

HOSPITAL  
ADMINISTRATION  
ORAL HISTORY  
COLLECTION

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Lewis E. Weeks Series

D. Eugene Sibery

D. EUGENE SIBERY

In First Person: An Oral History

Lewis E. Weeks  
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION  
Lewis E. Weeks Series

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D. Eugene Sibery

## CHRONOLOGY

1929 Born Muncie, Indiana, September 25

1953-1956 University of Michigan Hospital  
Administrative Assistant

1956-1958 Crittenton Hospital, Detroit  
Associate Administrator

1958-1962 Crittenton Hospital, Detroit  
Administrator

1962-1965 Michigan Hospital Services (Blue Cross)  
Hospital Affairs Division, Director

1965-1969 Greater Detroit Area Hospital Council  
Executive Director

1969-1977 Blue Cross Association  
Executive Vice President

1977-1980 Blue Cross and Blue Shield of Greater New York  
Executive Vice President

1980- Blue Cross of Iowa and Blue Shield of Iowa  
President

## MEMBERSHIPS AND AFFILIATIONS

American Association for Hospital Planning

Member, Board of Directors

American College of Healthcare Executives

Fellow

American Hospital Association

Personal member

Chairman - Research and Planning Council

Association of Health Facility Planning Agencies

President

Member, Board of Directors

Blue Cross and Blue Shield Association

Member, Board of Directors

BCS Financial Corporation

Vice Chairman

Member, Board of Directors

Member, Executive Committee

BCS Insurance Company

Vice Chairman

Member, Board of Directors

Member, Executive Committee

BCS Life Insurance Company

Vice Chairman

Member, Board of Directors

Member, Executive Committee

Chamber of Commerce

Member, Board of Directors

MEMBERSHIPS AND AFFILIATIONS (Continued)

Cost of Living Council

Health Industry Advisory Committee, Alternate Member

Detroit Mayor's Committee to Study Medical Care of the Indigent and

Medically Indigent and Hospital Emergency Care

Member, Professional Advisory Committee

Economic Club of Chicago

Member

Economic Club of Detroit

Member

Executive Club of Chicago

Member

Florence Crittenton Association of America

Member, Board of Directors

Member, Executive Committee

Chairman, Budget Committee

Treasurer

Governor's Commission on Health Care Costs (Iowa)

Member

Greater Detroit Area Hospital Council

Executive Director

Health Policy Corporation of Iowa

Member, Board of Directors

Member, Internal Affairs Committee

Treasurer

Health Services Foundation

Vice President

Member, Board of Directors

MEMBERSHIPS AND AFFILIATIONS (Continued)

Hitchcock Presbyterian Church

Member of the Session

Hope United Presbyterian Church

Member of the Session

Hospital Research and Educational Reserve

Member of Board of Corporation

Member, Board of Trustees

Hospital Society of New York

Member

Institute of Medicine, National Academy of Sciences

Committee to Develop a Policy Statement on Supply of  
General Acute Hospital Beds

Member

Metropolitan Detroit Health Research Fund

Member, Board of Directors

Michigan Association for Regional Medical Programs, Inc.

Member, Board of Directors

Budget Coordinator

Michigan Hospital Association

Vice President

Member of Ad Hoc Study Committee on Comprehensive Health Planning

PL 89-749

Michigan State Board of Education

Chairman, Committee on Education for Health Care

National Commission on Productivity

Member, Advisory Panel

MEMBERSHIPS AND AFFILIATIONS (Continued)

Northwestern University Graduate School of Management

Associate Member of Advisory Council

Ohio State University

Centennial Visiting Professor

Royal Society for Promotion of Health

Fellow

Spring Arbor College

Member, Board of Directors

U.S. Department of Health, Education and Welfare, Division of Direct

Health Care Services, Program Plans and Facility Requirements

Review Committee

Consultant

U.S. Public Health Service

Member, Hospital Advisory Committee

University of Dubuque

Member, Board of Directors

University of Michigan

Michigan Center for Theological Studies

Member, Board of Governors

University of Michigan

School of Public Health

Lecturer, 1966-1970

Westminster United Presbyterian Church

Member of the Session

Chairman of the Support Council



MEMBERSHIPS AND AFFILIATIONS (Continued)

YMCA, Dearborn, Michigan

Vice Chairman, Board of Management

Member of Operating Committee and Program Committee

Chairman of Youth Committee

## AWARDS

Outstanding Young Man in America Award, 1959

Meritorious Service Award, Michigan Health Service, 1965

Award of Merit, Spring Arbor College, 1965

Award for Meritorious Service, Michigan Association for Regional  
Medical Programs, 1967

Key Award for Meritorious Service, Michigan Hospital Association, 1967

Providence Hospital Award, House of Providence, 1969

Award of Merit, Detroit Common Council, 1969

WEEKS:

I have a note that you were born in Muncie, Indiana in 1929. Then, sometime after that, shortly after, you must have moved to Michigan, didn't you?

SIBERY:

Yes, we did. I was born in Muncie, Indiana, moved when I was a small child to Winona Lake, Indiana -- most famously represented by Billy Sunday, the evangelist. Then when I was a sophomore in high school, my mother took a position with the University of Michigan Hospital and we moved to Ann Arbor. My father had died of an industrial accident many years before, when I was only three as a matter of fact. So my mother had to raise me alone which was a major undertaking for her. We moved to Ann Arbor in 1944.

WEEKS:

Your family was and still is a great inspiration to you, aren't they?

SIBERY:

I'm glad you asked that. As I said, following the death of my father, my mother had to be everything to me. I've taken so much inspiration from her and she remains a close friend and strong supporter to this day. My wife, Verla, has truly been my partner through all of these years. Her guidance and support has been my sustenance throughout my career. With all the time I spent away from home, she handled many of the parental chores. The kids, Linda, Don and Doug, have also been a great source of pride, help, and understanding, not to mention all of our six grandchildren.

WEEKS:

You must have started working at the University at quite a young age, didn't you?

SIBERY:

Yes, I did as a matter of fact. I started in 1944 working in the occupational therapy department running the movie projector evenings for patients who were able to be transported up to the ninth floor of the old hospital. Then I started in the business office at a young age too. I might tell you how that came about.

My mother had some illnesses back in those days. She is a very proud woman. She never had to take a dime of welfare funds, and she had taught me to be industrious while very young. I had worked in Indiana while I was in the upper grades doing menial tasks. Then I worked at the publishing company where my mother worked, summers and part-time after school. It became necessary for me to drop out of school, which I thought was catastrophic at that point. But I had some good mentors over the years, so it turned out not to be a catastrophic experience.

Dr. Kerlikowske, who was then Director of University Hospital, took a liking to me and eventually I was invited, after being in the admitting department at the University Hospital for several years, into the business office. I was given an opportunity to join his administrative staff. It was interesting that Dr. Kerlikowske, at that time, did not feel the programs in hospital administration were going to flourish. He thought that people who took that route to become a hospital administrator were looking for an easy route to traverse and that really they wouldn't be good administrators. He said that if I came with him he would make a real administrator out of me. So I had a preceptorship under his tutelage for a good number of years.

He encouraged me to go back to school. I did that part-time for several years. I was night and weekend administrator at University Hospital which

gave me an opportunity to attend the University during the daytime.

WEEKS:

Had Harley Haynes retired at that time?

SIBERY:

Harley Haynes was there when I was working part-time. He retired in 1945, as I recall. I was not working full time. I was going to school and working part-time then. I remember Dr. Haynes, remember him well. I guess the one thing that impressed me was that every single requisition for any supply had to be personally initialed by Dr. Harley Haynes, hardly delegating and holding people accountable. That is just an idiosyncrasy I happen to remember about him.

Dr. Kerlikowske succeeded him in 1945, if my memory is correct. "Dr. Kerly," as we affectionately have known him all of these years, was the one who really got me into this field.

He was called the Chief Resident Physician, and did most of the insurance work back in those days. It was kind of a strange title. He was really pretty much an assistant administrator to Dr. Haynes, doing all of the insurance work that required medical judgment and oversaw the house staff, which was no small undertaking in itself. In terms of general administration, I don't really think Dr. Haynes used him as a generalist. But Dr. Kerly blossomed when he received the opportunity to become the director. They called him director in those days.

WEEKS:

The hospital in those days -- you were there probably when the hospital was twenty-five years old?

SIBERY:

Yes, roughly that, Lew. You know, we still had the large wards at that time. Very few private rooms. Simpson Memorial Institute was there, and so was the Neuropsychiatric Institute (NPI as it was called then). While I was here, they built that first unit for veterans having psychiatric problems. I don't recall exactly the name that that went under. Our parking lots were dirt back in those days. I thought that it was the biggest institution in the world. To me, it was just big. I knew it was great, but it was also huge. It's amazing how that medical center has blossomed over the years. The Kresge Research Unit went in while I was here. We closed down the old OB unit, as you recall. Of course, polio was so rampant when I arrived. We had that contagious unit, which was a wooden frame building. They would never let you occupy it today, from a fire and health standpoint. But it has always been a great institution, and still is.

WEEKS:

I have an idea that maybe the catchment area for patients has changed somewhat. I would think maybe, when you were there in those early days, there were people coming from all over the state, now maybe not quite so much.

SIBERY:

All over the state. I can remember one of the studies we did. There was no orthopedic surgeon north of Saginaw, Michigan. Now you find them interlaced throughout the Upper Peninsula and all around. It was a tertiary center from the state of Michigan. We certainly had Henry Ford Hospital as a major institution during those years, but in terms of the welfare programs that were in place, all of those patients funneled into Ann Arbor, into the University Hospital. Even the private patients. The state of Michigan was

really the service area, and that has changed over the years as it has for most major institutions around the country. It has been pleasing to me, being involved with health planning for so many years, to see how wisely things have happened in Michigan.

Of course, when Hill-Burton started funding those very small hospitals, at the time I'm sure it seemed a wise thing to do, but I can remember during my days of being affiliated with health planning in Iowa that we lamented that some of these twelve and fourteen-bed hospitals had been created because they really couldn't even provide a minimum scope of services.

WEEKS:

I heard a story that may be of some interest to you. Remember Governor Frank Murphy?

SIBERY:

Yes, indeed I do.

WEEKS:

Back during the Depression, he went to Washington to try to get some money to build a hospital in the Upper Peninsula. A group up there had come to him and he was fronting for them. I think it was I.S. Falk that was on the advisory committee called in to evaluate this plan. They turned thumbs down on building a hospital of probably fifty beds. It wasn't because there wouldn't be patients, but they didn't have any physicians. They couldn't show that they could staff it. I think that was a big problem.

SIBERY:

A real problem, indeed.

WEEKS:

You said something about closing the OB. Do you think the day is coming

when we are going to have more specialized hospitals?

SIBERY:

Lew, I really do believe that. It's distressing to me in one sense. For years, I have espoused the thought that hospitals should be the focal point for health in a community. As a matter of fact, when I was executive director of the Greater Detroit Area Hospital Council, we developed a policy there that hospitals should become comprehensive community health centers and put as much emphasis on patients who were ambulatory as those who were bedridden. But I have the feeling that we are going to see more complexes of hospitals but with specialties within. It won't be universally that way at all, but I think in the major urban centers they will tend to move in that direction. Just as the University Hospitals with Women's Hospital, combining OB and GYN. I think that certain types of illnesses and certain treatment modalities do lend themselves to some degree of concentration.

