how much the total cost of medical care is rising, 8% or 2%, but that doesn't interest the individual patient at all. The patient asks: "How about my bill? Is it going up or down? Where am I going to get the money?"

For the individual it isn't only the cost, it's the uncertainty.

If somebody tells you the average cost in America is only $25 a year per person, say: "OK, I'll settle for that. Will you guarantee you will give me care for $25? If not, then don't talk about averages." That's what people talk about: getting the care for $25 a year or whatever the figure might be.

I must tell you a story that fits in with our discussion of statistics and data collecting. In the early days we tried to get some legislation passed

for Blue Cross plans in Illinois. There was no legislation covering Blue Cross. The plans were organized as regular corporations. Blue Cross wanted to be under the Department of Insurance.

So, whoever was in charge of the department said, "There aren't any statistics about this." I happened to have a table of statistics about Blue Cross in St. Paul, Newark, and Cleveland. He almost looked like a dying man. He grabbed for it. I might as well give him the tabulation of the tensile strength of the suspension bridges in the world between the years 1900-1912, he would have been just as happy.

WEEKS:

I am sure you are often asked why you resigned from Blue Cross at a time when the movement was about to reap all the benefits of your pioneer work. Would you tell it for the record?

ROREM:

Possibly I haven't explained well enough why I left Blue Cross. The first reason, I say this at risk of repeating myself, was to stop traveling 100 nights a year all over the United States. The second was that I had an offer of a job which sounded interesting. The offer came from a place (Philadelphia) that would allow me to work in one neighborhood, and sleep in my own bed every night. Also, I felt the battle for health insurance was over. It was just a question of when it was going to come, and in what form, and how broadly it would be expanded. The concept, the principle, was not debatable any more.

There was still much work to be done in the coordination of care: in planning for hospitals; in group practice of medicine; and in the development of ambulatory care throughout the communities--now called primary care. In working along those lines, I thought the new job would be more interesting.

WEEKS:

To go back a bit, do you think that the work of the Committee on the Cost of Medical Care had any influence on later legislation?

ROREM:

I am sure it did have influence on later legislation. For instance, the recommendation #4 of the committee was that the study, evaluation, and the coordination of medical services should be considered important functions for every state and local community, that agencies be formed to exercise these functions, and that the coordination of urban with rural services receive special attention. That's the Hill-Burton recommendation. So, obviously, whether the Committee's work influenced it or not, it preceded it and was available for reference.

I might say that the five recommendations of the principal majority group can be encapsulated in just a few words.

The first was grouping and coordination of all services. The recommendation was that medical services, preventive and therapeutic, be furnished largely by organized groups of physicians, nurses, pharmacists, and others--such groups organized around a hospital. The form of organization should encourage the maintenance of high standards. In other words: group practice, coordinated service. All the principal people could accomplish more through cooperation than through competition.

The second was for the expansion of all basic public health services. Our figures showed that we paid $1 per capita for prevention and $32 per capita for cure. I said that was a 32 to 1 ratio, that I was not a free silver man, but I'd like to make that a 16 to 1 ratio. Just double the public health proportion to 1:16.

The third was to have the cost of medical care placed on a group payment basis.

The fourth was a recommendation about hospital planning, health service planning.

The fifth was a list of suggestions having to do with the education and training of health practitioners.

That's enough! If the professional groups cooperate, if you emphasize prevention rather than cure, if you pay for it on the basis that's convenient to the individual by removing the hazard, if you coordinate it citywide, and are intelligent about having good people, you have a program.

As I read that report over now, I wonder that we had as much sense as we did. You will notice there isn't a figure, a number anywhere in the six or seven hundred words of the summary of the report. We don't need numbers.

WEEKS:

Did your jobs in Philadelphia and Pittsburgh include activities in planning and in decision making about whether or not to build hospital facilities?

ROREM:

When I was in Philadelphia I was working for the presidents of hospitals. They held a trade association viewpoint. It wasn't until I got to Pittsburgh that I was on the outside looking in.

Why did I leave Philadelphia? First of all, I was 65. Second, the Pittsburgh job was in the field of areawide planning, and areawide planning was something I wanted to do. Also, it was very good pay.

There was an interesting contrast between the governing bodies of the Philadelphia and Pittsburgh agencies with which I was connected. Both groups excluded providers of health care such as physicians and hospital executives. The Philadelphia board of directors was composed mainly of bankers, lawyers, and insurance executives. The Pittsburgh governing body was dominated by manufacturing and merchandising enterprises. One group represented financial and legal viewpoints; the other, production and distribution.

The differences were also apparent in attitudes toward public problems. In Philadelphia there was special attention to safety and conservation, whereas Pittsburgh had a taint of the frontier with its optimism and experimentation, where one's friends and opposition were known and visible.

Hospitals administratively were more of a nuisance than a help. They are moving around to the point where they are calling themselves an industry. If they want to slug it out on that basis they are coming with wooden swords to the battle.

Maybe some of the hospitals thought they got the short end of the stick in dealings with Blue Cross. I don't know why they should think that. Usually, though, they think that, if a patient comes in and runs up a bill of $2,000 and Blue Cross pays them only $1,500, they have lost $500. They give no attention to the fact that without Blue Cross they might have got nothing. There is no excuse for Blue Cross underpaying the hospitals. With the formula

which includes the costs actually incurred or estimated in advance of being incurred--plus 2%--, if the cost is defined in a reasonable way, why is that a penalty?