WEEKS:

I talked with Stan Nelson last month and he said, among other things, Ford Hospital is too big.

He said it's getting more difficult. I said, "What are you going to do about technology?" You know we had a lot of trouble over lithotripters here in Michigan. A lot of the guys jumped the gun. At least four hospitals jumped the gun before they had a certificate of need or approval to buy these things. Then if they all put up a million dollars plus, what are they going to do with this if they are turned down. Nelson made the point that they are coming to the conclusion that they can't be all things to all people. Maybe they can't have every bit of technology that comes along. Maybe no one hospital can afford to have it all. Maybe they will have to have technology



centers, as an example.

SIBERY:

I think that's absolutely correct. That's an astute observation on Stan's part. Ford Hospital, as I recall, has diversified over the years too. They have set up satellite units. I think that specialization is clearly found to be terribly expensive. In the state of Iowa, where I am acting professionally now, we have had quite a public debate over lithotripters, as well. The feeling was that two really would be all we would need in our state. A third came along and the fact is that the two that are in place are being used to less than fifty percent of capacity. That is a tremendous standby cost for any community.

WEEKS:

Absolutely. There is this status need here that many hospitals feel. We've got to have all the latest things to prove that we are number one.

SIBERY:

Right. The business community is becoming quite impatient, I think, with the health care industry. At least the experiences of the last few years lead me to conclude that business and labor coalitions are articulating the need for a delivery system to become more price competitive. At the moment, they are service competitive. I think we are going to have to come to the day that we recognize that price competition is needed. I wish it would be possible for voluntary efforts to bring about all of the changes that would be needed, but community pride, ego of individuals, status of an institution, all of those things are factors which we have to recognize are very real. I think we are going to have to continue to have a blend of regulation, along with voluntary efforts to have healthy competition, if we are going to see the

delivery system respond in a manner that's going to be found to be acceptable.

WEEKS:

We have gotten away from your chronology. Crittenton Hospital, how did you happen to go there?

SIBERY:

Crittenton Hospital in Detroit represents one of my fondest memories. I was anxious to get out of the university setting because I felt that it was quite atypical, even though we have countless university centers around the country. I really wanted to get into a more typical community type setting. An opportunity came through a gentleman by the name of Cliff Randolph, who headed the Randolph Surgical Supply. Cliff apparently was quite impressed with my abilities. At that point, I had Purchasing as one of the units that reported to me. While I didn't have extensive contact with vendors, I did have some administrative contact because, as we standardized our supplies, we had an opportunity to work with him.

He put in my name, unbeknownst to me, to the search committee when Crittenton was looking for a replacement for Ellen Stahlreder. I don't know if that name rings a bell with you or not. Ellen Stahlreder was the Director of Nursing Service at the old Herman Kiefer Hospital in Detroit. A very shrewd and capable administrator. She was tough, but kind. She went to Crittenton Hospital. It was then called Florence Crittenton Hospital. It was started as a home for unwed mothers.

Then they expanded its services. In order to be able to provide the unwed mother services, it had to have physicians and support services. So, they started a general hospital. For many years, I was on the Florence Crittenton Association board, the national board. We really believed in that

movement. Florence Crittenton Home in Detroit was then the largest home for unwed mothers in the country.

Crittenton presented a unique opportunity for me to move into the non-profit community hospital field. I went there for the great sum of \$10,000, which at that point seemed like a lot of money to me because the University was not notorious for overpaying its staff. I went to Crittenton. I became very much involved in community affairs. I was asked to go on the board of the Greater Detroit Area Hospital Council. So I became quite involved in the planning activities. There was a need for a new facility up in the Rochester, Michigan area. One of the things that I worked in was with Jack Cousin.

Jack was a giant in his field. Jack and I concluded that Crittenton, because of its location, and because Grace, Sinai, and Beaumont Hospitals had all been built that the facilities were following the population movement, rather than the population movement always staying with the facility. I knew that tough sledding was ahead financially and quality program-wise for Crittenton. We started planning for a new facility which subsequently was built out in Rochester. A very fine institution, as I understand. We had completed the fund-raising activity under my administration, and had pretty well completed the architectural work.

Then I was approached by Bill McNary, who was then president of Michigan Hospital Service, the predecessor of Blue Cross in the state. I had chaired a committee of participating hospitals for Blue Cross which worked on what were called "participating standards for hospitals" who wanted to affiliate with Blue Cross and be an approved facility. That was long before the legislature said that Blue Cross had to recognize every hospital. We started these standards for new facilities that wanted to participate. Then we evolved into

a program of applying the standards to hospitals who already participated, so that over a period of time we could assure that participation with Blue Cross as a hospital really represented good quality care that was efficiently and effectively provided.

Bill called me one day in 1962 and asked to have lunch with me. If you remember Bill McNary at all, he was a man of few words, kind of a gruff individual. I had no idea what he wanted, but when he asked to have lunch at the Detroit Athletic Club, by all means, this young upstart said "yes."

He said, "Gene, you were instrumental in getting these qualifications for participating hospitals developed. I want you to come and run that program for us."

Ben McCarthy who had been responsible for all claims operation, payment systems for hospitals and all provider affairs. had been promoted from Director of Hospital Affairs to General Manager, under Bill's leadership. So that left this vacancy. Well, I wanted to stay in hospital administration. I loved it then. I still love it. But my wife and I decided we ought to take a crack at that. I had conferred with Walt McNerney, a friend of mine for years, who had just recently become President of the Blue Cross Association. Walt told me then, "Gene, the one who pays for the bill is going to call the shots for the long run." In essence what he convinced me was that, if I was really interested in doing the best for the hospital system in this country, that I could find a greater opportunity for impact by going with the third-party payment mechanism.

So I accepted Bill McNary's offer and went there in September of 1962, leaving Crittenton as its administrator. In 1962, it was interesting that we had considerable flexibility. The community leadership in the late fifties in

the Detroit area said we are not going to have fund drives for every hospital that wants them. We are going to set a mechanism to raise money. You will recall, Lew, that the United Foundation was set up to raise both operating monies for charitable organizations as well as to raise capital monies. That is how Jack Cousin was able to get a great boost for the Greater Detroit Area Hospital Council, which did the planning activities for southeastern Michigan as far as acute hospital care was concerned.

I guess that now that I am reflecting here with you, I would say those were the fun years.

WEEKS:

That period of cost reimbursement is often referred to as the "good old days," or some such thing as that — the days without too many problems.

SIBERY:

That's right. Government didn't interfere much. The licensing programs were reasonable. Subsequently, you know, it has gotten more complex. Thank God for men like Walt McNerney and Bill McNary who lead the Blue movement in a wise way. Unfortunately, there aren't many Bill McNarys and Walt McNerneys around any more.

WEEKS:

Another thing that Walt McNerney told me, which I think had an influence on a lot of lives, maybe including your own, was that he had gotten to the top of the heap as a young man himself. So he believed in youth. A lot of people were hired by McNerney who were quite young, but had the spirit and desire to get somewhere and do something.

SIBERY:

He did. That's right. I think both Bill McNary and Walt McNerney had

that characteristic. Walt certainly did get to the top of the heap at a very young age, and gave inspired leadership for, I believe, twenty-one years, to the Blue Cross Association, and later to the Blue Cross and Blue Shield Association. I was privileged, as you know, to be with him for eight and a half years. A great, great experience for me.

WEEKS:

Before we go on to your Blue Cross experience, I wanted to ask you one more question about Crittenton. Whatever happened to the hospital on Tuxedo?

SIBERY:

Just as we predicted, it phased out of business, was not salable in the marketplace and was demolished. But the new unit is flourishing.

WEEKS:

I have been in that. That's a very nice unit.

SIBERY:

Everything we planned it to be. I think, at that time, I was trying to give leadership to an organization to recognize that change was inevitable. I met a lot of resistance on the part of the board when I talked to them about building a satellite unit. They said this has served us for years, why do it? I said, "Just as sure as God made little green apples, the day is going to come that you are not going to be able to attract sufficient private patients to continue the quality that had always been paramount and to do it in a manner that would be economically feasible. So we built that unit. I had worked so closely with Blue Cross, and that's how I got with Blue Cross.

In 1965, the community leadership asked me to go to the Greater Detroit Area Hospital Council as executive director replacing Jack Cousin. In the end I decided to do that because I believed we have to serve where there is a

great need. It was not for financial reasons that I went. It was an opportunity that I didn't know whether I had deserved, but which I was honored and challenged by. That is how I became so active in areawide planning for health services.

I became very active with the state planning activities, helped set up the comprehensive health planning program that was spearheaded by H. Allan Barth, who was then head of the Michigan Hospital Association. I was also inspired by George Bugbee, whom you remember well. George was so concerned about wise planning for health services that he was instrumental in setting up the American Hospital Planning Association. It was my privilege to serve as president of that organization in the late 1960s. I really hated to leave the planning field. We had something going, Lew, that was successful. I think we made a positive impact on the health field in southeastern Michigan. We were getting involved in long-term care. Lloyd Johnson, whom as you will remember, was one of those who wanted the community to plan wisely for long-term care, came on our board, and was very instrumental in helping us as we moved in that direction.

Then the federal government, in its wisdom, decided they were going to change the planning approach. Comprehensive health planning came in. I was very involved with Dr. Myron Wegman, then Dean of the School of Public Health at the University of Michigan, in setting up the first statewide effort for comprehensive health planning. But I think this is one place where history will record quite accurately that government intervention really detracted from some of the good work that had been done. Really, through the days of seeing comprehensive health planning and then through the health systems agency -- never did any of these ventures prove as successful as the old

voluntary efforts of years ago. Maybe that is nostalgia on my part, but I really believe that is the case.

I was very much involved in everything that was going on in health in southeastern Michigan. Those were exciting days. Those, too, were great days of joy because it was a lot of fun.

WEEKS:

How about the legislation that came in -- did you prepare for Medicare and Medicaid?

SIBERY:

Yes, we did. I was at the Hospital Council. We really took the position back in those days, Lew, that this was going to be a change in financing rather than a change in demand. I honestly believed that most of the hospitals in our service area of seven counties in southeastern Michigan were taking patients who had medical needs. I really think the physician community was largely taking care of those people. Little did we envision that the infusion of dollars into the health system would ever have the inflationary impact that it did. So, while we planned for it, we really saw it more as a change in the funding method than a significant increase in demand for services.

WEEKS:

There is no question that the actuaries underestimated by far what the cost of this would be.

SIBERY:

Indeed they did. You see, we had a stable delivery system, basically. With an infusion of more money, it was inflationary. I think history records that very carefully. There were those who were greedy, in all candor. But



the overwhelming majority in the health field, in my opinion, worked very hard to help Medicare and Medicaid work.

WEEKS:

Blue Cross and Medicare and Medicaid made great changes in the way hospitals had to keep their books. Wasn't that an important part of your job?

SIBERY:

That was. One of the qualifications we put in back in 1962, interestingly enough, was that a hospital must have its financial records audited by an independent CPA. Today, that is just a given, you know. But back in those days nobody required it except Blue Cross. Many hospitals did it on their own. I don't mean that they didn't. That was one of the things that we did. We required a certain method of cost reporting. That really revolutionized the way the hospitals kept their books. It had to become a much more formal process. It was the basis of real cost accounting rather than almost revenue accounting that had existed for so many years in so many hospitals.

Back in those days, a fellow by the name of Franklin Carr was administrator of Detroit Memorial Hospital. Franklin was on the board of the state hospital association. He believed -- and I was a strong supporter as an officer of MHA at that time -- that there should be a real, meaningful relationship between charges and cost. There was just no rationale at all for the charge patterns that were in place in so many areas.

WEEKS:

What kind of community support did you have for that notion? Any good anecdotes about this?

SIBERY:

Walter Dunn was head of the Wayne County Department of Social Welfare. Walter was an interesting man, a crusty, tough old soul. I fought hard to change the rules under Act 267 of the state of Michigan for welfare, Act 158 which created the Crippled Children Commission, and Act 283 for crippled and afflicted children in the state. Almost all of that care came to the University Hospital here in Ann Arbor. But Walter out-foxed me. When I was with the Greater Detroit Area Hospital Council, we wanted to change the policy of a county board, which was to pay hospitals 75% of the preceding year's audited Blue Cross costs. Well, with inflation you weren't getting 75% of this year's cost, you were getting last year's cost. We fought and we fought. I took hospital administrator after hospital administrator to try to change this with Walter Dunn. Finally one day I had an inspiration. I said to myself, what we ought to do is to take some of our strong community leaders. They can't say we are not going to change it. So I took Bill Mayberry, who was chairman of the board of Manufacturer's National Bank; I took the chairman of our board who was executive vice president of the Ford Motor Company; and I took Ray Eppert, who headed the Burroughs Corporation. We went in there and those men performed brilliantly. The county board changed its policy. They would pay 100% of last year's audited cost, but not until the county could afford it. And of course, the county could never afford it, so the policy was never implemented. So Walter Dunn out-foxed me at that point. He was a shrewd guy. I'll tell you this, I will say for the hospital and medical community here in Michigan, that in those years it was just a given that if people came to your door you were going to give them care whether they were eligible for any of the public acts coverage or not. So I honestly thought

that Medicare was going to be just a change in financing rather than a change in demand. History proved us wrong.

WEEKS:

I think a problem with Michigan Blue Cross was the national accounts, wasn't it?

SIBERY:

Oh, yes. That has always been a major problem. You had the autoworkers, auto company coverage that made up over half of our business in that day. The problem with national accounts has never gone away, still with us. There now are just over seventy Blue Cross and Blue Shield Plans in the country. I can remember when we had 145. Before that we had even more. But those Plans all operate differently now. Service or delivery, as you tend to call it, is not uniform around the country. As a result, that poses a tremendous problem for Plans like the Michigan Plan, which is the control Plan for the auto industry. That still poses a problem. In Iowa, where I am at now, we only have seven percent of our business in national accounts. Ninety-three percent of our business is what we call "local." If you come here to Michigan, Michigan would probably have 60 or 65 percent national accounts and a small amount "local." They are dependent on Plans like the one I am president of to service their accounts well. Even here in 1987, that is one of the major problems that the Blues still have.

I have heard it said by some leaders over the years that they predicted that we will have a national Blue Cross and Blue Shield organization some day. John Mannix is the first one that I recall articulating that. Tony Singen, who was with the nationals for so many years, espoused that theory. I must confess, I espouse it. But I have great doubts on whether it will occur.

WEEKS:

Maybe it will come about through the HMO network.

SIBERY:

I think it could well be. You know, for years Senator Edward Kennedy was saying that he thought a very substantial amount of care would be given by HMOs.

I am jumping ahead, and you will edit appropriately. When I was with the national association, executive vice president under Walter McNerney, I did most of the testifying during those days and I testified before Senator Kennedy's health subcommittee. I remember saying then that we didn't believe that more than seven to ten percent of the population would opt for an HMO if you had one on every corner. How long we worked. Now in Iowa, we have almost 30 percent of the people in major urban areas who are enrolled, are enrolled in HMOs. They are growing rapidly. But things have changed over the years, too. It is now an acceptable form of care. The long waiting lines that characterized some of the early HMOs are not there. Nor are the allegations that they won't give care because of the fact that there is more demand on their time and it will cost them money. HMOs have come alive, and they are good. We have two now that I am president of. They have been responsive to the community and are serving well.

WEEKS:

I wanted to ask you one more thing about national accounts. What is the mechanism? Do you have a clearinghouse?

SIBERY:

There is a clearinghouse. You see, on a national account, the control Plan, where the company is headquartered, is primarily responsible to relate

to that account. Then Plans like Iowa are participating Plans for people within installations within our geographic area. So, through the control Plan -- we process claims through what we call our Inter-Plan bank. It is very much like a banking service. It is a clearance for claims operated by the Blue Cross and Blue Shield Association. The benefit to the national account is that any of our local efforts to contain costs, including volume discounts for the services rendered, our quality programs such as peer review, utilization review, and managed care, all inure to the benefit of the national account. So we have felt that that is good for the national account business. The problem is that the Plans around the country are not uniform. Some perform very well and others not quite so well. The national association continues to struggle with this problem.

One little thing I would like to add about my philosophy about planning. I developed a little cliché when I was president of the American Hospital Planning Association. I gave a speech in Milwaukee in 1964, and as I was preparing for that I said, "What makes planning really essential?" I developed a little saying at that point. "Planning without action is futile, but action without planning is generally fatal." I still believe that.

WEEKS:

This is when you left Michigan Blue Cross, wasn't it?

SIBERY:

I left Michigan Blue Cross at the end of 1964 and went to the Greater Detroit Area Hospital Council, served as its executive director until July 29, 1969.

WEEKS:

Of the goals of the organization as a not-for-profit, trade association

type of organization, planning clearly was your biggest goal.

How about research and representation and education?

SIBERY:

We were a trade association as well as a planning organization. Many people said there were conflicts in doing that. I never subscribed to that because I really believed that you could accomplish both if you were objective. One thing that we had then that very few trade associations even have today is a public board. The Greater Detroit Area Hospital Council had the leadership. We had the Burroughs' executive, the head of Hudson's, United Auto Workers, all three auto companies were represented. The heads of all those organizations were on our board and on our executive committee. We had a large executive committee which really kind of functioned as a board, and the board met a couple of times a year. It was more to ratify actions of the executive committee. I think that even though we didn't get Walter Dunn ever to pay us 100% of cost, that little anecdote I think best tells why I wanted a community board. They are powerful. They did represent the decision makers of the community. If our hospitals were voluntary or public community hospitals and if they were not-for-profit, which was the requirement back in those days, then I perceived that it was best for the hospitals that the trustees really speak for those hospitals. That same philosophy prevailed with respect to the Hospital Council because the community ought to speak as the policymakers over planning. We just had the power structure of Detroit involved. They were great, great leaders. I never saw a personal conflict. I guess if there were ever a question, I always went with what I believed was best for the community. I'm not here to say that I was loved by all the hospital administrators. Some of the small ones feared me I guess. But my

philosophy was that we must do what is good for the community above anything else, and if we honestly try, even though we may not achieve it every time, we will come closer to meeting that objective than through any other approach. We had our regular administrators' conferences each month of the participating hospitals in the Hospital Council. I think we gave them great programs. We had trustee institutes regularly to educate the trustees.

We were not doing a lot in research, feeling that centers such as the Program in Hospital Administration in Ann Arbor ought to be supported and encouraged. We worked very closely with John Griffith, who was then head of the Program in Hospital Administration. It always was a source of satisfaction to me that we were able to have an impact on care.

If you don't mind, I do want to tell you one little anecdote about Ray Brown. When I was here at the university first, our overall costs were just under \$10 per day. I hate to think what they are today. By the time I had progressed professionally to be Executive Director of the Greater Detroit Area Hospital Council, hospital costs were \$30 per day. I remember Ray Brown coming in and speaking at one of our trustee institutes and absolutely incensing the majority of his audience by saying that the day will come when the per diem cost will hit \$100. Business and labor leadership said, "We can never tolerate that." Look what's happened.

Ray Brown was a great man. He was absolutely brilliant. I wish you could have talked to him. One of the great leaders in this field. An inspiration to all of us. He, too, got started very young.

WEEKS:

I wanted to make a comment on your idea of bringing trustees into the board of the Greater Detroit Area Hospital Council. You were sort of ahead of

your time in this respect in that you were almost doing the coalition bit, weren't you?

SIBERY:

We were, really. And there was considerable criticism of doing that, Lew, but I honestly believed that this was best. We did, in essence, have a big business/labor coalition in southeastern Michigan. We really did.

I have never seen a community like the Greater Detroit community. I have been active in New York, I have been active in Chicago, now active in Iowa. Never have I seen the degree of unanimity of purpose and the commitment to achievement that is characteristic in Detroit.

WEEKS:

I think this may have had something to do with the nature of the automobile business. It was a business that grew rapidly and had a lot of young people in it. Anything was possible. I think this maybe explains some of the spirit of the people of Detroit.

SIBERY:

I think that is undoubtedly true. I can remember when the United Foundation had as a goal \$21 million. It seemed as though that was all of the gold in Fort Knox, you know. This community rallied. But you are right, I think it is very characteristic of what was happening within the auto industry. And Walter Reuther. He was another man who left this world in his prime. An outstanding leader. We were so privileged. Mr. Reuther brought in Dr. Melvin Glasser.

I introduced him one time as one of the most outstanding union leaders that I had ever been privileged to know. He stood up and corrected me. He said, "I am not a union leader. I am a professional who is working for the



union." There was a difference. Mel Glasser was a giant in Detroit, and became active on our board after he arrived. Mr. Reuther became less active, which I understood. I don't know how it is in Detroit today, but when I left this community years ago now there was a unification behind the community which was unparalleled by anything I have ever seen elsewhere.

WEEKS:

George Bugbee started the American Hospital Planning Association. Before this happened, didn't he have some seminars? Wasn't he trying to get the group together?

SIBERY:

Oh, yes. At the University of Chicago, yes. He really believed in planning. He was ahead of his time too. I think it is a sign of getting older, Lew. We don't have the giants in the field that we had back in those days, the George Bugbees and Ray Browns, the Bill McNarys, Walter McNeerneys, Dr. Kerlikowskes. Maybe that's just nostalgia, but I don't believe it is. The system has changed. You can't be the superstar today as you were at that point in time. Maybe we just have more superstars so it becomes the average performance that you are looking at.

George Bugbee was so much in support of planning for health services on a rational and reasonable basis. He would hold seminars. He was instrumental, though, in the formation of the American Hospital Planning Association. We held most of our meetings at the University of Chicago.

WEEKS:

One organization in the planning groups that I am not familiar with is the Society for Hospital Planning.

SIBERY:

To my knowledge that is no longer going. That was more for the individual professional as opposed to an organizational emphasis. More like the American College of Hospital Administrators, as opposed to the American Hospital Association.

WEEKS:

Another, the Association of Health Facility Planning Agencies. Did that come in after some of the government regulations?

SIBERY:

It did indeed. That was largely an effort by the government to have a common forum for discussion and understanding of performance.