One thing the hospitals want more than anything else is to set their fees like the doctors do, and collect whatever they ask.

We talk about the free choice of hospitals, but it's a pretty feeble choice really. You go where your doctor tells you.

WEEKS:

What do you see as the most serious problems facing the provision of health care in the United States?

ROREM:

I think the big problem in the United States and in the world is to make wise and orderly and efficient use of our physical facilities and our professional personnel. All the things we are trying to do are just that: not to have too many hospitals, have them in the right places, have them coordinated with each other, have them set up so they can be occupied to a reasonable degree of capacity, have them defined so you express their capacity not in terms of beds or flat surfaces but in terms of services that can be rendered in a course of a year, and from the standpoint of production. I think coordination of facilities and personnel is the big problem. From the standpoint of payment, hopefully we shall achieve a manner of equity which will enable a person to get good medical care under conditions he can afford. If he is without money, somebody has to pay it for him. If he is an average person he ought to be able to budget the way he budgets his rent, etc. In other words, you can't make sickness voluntary or controllable, but you can

make the payment of the bill controllable. To control that you place health care in the family budget along with other necessities. Whether you pay it out by taxes or insurance is secondary. It can be documented all the way down the line.

WEEKS:

You have received several awards during your professional life. Just recently you received one from Blue Cross didn't you?

ROREM:

On April 19, 1979 I was presented with the Blue Cross Pioneer Award at the Fiftieth Anniversary Celebration of the Blue Cross and Blue Shield Associations at the Drake Hotel in Chicago. At that time I said:

> Early in the year 1928 a national Committee on the Costs of Medical Care began a study to develop recommendations for changes in the production and financing of health care for Americans. It was a period of high employment and low prices, but there was a general feeling that adequate medical services were not available to the average man, who was defined as a "person of moderate means." Six philanthropic foundations contributed a total of about one million dollars to support the project. Two others refused to help finance the venture, on the grounds that research was unnecessary and that the time had come for action.
>
> The total capital invested in health facilities has been provided almost exclusively from taxation and philanthropy. It should not exceed the limits required for adequate prevention, treatment and rehabilitation. The services of institutions and the professions should be coordinated on a community basis. Cooperation and planning are as important for an entire community as for an institution with its multiple professional and administrative functions.
>
> Hospitals are social capital. This is also true of the public's investment in scientific knowledge, education and training of practitioners, and production of supplies and equipment. A moral obligation rests upon each community to provide and replace facilities only after certification of unmet needs of the population.

WEEKS:

Would you care to say a few words about some of your colleagues and co-workers from your distinguished career?

ROREM:

When one reminisces it is natural to think of individuals who were co-workers in the health care field:

Dr. Odin Anderson, University of Chicago, has a job similar to what mine was with the Rosenwald Fund. He is a free spirit. He can say what he wishes and no one can do anything about it. His ideas are always worthy of consideration.

Monsignor Maurice F. Griffin and I considered health care problems from different points of view. He never accepted my concept that hospitals belonged to the people rather than the governing bodies, or that health practitioners were essentially servants responsible to the public which legalized and financed their services.

E.A. van Steenwyk was a personal friend over a long period, from 1934 when he developed the Blue Cross symbol until his death in 1962 in Philadelphia. He served as the first chairman of the Blue Cross Commission and identified with consumers rather than the providers of health services. In this respect I shared his viewpoint. I was frequently criticized in Philadelphia for placing the interests of patients ahead of those of the providers.

Walter J. McNerney came to the Blue Cross field in 1961 when I was engaged in areawide planning and no longer involved directly with Blue Cross or hospital management and financing. He brought to the field understanding and knowledge derived from several years of research and promotion in health care organization and delivery. His coordination of the Blue Cross Plans with each other and with Blue Shield has been successful against opposing forces and

indifference. He has convinced public leaders of the importance of voluntary health insurance in America. Although he can speak officially only for Blue Cross and Blue Shield, his influence is throughout the whole field as the voice of mankind.

Michael Davis. A good friend and colleague. A good way to end this talk might be to quote from the book of tributes to Mike Davis after his death. I said:

> When Michael Davis came to my office in Chicago December 1928 there began an acquaintance and friendship which involved eight years of daily professional contacts, and thirty more years of mutual concern with the production and distribution of health services for the American people. Although we started in the roles of master and apprentice, the relationship soon changed to that of colleagues with separate but related interests in the economics of health care.
>
> The four decades were rewarding for the opportunity to share professional activities, but even more valuable for the personal character of Michael's work and life. Although there was only fifteen years difference in our ages, he always maintained a feeling of responsibility for, and interest in, my professional and personal activities. This concern included our respective families, both wives and children, and many times we enjoyed friendly associations in Chicago, in New England, and at Lake Memphremagog.*

This seems a good place to end this conversation.

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* Michael M. Davis: A Tribute Chicago: The Center for Health Administration Studies, The University of Chicago, 1971, pp.61-62.

Interview in New York City

September 19, 1978

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