WEEKS:

Weren't you chairman of the Council on Planning for AHA?

SIBERY:

Yes, for a number of years. When it first started it was called the Council on Planning and Research. Later, it became the Council on Planning. It was my privilege to serve as chairman of that for a good number of years. Ed Crosby was then the executive vice president of the American Hospital Association. Ed gave very strong leadership. I felt it was a real privilege to be able to serve in that capacity. I think we did some good work for them.

I believed in those days, even more so than now, that the American Hospital Association, as an organization, saw the need for adequate and reasonable planning and some breaks on capital formulation and programs. I think, perhaps that AHA over the years has not retained as much of that commitment as was present in the mid-1960s.

WEEKS:

I notice there are some proposals for changing the methods for

legislating within the AHA through the regional advisory boards.

My understanding is that by the time some of these proposals get to the House of Delegates that everything is pretty well decided. There isn't much to argue about.

SIBERY:

There isn't. I'm not sure that that is good. The other thing about it is that I'm not sure it's timely. AHA has to react very quickly, as does any organization. Just today the newspapers are full of the House acting on the catastrophic health bill yesterday. That will be a historic thing regardless of whether it is passed. You have to be able to respond quickly. I am not at all sure but what the present approach of AHA is not a bit cumbersome. In those days Dr. Crosby had his supporters. There were those detractors, but any time you are given strong leadership... I guess my feeling is, if you try to please everybody all the time you are going to fail. Dr. Crosby took some very courageous stands during his tenure. I'm not saying that he was an autocrat, but he was an individual.

WEEKS:

I have heard many stories about him, anecdotes that may or may not be true. Someone has suggested that maybe some of his attitudes and his goals were influenced by his father being in the Salvation Army.

SIBERY:

I think that is true. He had a good value structure. Ed Crosby very much supported the Salvation Army. He was a generous man with them. As a matter of fact, I remember his memorial service. They were the religious leadership for his memorial service. It was held there at the AHA headquarters.

I remember Ed Crosby calling me one time. Ed did show his emotions on occasion. He was very irritated by something that the Council on Planning and Research had done as a position. He called and wanted me to authorize them to change the minutes. I said, "I can't do that. The minutes reflect the action. I'll be happy to go back to the next Council meeting and ask them if they want to reconsider, but I won't doctor the minutes to change action."

Really, from that time forward, I developed a very close relationship with Ed Crosby because he knew I was a man of principle and he was one of the best. As a matter of fact, we did go back and re-address the situation, and we left it as it was because he changed his mind after we talked it through.

Sometimes, you know, a little conflict often brings you close together. He was a great guy.

WEEKS:

One point you mentioned about testifying at legislative committees and so forth. In your role in Blue Cross of Michigan and BCA and your role in Greater Detroit. Did you have a representation role in all of them?

SIBERY:

In all of them, Lew. When I was with Blue Cross in Detroit, we did not choose to testify much. There weren't too many bills that were of interest, but we did try to educate the legislators on what is best on those issues with potential impact on us. Regardless of what you call it, education or lobbying, we did a lot of that. John McClelland was then the lobbyist for Michigan Blue Cross, and I spent many hours with legislative leaders and John trying to help them understand better what they were dealing with from our vantage point.

When I went to the Greater Detroit Area Hospital Council, because we were a 501.C-3 organization, we were very careful about lobbying. But I got around

that by always finding a way to be invited. If a legislative committee wanted me to come, our lawyers said, "Yes, you can go." Ben Long, who had been our counsel for years, said, "You can always respond to their requests, but you can't take the initiative." Many times I did take the initiative by going to someone and saying, "Wouldn't you like to hear from us? If you would, ask us." Maybe that was a technicality, but it still was legal.

At BCA in Chicago, Walt McNerney gave me tremendous latitude. I did much of the testifying there. Walt, of course, handled the critical issues and was terribly effective.

Today, I am still very much involved in representation with all kinds of community groups. I enjoy that. I enjoy that outreach. I'll tell you this, I think the professional who is not concerned about outreach is not going to let the tentacles get out in the community as they need to be.

WEEKS:

You, as the head of an organization, have access to information that other people don't have. If you act only in supplying information you are doing a service because we can't all be experts on all things.

SIBERY:

Absolutely. Mentioning again the timeliness with which AHA responds, let me tell you a little anecdote. My daughter, who was then a student at the University of Michigan, was privileged to be given a fellowship to study abroad for a year. My wife called me at the office one day and she was all upset saying that my daughter and her roommate were going to hitchhike to London, spend the weekend and hitchhike back. It was very popular to hitchhike in England in those days. My wife wanted me to do something about it. She was really fearful. So I said, "What date did she write the letter?"

My wife told me. I said, "When did she say she was going?" That weekend. I said, "Look, my dear, whatever it is has already happened, you know."

That is what I fear. If we don't have a rapid mechanism for making decisions, we are going to have history record that things bypassed us and we didn't influence on a timely basis.

WEEKS:

Did you gather information in these organizations -- I know Blue Cross does, but in Greater Detroit, as an example -- did you gather information on hospital activities or whatever?

SIBERY:

Oh, yes. It wasn't pure research in some respects, more applied research. We gathered all kinds of information on patient origin studies, the case-mix of hospitals. We wanted to know where they were drawing their patients from, where people were going for their care. It helped us in our planning.

WEEKS:

Also probably helped you when you went before that committee. You could say we have these figures.

SIBERY:

Of course it did. I was privileged to be the chairman of the Commission on Medical Education of the State Board of Education for several years while I was in Detroit. At that point in time -- whether it was a good or bad decision, others will judge -- I thought it was a good decision. We did some research showing that 55 percent of the primary care in the standard metropolitan statistical area of Detroit was given by DOs. That's back when MDs and DOs weren't talking much together. Now, of course, we know staffs are

pretty integrated. It's amazing to me to see the number of clinics where MDs and DOs work side-by-side, and they don't think a thing about it.

The point was, as a commission to the Board of Education, we told the Board of Education to support education of osteopaths because so many of our people are dependent upon it. That's when, if you remember, the Michigan College of Osteopathic Medicine was out east of Pontiac, out in the country. We said, as a policy, that we would recommend to the State Board of Education, and they in turn to the legislature, to fund osteopathic education if it was done in a university setting where the university had mature, graduate programs in biological and social sciences. That's how the College of Osteopathic Medicine ended up at the Michigan State University. My point being, that was research that we did at the Hospital Council that let the state understand that there was dependence on osteopathic medicine for primary care that could no longer be ignored.

WEEKS:

I know two or three incidents during World War II when the MDs were drafted into the service and there was just the DO left to take care of the community. In fact, McPherson Community Health Center in Howell was where I first got started in this business, working with John Griffith on a study of progressive patient care. One of the things I discovered in going back over the history of the thing for writing our final report was that during the war there had been one osteopath who had not been in the service. He had stayed there and worked all kinds of hours taking care of people, selfless devotion to his duties. So when it came time to build a new hospital -- they had had an old hospital in a mansion -- when they were ready to build the new one, these people who had been served by this osteopath said, "We want an open

staff here."

SIBERY:

That's right. They were the first in the state.

WEEKS:

Because Dr. So-and-so was here during the war and took care of us, we can't tell him that now with a new hospital that he can't work in it.

SIBERY:

I remember that situation very well, Lew. Jim Sullivan was the administrator then. Jim was on our board at the Hospital Council. We talked frequently about the very real problems this presented for him. I had been in situations around the country, which need not be identified, where it was just like the days in the South with the racial situations that DOs were not permitted to use the doctor's lounge and other facilities. Thank God those days are behind. There is a pretty open mind, at least in the areas that I am involved. We do have a Des Moines General Hospital which is entirely osteopathic. Osteopaths are on the medical staffs of all of our hospitals.

WEEKS:

I know you have been in health education for a long time. Are we training too many people in hospital administration right now?

SIBERY:

I think we could be frankly. I am concerned. I guess part of the problem is that our hospital administration graduates want to start out at the top. If they could see their way to become good departmental managers, or division managers, and work their way up, I think it would be better for them in the long run. I think that is the phenomenon that Dr. Kerlikowske was talking about thirty-five years ago that the young people go through the



programs, and then they suddenly want to come in and run things.

WEEKS:

Entry level in most professions is somewhere stepped-down a bit, but here in hospital administration, you can step in as an assistant or associate.

SIBERY:

I think that is a mistake. I hope that, someday, we can encourage more people to recognize that some of these other positions are good stepping stones and would give them opportunities for experience that they couldn't get any other way.

Lew, I think we are training too many physicians. I think it may be that, if we are thinking only of entry levels at the assistant or associate administrator level, we may be training too many administrators. I would still hope and believe that it is wise that many of our people will be willing to enter at department levels and gain that experience that is so great.

I know in my own case, I look back on my days at the University of Michigan Hospital and those early years were just formative years for me.

WEEKS:

They paved the way for what you were able to do later.

SIBERY:

Indeed. And later you understand when someone comes in and describes a problem where you are dealing with something, you have been there and you understand it.

WEEKS:

Your big step from Greater Detroit Area Hospital Council was to BCA.

SIBERY:

Yes. That was in July of 1969. Walt McNerney and I had been friends for

many years and continue that friendship to this day. Walt contacted me several times about coming to BCA as executive vice president. I was very honored that he would want me, yet I thought that I was getting so far away from the delivery of care, I still felt in areawide planning for health services and the trade association functions that it was quite closely allied to it. Finally I became convinced when Walt said, "He who pays the bill is going to influence the most." So I went there in July of 1969, and have never had any regrets about going.

WEEKS:

You were number two man there, weren't you?

SIBERY:

Yes, I was. I was the executive vice president and served as the chief operating officer.

WEEKS:

I want to talk about those troublesome days in the 1970s at BCA. I don't know whether I have my chronology correct or not, but it seems to me I remember from talking to somebody from Blue Cross that the 1970s were a bad period. You were trying to get adjusted to Medicare and the fiscal intermediaryship and the loss of some of your members. Talk about those days, won't you?

SIBERY:

Those were critical years. Barney Tresnowski, now president of Blue Cross and Blue Shield Association, reported to me and I enjoyed that working relationship for over eight years. Barney was brought in to head up our Medicare program before I went to BCA. As you know, Medicare started in 1966 and Barney was brought in to head that up. Those were turbulent days. We

were learning rapidly about a horrendously large undertaking. I think everyone underestimated how complex the intermediary relationship would be. As you know, the American Hospital Association was very influential in getting the intermediaryship given to the Blue Cross Association because it encouraged its hospitals to elect BCA as the intermediary. That was under the inspired leadership of Dr. Crosby. I think we should all be forever grateful to him for having the vision to see that this was highly desirable.

Part of the problem in those days was the feeling that you couldn't be an intermediary. We were to be a buffer between the hospital as the deliverer of care and the federal government. There was considerable concern by some of the people that that was an impossible role to fill. You were either going to lean one way or the other. I think Barney filled that role uniquely. I think the reason that we have continued to be successful is because we had the vision to see the uniqueness of the intermediary role. Alex McMahon, when he succeeded Dr. Crosby, saw the uniqueness of that role.

Blue Cross, when it first started, was the only game in town. Fritz Lattner, the founding president of Iowa Blue Cross, frequently drops in to chat about the good old days when they had no marketing people out in the field at all. Because the commercial insurance field did not believe that health was insurable, the wisdom of Justin Ford Kimball of Baylor University and other people who started the Blue movement, has been proven. The Blues were set up as non-profit community social organizations and they were very popular.

By 1970, the competition in the health field was becoming bitter. It is even worse now. Had the Walt McNerneys of this world felt that the Blues could go on as they were with no change, I think it is questionable whether we

would have a meaningful impact in 1987 or not. But Walt was a very visionary man, and he gave strong leadership to the board. We had to start thinking about HMOs and about selective contracting, and things of that kind. So, as we saw the erosion in our base business, it had to be that we increased our penetration in some of these other areas.

Illustrative of that is this little anecdote. When I went to Blue Cross and Blue Shield of Iowa as president in 1980, they did not have a comprehensive major medical program. The marketplace was demanding it. We put one in in very short order. Today over sixty percent of all of our private fee-for-service group business is comprehensive major medical. Had we not seen the need to change, just think what that would have led to. One little state like Iowa. Now we have two Blue Cross/Blue Shield HMOs. We have all the State of Iowa employees on managed care -- pre-certification discharge planning -- and all the features that managed care connotes. We expect in just a few years to have over half of all of our subscribers on a managed care program. We put in a preferred provider organization. This is growing quickly. We are a different animal than we were in 1980. Walt McNerney saw that in the 1970s, saying we are losing money, we are losing enrollment, we are going to find the competitors outstripping us. It was his impetus that really brought about, I think, the dynamic changes that have taken place.

I really don't want to belabor about Walt's leaving the field, but I think sometimes a leader can be a little too far ahead of those who are following. The thing of it is, Walt was right.

WEEKS:

Would you like to talk about that interplay and the forces that made it difficult? In the first place, I have often wondered whether Walt's

willingness to succeed Dr. Crosby at AHA weakened his position.

SIBERY:

Yes, it did. Clearly, it did. Some felt that he no longer was really committed to the Blues. I must confess to a certain disappointment that Walt was so willing to consider appointment to succeed Dr. Crosby, not because I don't think AHA is important, but I really felt that his role as president of the Blue Cross Association was so critically important to the community and to the country as a whole. I think that weakened his position. I have heard the leadership of the movement say that Walt was too far ahead of them, leading them in ways that they didn't want to go. That's what I mean when I say that you can be too far ahead. But history is recording that Walt was right. I think in Iowa we are only a mirror of what is going on elsewhere.

In my opinion Walt was an inspired and an inspiring leader, but he was ahead of his time.

WEEKS:

Wasn't there another element there too, the natural rivalry between the Blue Cross and the Blue Shield -- the hospital versus the doctor?

SIBERY:

Much of it, yes. No question. You see, when I was there it was just the Blue Cross Association. Blue Shield Association was a separate legal entity. That organization then subsequently, as you know, merged with the Blue Cross Association and became the Blue Cross and Blue Shield Association. Walt, from Blue Cross, got presidency, but that did not come without a price. I think that was another thing that started Walt's demise within that organization.

WEEKS:

But Walt has a distinct style, too.

SIBERY:

Yes, he does. A unique style. Walt's skill has always been public representation and vision. He is not a great day-to-day administrator.

He knew to have somebody that he could trust and hold accountable. He held me accountable. I ran the show on a day-to-day basis, but Walt was seldom in the office. That was representation, that was involvement, that was leadership that was critically needed. I think history is going to record that the Blues clearly were on the way down and Walt moved them.

WEEKS:

I think there is no question about it. When he came into BCA it was a pretty weak organization.

SIBERY:

Terribly weak.

WEEKS:

He made it something.

SIBERY:

They disbanded total plan review. Total plan review was a mechanism whereby the nationals sent in teams of specialists to a Plan and did what the name connotes, a total plan performance review. I was very supportive of that, encouraged its development. I think we rendered a great service, but that too was resented. Nobody likes to be told that they are not doing a great job.

WEEKS:

But there were some Plans that needed to be told, weren't there?

SIBERY:

They desperately needed to be told. That's where Walt's style -- he

could go in and tell the CEO of a Plan, kind of sell a refrigerator to an Eskimo or make you swallow a bitter pill and make you think you ended up liking it. Walt had that characteristic about him. We were trying to do total plan performance reviews as objectively as we could. I think that was a great service, but it was resented very, very much.

WEEKS:

As it relates to performance for government business, aren't there differing interests among the Plans?

SIBERY:

Absolutely! Some Plans are highly dependent on government business and some don't handle government business at all. Our performance has been good, but it has been spotty. This is where Barney Tresnowski has really excelled, in my opinion, over the years. Maybe I am biased because for eight years he headed the government programs while I was there with BCA. I know how skilled he has been in that. We are seeing tremendous pressure on that intermediary relationship now. The government does not want to pay the price for what it is costing to provide that service, if you did full costing. The marginal costs are met and prudent decisions are made to go ahead even though you don't have full costing.

But you are absolutely right. A number of Plans could not survive, even today, if they didn't, either for Part A, be an intermediary subcontractor of BCA or, for Part B, be a carrier directly.

WEEKS:

If you carry this a little further, aren't some of the many mergers resulting from the weakness of certain Plans?

SIBERY:

Yes. The national association developed its long-range business strategy back in the early eighties. Part of that proposition 1.1 called for joint Cross and Shield Plans rather than separate legal entities. For example, in Iowa there were two different laws that governed medical and surgical on one hand and hospital on the other. That's why we have two separate corporations. That law has been changed and we are right in the midst of negotiations now of merging Cross and Shield. The other proposition said that by 1985 that that single legal entity would have to be at least statewide. In Iowa, we have two Blue Cross Plans, the one I head, and we have Blue Cross of Western Iowa and South Dakota. So we are in the midst of considering merger with Western Iowa and South Dakota at this point in time. Blue Shield of Iowa, as are all of the other corporations which I head, are statewide. Lew, there is no question that competition and administrative expense ratios are becoming critical elements, and the small Plan just can't go it alone. We are going to see fewer Blue Cross and Blue Shield Plans, bigger Plans. I think regionalization is going to be the thing in the future. The thing I hope we can maintain is a close relationship with the provider community because it is only their services that we have to offer to our subscribers.

WEEKS:

Would you like to say something about the merger of BCA and BSA, and the forces for and against? The inner-workings that might be of historical interest?

SIBERY:

There clearly were those in leadership roles who understood that the phenomenon that was being experienced locally had to be experienced



nationally. I'll explain what I mean. When General Motors buys health care coverage they don't want to have several points of accountability. They want to be able to point the finger at one person and say, "The buck stops here." Therefore, the artificial separation of Blue Shield, covering medical/surgical, and Blue Cross, covering hospital and other institutional care, which had so much historical significance, has no practical significance: in fact, is seen as an impediment to bringing this together in terms of a health care package that is under the control of one entity. Accountability can be assured through one entity, eventually through one person.

There were those who recognized that that was increasingly important at the local level, and if it was important at the local level, unless there was a unified decision-making process at the top, that BCA and BSA couldn't possibly interrelate in a positive enough way to get the job done in this changing environment. So the pressures really started building in the early seventies for a more unified movement on the part of the two national associations. During my years there, every Monday morning we met as a joint staff and tried to do things much more collaboratively and cooperatively than might have been done in preceding periods. But, at the same time, they were still two entities with two decision-making policy boards. It just didn't work.

Now, Walt McNerney, behind the scenes I think, gave a lot of leadership to this. But the visibility was not apparent. He felt that the physicians and the American Medical Association and the hospitals and the American Hospital Association needed to say that this is going to be in the long-range best interest. As you know, it took many years to bring this about. While I

was with the nationals the ownership and control of the names and mark of Blue Cross shifted from the American Hospital Association to the Blue Cross Association. Many said this would be the demise of an effective relationship with AHA. It was not, particularly while Dr. Crosby was there. I observed first hand a very strong, continuing relationship. There are those who felt that Blue Cross had dominated the picture too long, that Blue Shield was kind of given short shrift. I think there again, wisely, Walt was not giving too much visibility to it. He didn't want them to think that BCA was trying to gobble them up, swallow them, chew them up, you know. I think history will record that as a very significant posture on Walt's part.

The merger did become reality. It is one of the best things, Lew, that has ever happened. Because you don't make policy in a vacuum. At my local level, I told you, because of unique state laws we have had separate Cross and Shield organizations but we meet jointly. The boards meet jointly. So there is one consideration of the policy issues. It's helpful. It is good in the marketplace that we can say we are now unified.

WEEKS:

Didn't this BCA-BSA merger come sort of in steps? Didn't you retain separate boards for a while?

SIBERY:

Yes. It was phased in. But, thank goodness, not for long.

WEEKS:

Wasn't there also a certain amount of tension and uncertainty about who the heads of staff would be?

SIBERY:

Oh, yes. Very much so. I had left by then and had gone to New York.

Walt and Bill Ryan, as president of Blue Shield, were the contenders for the position. Some felt that because they didn't want to pick from between them that they should look for somebody totally neutral and new to come in and head it up. I'm glad they didn't. Both Bill Ryan and Walt are close friends of mine to this day. I think the boards chose wisely in bringing Walt into that new position. Bill stayed on as executive vice president for several years. I was chairman of the search committee and board of directors of BCS Financial, which by then had been reorganized. It just seemed a natural thing that we would look to Bill Ryan when we had need to fill the position as president and CEO of BCS Financial. Frankly, I think it was a relief to Walt because Bill was happier being a CEO than he was as the executive VP. I think it was good for Bill Ryan, and it certainly has been good for BCS Financial. Ryan pretty much had hoped that he might be considered when Walt's relationship was severed with BCA, but he was never really a serious contender for the presidency and CEO position.

WEEKS:

In the meantime Barney Tresnowski had moved up to executive vice president, and then was chosen as president.

SIBERY:

Yes, I think it was an excellent choice. He understood the operations. He knew Medicare from ground zero. He had been the father of that program as far as BCA was concerned. He knew that operation like he knows the back of his hand. To me, it was a very natural thing. There were others considered. I, too, was considered for that. We make decisions. I felt that I had served well in my eight years with the Blue Cross Association. Frankly, at BCA when our youngest went off to college it left my wife, Verla, alone too much. I

was traveling over 75 percent of the time. Many of the weekends were tied up because of Plan meetings on weekends. So I decided that I would go back into a Plan and get away from the night and weekend travel. The fact is that in these rapidly changing times, you are still tied up with evening meetings and weekend meetings, but at least you are home at night. It's different than being away.

WEEKS:

In looking at the description, I think every man wants to run a show of his own at some time. It didn't seem to me that from your standpoint, looking back after 1972 -- you knew Walt was going to stay after he didn't get the appointment at AHA. After all, Walt is only about four years older than you, isn't he?

SIBERY:

That's right. He is a contemporary in every sense of the word.

WEEKS:

It wouldn't be like following an older man who might retire next year.

SIBERY:

No. I fully expected that Walt would retire as president of the national association. I really respected him as a leader. I never aspired to be able to replace him because I felt he had strengths that were far greater than any I could bring to that, and frankly, greater than most people could bring to it. I was not anxious to be the CEO, and that is part of why -- you know, I spent eight years with Walt as the chief operating officer and executive vice president. Those were great years, very pleasant years, troublesome in many ways professionally because of the problems that we were encountering. But I think we made great progress, and I think we served the system well.

Someone asked me why I went to New York as executive vice president. The reason I did that is that all of my history had been on the hospital side...

I thought that I needed additional exposure to the physician side of the business. I also wanted to go back to the individual Plan level, where I could influence local decisions and see the impact on a more directed basis. The New York Plan is, by far, the biggest in the system. It's more like running a big company than a small Plan. With a 70 percent market share, Blue Cross and Blue Shield of New York represented a good career move for me. It gave me the background to run a Plan of my own.

WEEKS:

Which brings us to your move to Iowa in 1980.

SIBERY:

Despite the great experience in New York, I longed for my roots in the Midwest. Having spent all of our lives in Indiana, Michigan, and Illinois, Verla and I were anxious to get back home. When the Iowa vacancy occurred, we were elated. One of our sons had gone to school and played football at the University of Iowa, and we loved the country and the people. Fortunately, I was selected and have never regretted that decision, though my years there have been filled with change and stress.

WEEKS:

How so? What were you faced with when you got there?

SIBERY:

In short, we had one of the highest hospital inpatient use rates in the country. The business community was demanding change throughout the whole health care system. The providers had strong control over all aspects of the delivery system which, while not inherently bad, meant that change would be

hard to instigate. Costs were escalating to intolerable levels. And Blue Cross and Blue Shield were viewed as rather lethargic organizations which were not major community leaders. But perhaps our biggest problem related to our data processing systems.

WEEKS:

Tell us about that. Didn't you have real computer problems in the early '80s?

SIBERY:

To understand that, you really need to go back to the '70s. In the early '70s, the Iowa Plan put in one of the most innovative computer systems of its time. But the tremendous growth of the late '70s and a relatively patchwork system of data processing enhancements stressed our data processing capabilities and rendered that system antiquated by 1980. Couple that with a data processing staff whose training was not state-of-the-art and we had a major problem.

Recognizing the impending problem in the late '70s, my predecessors, Dave Neugent in Blue Cross and Bill Recknor in Blue Shield, joined a national association effort to develop a nationwide, long-range computer system that was being billed as the future of Blue Cross and Blue Shield data processing. Known as Long-Range System Planning, LRSP was designed to solve our lack of uniform processing for national accounts and also to meet local processing demands.

LRSP never really met its objectives. I think there is a very simple reason why it did not meet its objectives. It was trying to be all things to all people. When I left the national association, LRSP was still alive. You can't develop a computer system that is going to please everybody. It is just

as I told my sons many times, don't try to please everybody all the time because you are going to be a miserable failure if you do. We should have frozen the design of that system years before it reached that point and said, "You can make your characteristic changes at the local level if you want to. We are going to freeze the design of that system."

Blue Cross and Blue Shield of Iowa had been dependent on that system, but version one and a half, which is what ended up being the final product of LRSP, was not nearly advanced enough to meet our needs in Iowa. For all the reasons I stated before we had no choice but to go with a facilities manager. Because when I went there in 1980, we had a real crisis on our hands. A lot of other Plans had the same experience. We had spent millions of dollars on it.

We talked earlier about the fact that Plans want to have their autonomy. There was never a commitment by the majority of people to make LRSP work. They were saying our situation is so unique that we have to do it our way. To me that is sheer nonsense.

WEEKS:

Those early days of the big computers I think were years when the knowledge wasn't keeping up with the demands.

SIBERY:

When I was with Michigan Blue Cross we tried to set up a health data network. I guess we were twenty-five years ahead of our time then. It seemed to me that it was ridiculous for Blue Cross and Blue Shield to be the repository of so much information that could be used by the state health department and other organizations for certain purposes. Obviously you have to have security built in so that the confidentiality of sensitive material is

assured, but there were certain types of data that could have been shared. I honestly believe we are just at the edge of some major breakthroughs in terms of sharing information. While I want confidentiality at all costs, there are lots of data that could be shared for the good of everyone.

WEEKS:

There are some things that have to wait for their time to come.

Going back to BCA...I have one listing that one of your duties was special Plan services.

SIBERY:

That's this total Plan review that we were doing. Yes, we had a unit that did special Plan services, a combination of the total Plan performance review, a combination of lesser reviews at the request of Plans and then consulting services where Plans would ask us to come in and be of assistance to them in handling a specific problem. I regret that BCA and BSA subsequently did away with the total Plan reviews. I think they are still needed today. But here again, you have egos that come into play. Many of the Plan presidents thought they knew a lot more than the people coming out of BC/BSA, and they resented being told that an improvement needed to be made. I guess that's a human nature characteristic of many people. Most of us probably have it.

WEEKS:

Sooner or later there are going to be complaints from someone about a certain Plan not producing the way it should or some relationship with that Plan will come to light that is not acceptable. Then the national organization is going to have to do something, aren't they?



SIBERY:

Well, they still try to look at performance indicators called NMIS, National Management Information Systems. They look at those, and if a Plan is not meeting those performance indicators they want to come in and find out why. So, yes, absolutely the nationals have an obligation. I guess my feeling is that statistics are not always an accurate portrayal of what may be going on. You may be rendering a service at a satisfactory enough level to pass the standard, but you may be giving lousy service in the area that you aren't meeting it. Relying solely on the statistical approach does not really give me the kind of information that I need to know about a Plan's performance. I suppose because of my orientation, I have tended to use consultants, whom I use cautiously, but for special projects to help assure we are on the right track. But you are right. The nationals still have an obligation and they still try to render a service. I only regret that they abandoned the performance review mechanism that they had in place and that I think was serving quite well.

WEEKS:

Would you like to talk about Bob Sigmond's role?

SIBERY:

Yes. Bob Sigmond has been a consultant on hospital affairs for a number of years. Walt McNerney brought him in, and Barney Tresnowski has kept him on in a relationship. Bob is now moving into retirement years. Here again, as I said earlier, we in the Blues must clearly understand the delivery system we are trying to finance. Bob Sigmond is one of the sharpest and most astute observers of the delivery system. He, too, has been ahead of his day in many respects. Years ago, he was trying to work out a capitation program, that you

may recall, in the state of Colorado. It never got off the ground. Today it would. Back then it wouldn't at all. Bob understands the delivery system. Like many people, he was not a great administrator as such in practicing the profession, but I think Bob is one of the greatest minds that we have ever had. I think Bob has played a very unique role at the Association in making sure that they really think through the implications of something before moving. I think it was an extremely wise move on Walt McNerney's part to bring Bob in. I have been pleased that Barney has continued that relationship.

Walt came out of the hospital field. I came out of the field. Barney was a hospital administrator. I think we were sensitive, but many of the younger people coming out today come from other disciplines. This is where I think Bob has been particularly useful in being a resource to these people saying, "Do you understand how this will impact?" and, "Think about this twice before you do it." He has been a great resource.

WEEKS:

I was thinking of describing him as coolly logical. He has a sharp mind.

SIBERY:

I have known Bob for thirty-five years. We were in health planning together. Then Bob went on to other things. I can think back and maybe there are ten real giants in the field. I would put Bob Sigmond among those ten.

WEEKS:

We have you leaving for New York.

SIBERY:

I went there in June of 1977 as executive vice president. They were very fruitful years for me. I must confess that I enjoyed the Plan very much,

enjoyed my associations there, but New York is not really my first choice of where I would like to live. While we enjoyed our little community of Bronxville, just north of the city in Westchester County, and had a fine church there and made many friends, there is a work ethic in the Midwest, there are values in the Midwest that you just don't find on the East Coast. Frankly, I was quite anxious to get back to the Midwest.

WEEKS:

Would you like to talk about the situation among the Blue Cross and Blue Shield Plans in New York State?

SIBERY:

When I was there, they still had thirteen organizations in the state. Subsequent to that, Albany, New York Blue Cross has merged with Greater New York Blue Cross into what is now called Empire Blue Cross and Blue Shield. I am sure there will be other mergers. There are mergers underway now between Western New York Blue Shield and Blue Shield of Albany. As I recall the data, over 80 percent of the population in the greater Rochester area are with Blue Cross and Blue Shield -- tremendous penetration. Tremendous penetration in New York City as well, but not on the part of Blue Shield in New York City. It is Blue Cross that has the penetration because of their tremendous hospital discount. There is no one paying billed charges as a commercial insurer who could ever compete with Blue Cross of Greater New York, which is now Empire Blue Cross.

WEEKS:

What about HIP?

SIBERY:

HIP is important in New York, but it has never been a major threat for

the Blues. Now, by state law, the discount has shrunk on the part of Blue Cross and I think Blue Cross and New York State will have a much more difficult time.

WEEKS:

HIP doesn't cover hospitals anyway, does it?

SIBERY:

They were basically physician services, but they were in the process of developing a program to encompass hospital care as well. I have lost track of that for the last seven or eight years. I don't know where that stands now.

WEEKS:

Then you have the situation of so many municipal hospitals in New York City, too, which changes the character of things.

SIBERY:

It was that hospital discount, which frankly I think was too high, that permitted the Blue Cross Plans to dominate as they did. Clearly the state of New York doesn't need thirteen legal entities to operate the Blues. Probably at least two should be there. I don't think that we need much more than two. There ought to be Cross and Shield Plans as a single legal entity. I think the greater New York area has so many unique characteristics that at least the eastern part of the state of New York should be one. Whether they will ever be statewide I don't know. Probably not in my lifetime at least.

WEEKS:

In looking at these mergers, it seems to me there has to be a time coming when one of the chief executives is ready to retire. If you have two active chief executives, neither one wants to give.

SIBERY:

That's right. Massachusetts is a good example of that. They have just merged their corporate interests, and Dave Frost, the president of Massachusetts Blue Cross, decided to take early retirement. He is going to go back to law school now. He wasn't ready to retire, but he took early retirement. But you are absolutely right. When one is ready for retirement and retires and moves out it makes it much easier to merge interests.

WEEKS:

Another thing I have wondered is if there isn't a local loyalty like there is for small town hospitals.

SIBERY:

Absolutely. No question about it. This is our Plan and we aren't going to let it slip away. We can handle the computer applications by remote entry, but provider relations, customer relations, public relations, those type things, you have to have a local presence. I think we haven't yet mastered the art of knowing what can be centralized and what needs to be kept local. Those three I think really need to have a local presence.

WEEKS:

Both sides wouldn't agree to accept Dave Stewart?

SIBERY:

That is correct.

WEEKS:

Not because of any weakness on his part, but just because he was on the other side.

SIBERY:

They didn't think that he would take their interests seriously. Dave is

a marvelous man. You are right. I think we ought to be very careful to make it clear that it was not an anti-Stewart, it was just a fear that he wouldn't understand their needs and therefore wouldn't be responsive to them. Often, we find that sometimes it is sheer necessity. Before I went to Iowa, they had separate presidents of each of the Plans. I'm the first joint president that has been appointed. Now, as I say, I am having joint board meetings until we can become a legal entity as one body. Neither of my predecessors was acceptable to the other side, so both stepped out of the picture and I came in as the first joint president.

WEEKS:

Didn't you run into some confusion from a leadership perspective when you first went to the Iowa Plan?

SIBERY:

Absolutely. No question about it. The sheer complexity of the decision-making process made it difficult. Some feeling that I hadn't had enough experience in certain areas. The legislature ultimately decided that they were going to change our board makeup. Before, our boards had to be a majority of providers. Now the law is that not more than one-third can be providers. At least two-thirds must be subscribers. Our board changed overnight. We had nominations to the board controlled by independent subscriber nominating committees appointed by the Insurance Commissioner. He made sure that we got new boards in there. It has worked out very well. But you are absolutely right. It was not easy to move in as the single president.

WEEKS:

Do you want to talk about your HMOs?

SIBERY:

Yes. We had an HMO long before I went to Iowa, in Bloomfield, Iowa, which was a failure. I guess the most charitable way to record that for historical purposes is that, if you read the file, it was a classic example of how not to plan an HMO because it was doomed for failure. There were no controls on it. It was too small a geographic area. It had too few enrollees to spread the risk; some adverse selection on the part of people who were really ill and bought into this for care meant that the claims expense was just out of line. So it folded its doors.

Immediately upon going to Iowa in 1980, one of the things I wanted to do was at least start the planning for an HMO. I had immediate resistance from the boards because of the failure of the Bloomfield HMO. The feeling was that they didn't want a repeat of that. I didn't want a repeat either.

We were planning an open panel, an IPA, an Individual Practice Association, based largely on negotiated fees. I hired a consultant. I try to use consultants very conservatively. I think too often they come in and ask you what you want to be told, and then write a report to tell you that. I don't need that. What I want is somebody who is going to give me professional judgment as to what is best and what is appropriate. That is where your university has excelled over the years at being a very practical organization in consulting. Not too many are, as I'm sure you will agree. But I hired a consultant, Dr. Zachary Dyckman to come in. Zach said to us, "Your model is wrong. You are going to have to have controls in place greater than what you envision." He told us to go with the gatekeeper concept where you have a primary care physician assigned, then have your specialists all on a capitated basis. To make a long story short, that is the design of our HMO called Total

Health Network. We now have about 30,000 enrolled in that. It is growing rapidly. We have expanded the service areas to cover many more counties. We are now in six metropolitan areas, if you will permit me to call any a metropolitan in Iowa. We are now in six metropolitan areas and reaching out. It has been a good design, but even with all the controls we put in financially, it has still been a very difficult thing for us to overcome the problems of adverse selection. The providers in one service area have higher average per hospital admissions and hospital days per thousand subscribers than what our traditional Blue Cross and Blue Shield had. You know, historically, HMOs have always had fewer inpatient days and fewer admissions. This is one of the ways they have been successful.

When the opportunity came to acquire Family Health Plan, which was another HMO operating in Des Moines, we looked at it carefully and recently acquired it. That legal transaction is in process. That has the open panel. It has an independent practice association model. It does not use the gatekeeper. You can go to anyone on the panel that you wish. They aren't seemingly losing any more money during these formative years than we were with our closed panel, gatekeeper, primary care approach. So I told our boards that I would like to gain experience with both of these. We will hopefully learn a great deal from them. Our objective is to have between thirty and thirty-five percent of our business in HMOs by 1990. We are doing that, in part, by tremendous growth in our own founded Total Health Network and we are doing it through the acquisition of other HMOs.

I think that HMOs will grow. We want to be a major force in the HMO picture. I think many HMOs are going to fail financially. They just can't succeed. It takes an infusion of a lot of capital. So far we have put up



over \$14 million in our HMO activity.

I would like to comment just a bit about Preferred Provider Organizations. We started out with an Alliance program, which is basically managed care -- preadmission certification, concurrent utilization review (UR) -- discharge planning, case management. Then we had a line of select providers which includes all of those managed care concepts, but in addition, selects providers who have agreed for a price to render service. I think selective provider relations will grow. Basic managed care and our PPO, called Alliance Select, now cover well over a fourth of our non-Medicare business. We think it will probably cover at least half of our business within the next years. As a matter of fact, we are studying a new diagnostic related grouping payment system for our hospitals. As part of that, it is our plan to have at least preadmission certification on all admissions. So the day will rapidly come when these characteristics become the norm.

The whole area of alternative delivery systems and managed care has reshaped the health care delivery system. The fundamental balance is changing away from first-dollar, open-access coverage to restricted access, alternative delivery care.

Based on our market research, we believe that in Iowa, which admittedly is a bit more conservative than many states, between 25 and 30 percent of the population will choose an HMO model. In that regard, I would really put PPOs in the same category -- an alternative delivery system, let me say it that way, which would be all encompassing.

WEEKS:

What is going to happen to the hospitals that are giving discounts in order to get the HMO or PPO business?

SIBERY:

Some hospitals, I think, have been very unwise in their bidding process. You know, if you only get enough income to cover your marginal costs, there are going to be some focal point costs that are not picked up by anybody. In our pricing we try to do full costing. Even on our intermediary functions for government, we don't get our full cost in a technical sense, but we more than get our marginal costs. I think the point that I want to make is that hospitals are going to have to be realistic in having a relationship between the costs and the charges and they are going to have to recognize that their margin, cannot be excessive. You have probably read some of the utterances of some of our congressional leaders in the last few weeks of questioning whether the hospitals are deserving of a continuation of a non-profit status tax exemption. I think there are going to be a lot of pressures. The Blues just became tax entities in January 1, 1987. Many of them have had to pay premium tax in their states for several years as we did in Iowa. We avoided it until a year and a half ago. We now have to pay premium tax. I think the hospitals are going to have to be sure that they aren't greedy and be sure that their net return, the bottom line, does not produce so much that it's unrealistic. Selective bidding, as far as I am concerned, should be for the purpose of saying that there is such an economy of scale in buying large quantities that is deserving of a discount. I don't think the Blues deserve a discount because they are community social organizations or for any other reason other than they are a mass purchaser of services.

Along this line, when the Blues started nearly sixty years ago, I think we were basically perceived as community social organizations. In my lifetime, I have seen the reality of the fact: we have evolved into what they

had to become, community social organizations with a business purpose. Now there are few of us in the field who really believe we have evolved into a business organization with a social purpose. We have to be financially successful to survive, therefore, you must be a business organization, but you should maintain that social purpose. The social purpose dictates that you do for others what you might not normally do strictly from a business standpoint. But it does require you to be guided by the business implications of your decisions.

I think for too long the hospital community has said, "We give you a discount because we are different." I really think the only logical argument we can use is that we deserve a discount because we are a mass purchaser of services. Economics in this country dictate with logic that the mass purchaser gets a price break.

WEEKS:

It happens in every line of business.

SIBERY:

It does indeed.

WEEKS:

Someone was saying the other day while talking about this question of hospitals giving discounts, when is the time going to come when the competition factor is no longer there. It reminds me of what the man said that a health insurance company, Blue Cross or anyone selling health insurance, especially on a capitation plan, should never ask the doctor to try to enroll people. He said, "The doctor who sees the patient who has an expensive ailment says, 'You should join the HMO.'"

SIBERY:

It's a good point. Your adverse selection you just have to avoid.

WEEKS:

What do you see in the picture concerning AIDS?

SIBERY:

I'm very worried about that. I think we have an unfortunate reaction in this country. In our own Plan, we will not underwrite if it is known that there is an AIDS victim on an individual policy -- if it is pre-existing coming into our organization. But that is true with heart disease or cancer or anything else. Individual coverage is not where I am worried the most. Where I am worried the most is that there is no way to control your risk in your basic business, your group business. I guess I am very fearful that if the projections in terms of the numbers of people that are going to be infected with the AIDS virus are even close to being true, we may have a catastrophe on our hands that even the best of conceived insurance and Blue Cross programs can't handle.

Now, I do not panic over this because I happen to believe that somehow we will get this under control. But I think this is far worse than the plague ever potentially was. I have a doctor friend who is a missionary in Africa. He is absolutely convinced that the disease is transmitted by mosquitos because of the number of cases they have in Africa. When you look at their death projections in the next five years, they are just staggering. The only reason I use the anecdote about passing by mosquitos, it may not be just educating people about their sexual behavior, it may be a much more insidious process of transmission than any of us dream of. I guess we just don't know the parameters of what the problem is going to bring. It may baffle us, it

may confuse us, it may frustrate us, but it too can be handled if we set our minds to it. It may be close to impossible, but I still believe it can be handled within the insurance mechanism.

WEEKS:

Within the insurance mechanism?

SIBERY:

I do. Maybe that's cautious optimism that is unfounded, but I think we can. I would hate to think that government has to be the solution for it. One of our senators said on the air this morning that he thought the passage of the catastrophic bill was just a step away from a comprehensive health program for all citizens. By implication, I guess he is talking about national health insurance. I'm not sure that is good for us. I would much rather see the private sector handle it if possible.

WEEKS:

I think national health insurance is easy to talk about, but it is much more difficult to put into operation than they think.

SIBERY:

Absolutely.

WEEKS:

Have you any ideas on what we are going to do with the aged? The passage of catastrophic legislation in Congress closes some gaps but it still doesn't cover long-term care.

SIBERY:

I have some ideas because we are right in the midst of introducing in the marketplace a new long-term care product. I tried three years ago to get that approved and the insurance department leadership at that point in time felt

that this was not insurable, just as years ago they felt health wasn't insurable. We are going to have to take some risks. We got approval for this product this fall and will be one of the first Blue Plans to provide this coverage to the market place. We think it is going to be good for Iowans. It will cover nursing home care, home health care, and adult day care in addition to skilled nursing care. Residential care is not covered. There must be medical necessity for the care. It will cover home health agencies as well. I think it has been well conceived. I am anxious to see it work. To me, when somebody tells me you can't do it, it is only a challenge to prove they are wrong.

I am a great believer in hospice. I think those services are critical to letting people be served with dignity.

WEEKS:

This is where they want to be at a time like that. We can't empathize entirely with it, but I would assume that if I were ill and knew that my days were numbered, I would want to stay at home.

SIBERY:

We have only one family situation upon which to reflect and that is not enough to generalize, but I certainly know my mother-in-law wanted to be home when she knew she only had a few days. I just can't help but believe that many people prefer that.

WEEKS:

I am sure they do.

Maybe it isn't your place to consider housing for the aged.

SIBERY:

We have no plans. I do not believe that it is the proper role of Blue

Cross or Blue Shield to purchase facilities, except in the HMO area. That may be a possibility, but generally speaking, I think we have enough to do on the insurance side, the financing side, not to get into the direct delivery. We have been asked, "Don't you think it might be a good idea for you to provide housing for the elderly?" I would much rather work with other community groups to find a broader base to support that than to think that we can do it through the Blues.

WEEKS:

The reason I asked that, I remember talking with Walter McNerney about five years ago about care for the aged. He was quite concerned about it. Even when he went to BCA in the beginning one of the first things he did was work with AHA in studying the needs of the aged for health care. This was before Medicare and Medicaid. So I wondered if, by any chance, you or some other Plan in Blue Cross might be thinking of housing for the elderly, or even congregate living.

SIBERY:

Let me tell you a broader answer than just to the question you raised. I think one of my major roles is to work with other community leaders in bringing about desired changes in our community. We are working now with a number of organizations on the coverage of their skilled nursing portion within a facility that they are proposing. I think that is a proper role for us. We have encouraged the legislature, and they have taken the leadership in appointing commissions to take a look at uninsured and uninsurables -- a distinct difference between the two. We are saying again that we can't do it all alone, but we are willing to do our fair share. I think that it is better for us to give personal care than it is to provide facilities basically. We

don't have those kinds of reserve. We don't have that kind of money.

WEEKS:

I think, as you say, you are fulfilling a good position in the health field by being in an advisory capacity, or even a planning capacity, or in a capacity of exciting other people to do something, whether you can do it yourself or not.

SIBERY:

I was on the Iowa Governor's Commission on Health Care Costs. Subsequent to that, we set a new corporation called the Health Policy Corporation of Iowa as a public policy organization bringing all providers, consumers, government, the private sector, labor, business to the table. It is that forum in which I am very active and that I think is best to address some of these broader issues.

WEEKS:

We mentioned in passing something about the commercial insurance companies getting into various new fields. What is the competitive situation now between Blue Cross and the commercial insurance companies?

SIBERY:

It is cutthroat competition. It is unbridled competition. You see, except for the uninsurables, there aren't too many that don't have some kind of coverage. So it isn't where we are writing coverage for somebody brand new, it is a matter of taking it from some other carrier and bringing it in. Fortunately in Iowa we have stayed very competitive and are holding our own quite nicely. But the competition is cutthroat with respect to our business. The commercials -- I want to give them all the credit they deserve -- but I think they are getting into PPOs and HMOs because they fear that they will



lose their regular business and if they don't build over here, it is going to diminish their influence. Much of our competition, however, is coming from two non-traditional sources -- alternative delivery system, and third party administration.

WEEKS:

Let's switch gears for a moment. I notice that you have been very prominent in the Presbyterian Church. First I want to ask you one question. I assume that it is your present church connection when you mention UP church. Is this the new UP?

SIBERY:

It was the name under the old one. Now it is just Westminster Presbyterian Church.

WEEKS:

It was originally a UP church? The reason I ask that is that Frances and I belonged to a UP church in Detroit before the merger.

SIBERY:

Yes, this was a UP church before the merger. Now we just go by Westminster Presbyterian Church. I have been very active in the church. My wife is very active, particularly in the women's associations.

WEEKS:

I was going through the AHA Guide Issue and was thinking of all the churches with Presbyterian in the name somewhere. I was wondering what the Protestant church's role should be. Should they take a greater role in supplying health care needs?

SIBERY:

I think there are several things that the church ought to do and we are

trying to do this in our church. One, I think housing for the disadvantaged and elderly is something that the churches ought to be involved with. We have our Presbyterian home that is just down the street from our church. We are building a second unit that is as large as this. We have a health unit within it for which we will be paying care as part of our long-term care product. But I think the church has a definite responsibility. It is called Calvin Manor and is an excellent, excellent program. We can't take on all of the public policy issues with respect to the disadvantaged, but I think we are doing something, particularly for minorities. I think the church has a responsibility. I have given a lot of leadership to trying to do this. I think the day and age has largely passed, except perhaps for those of limited persuasion. I give no leadership in our church to having a Presbyterian hospital, for instance. I feel quite comfortable that our religious values can be met in our community hospitals and do not have to be in a segregated facility in order to be met. I know that there are those of other faiths who don't feel quite that same way. I guess my feeling is that I would much rather see the church, through its board of deacons, have an outreach program for the disadvantaged and the elderly in terms of housing and sustenance. We have many people who are totally dependent upon us, our church, for their sustenance. They have no other income. I believe Christ would want that of this church. I have tried to give leadership to help bring that about. I am active on the board of the University of Dubuque, its college and its theological seminary. I have been active on other boards. I believe there is a role for the Protestant church in Christian education. I don't think everyone is ready to go to a large state university, or even a private university. I think that what we have to do is keep in perspective that there

is not one answer for everybody.

WEEKS:

I noticed that you were on the board at Spring Arbor College too.

SIBERY:

Yes, I was. When I was here in Michigan, I was very active on the Spring Arbor board.

WEEKS:

That seems to be prospering. I was through there the other day.

SIBERY:

It is growing by leaps and bounds. They are just appointing a new president. The old one retired at the end of the academic year. I have had no relationship there now since I left Michigan, but I thoroughly enjoy the University of Dubuque and the theological seminary. It is an ecumenical seminary.

WEEKS:

Is that right?

SIBERY:

Yes. We have a formal affiliation with the Methodist seminary in Dubuque and also did with the Catholic Church, through Aquinas Seminary which has since moved. I will admit to having had some influence on what has happened there. Michigan State University, for example, human medicine, osteopathic, allopathic, your first two years are the same. You don't have to decide until later. The first couple of years of a seminary ought to be pretty much the same, should it not? Comparative religions and all of those things. It is only later that you specialize. Some of those things that we are doing at Dubuque I just find terribly exciting.

WEEKS:

Was this a church college originally?

SIBERY:

Yes. It started as a church college. We have more non-Presbyterians attending now than Presbyterians, except in the theology seminary. In the undergraduate program -- it is located in Dubuque, a heavily populated Catholic community. We are growing and we are successful.

WEEKS:

Are you able to keep your tuition down?

SIBERY:

Yes. We've kept it down at more than competitive levels. Through a fund drive which I was privileged to co-chair, we added about \$11 million to our endowment fund. And we are breaking even operationally. That's rare for most church colleges.

WEEKS:

I should say so. One thing which is different but that I have admired in Berea College is that they seem to make things work and make it easier for students to attend their school, work their way and so on. That is the old Midwest Protestant ethic that we were talking about, which I believe also.

I didn't recognize the University of Michigan Theological Center.

SIBERY:

That was a center that was established years ago that really got nowhere. That was set up and that was the official name. This was back in the early 1960s. You will find it as non-existing.

WEEKS:

It struck me that being here all these years I wasn't aware of it.

SIBERY:

It never really got off the ground. It too was designed to bring an ecumenical influence. It never got off the ground in any meaningful way.

WEEKS:

Would you like to move on and to elaborate on the oversupply of physicians? I think we have something like 15,000 graduates from medical schools this year.

SIBERY:

I really feel that we do have an oversupply developing. I think it is going to make it very difficult. It still is difficult for many communities to attract a physician. To get quality education for his or her children, values of that kind make it difficult occasionally to go into rural settings where the values cannot be translated into meaningful programs. I have a distinct feeling that the medical profession is training too many people. Our own university medical school in Iowa City is cutting back. I think others should consider cutting back. I don't mean to denigrate the researchers, but there are research studies that say we are not turning out too many physicians. Others who say we are. Supposedly they are all being objective in looking at their data. I happen to be of the persuasion that we have too many physicians and the glut of physicians on the market will not mean that we have lower prices. It will mean higher because they are going to see fewer patients and they have to have so much income. I think it will have the opposite effect of what those who argue for all of the physicians they want. I think that will not be good for us in the U.S.

WEEKS:

We were talking about the oversupply of physicians and the fact that it

may not bring us any savings in cost.

SIBERY:

I think just the opposite will be the case.

WEEKS:

Which brings me to the next big cost item and that is malpractice insurance.

SIBERY:

A real problem.

WEEKS:

Is anything going on in Iowa?

SIBERY:

Yes, the legislature grappled with this a year ago and took a step in the right direction. I think we are going to have to have tort reform. I have a little personal problem with limiting awards that can be made because if there is a real case of medical malpractice with a deformity or an injury that the treatment of which is catastrophic, I think the award ought to cover it. Therefore, I think artificial caps of \$250,000 or \$500,000 may not always assure that equity prevails, or fairness prevails. On the other hand, I think it has gotten sufficiently out of hand in Iowa that I have been giving, through the Health Policy Corporation of Iowa, leadership to a concept that we have to have some legislative relief. I admire the medical profession. I don't think they police themselves strongly enough. I admire the legal profession. I don't think they discipline themselves well enough. I think we are probably going to have to have some tort reform relief.

The insurance commissioner would like to think he can do it through controlling rate increases. But you know what happens. Those companies are

just refusing to write coverage then. That doesn't help anybody. So, in the long run, I think we are going to have to have fewer cases. I think there are ways, perhaps, to adjudicate cases short of going through the elongated problem and tortuous problem of long litigation. I think there can be review panels, appeal panels. I think there are a number of things that can be done.

WEEKS:

It would seem to me that something could be done. Otherwise many on the jury will think the insurance company has deep pockets...

SIBERY:

Right. So just give them anything. Some of these awards are just absolutely ridiculous.

WEEKS:

One of the health journals had an article the other day about seven counties in southern Illinois without an OB/GYN physicians.

SIBERY:

That is happening in Iowa. You would be amazed how many physicians are giving up OB. The family practitioners are virtually not doing OB any more. We at Blue Shield have just made some special changes in our profiles in order to accommodate medical malpractice for OB. It is the most critical of all of them. We are looking at others; anesthesiology, neurosurgery, orthopedics, those that are high risk groups. I do think the legislatures around the country are going to have to come to grips with that.

WEEKS:

I have a feeling that we are going to have to have a means test again someday. We'll have to have another name for it. We certainly can't call it that. But there is a sneaky way it is coming about. I'm not against it

because as long as I can afford to pay the tax I feel that I am well off. Being of Social Security age and receiving a check each month from Social Security, we are past seventy-five so we don't have any deductions on money earned. I don't earn much money any more, but our Social Security checks are taxable where our income is above a certain amount. To me that is a fair way of doing it if they have to tax at all. What do you think?

SIBERY:

I think it is a fair way to do it. I think the use of the term "means test" -- you are absolutely right -- we can't do that because it has too much of a stigma attached to it. I happen to believe that we cannot afford in this country to provide free care for everybody. There is no such thing as free care. Somebody is paying for it. I agree with you, as long as I can afford it for myself and for my family I ought to pay for it. I tell you, Lew, I think the one thing that is most critical is the lack of an articulated, well-defined, public policy to help guide the tough decisions that are going to have to be made. Who gets the organ transplant? Who gets the kidney transplant? Are we going to continue to pay out the percentage of our health care dollars that are going for those last few months of life? We are doing all of these heroic things, and I think the quality of life has to be considered. The hospice, I like, because they give the maximum quality to the life in the time that they have those patients. I really believe that. But in our hospital settings, because of our training for all of these years, we give everything. My own granddaughter died after eleven days. They didn't happen to have insurance right then. The bill that that child incurred was enormous with seven CAT scans that they ended up doing in an eleven day period. Finally I went to my daughter and son-in-law and said, "I know you



love this little girl. She was just born. You hate to give her up. But the quality of life she is going to have -- they tell you she is going to be a human vegetable -- think of the implications for your other children. Think of the implications for you, but think more of the implications for this new child." We pulled the plug and within an hour she was gone. Is it fair to incur \$20,000 plus for eleven days? Those are tough questions that are going to have to be answered. I don't think the answer is in seeing the percentage of the gross national product going for health continue in decline. I think we are going to have to make some tough decisions. I have been criticized for stating this publicly in Iowa, but I really believe it with all of my heart that we simply can't go on on the path we are on.

WEEKS:

We had a friend who was taken to the University Hospital. He was kept alive for two days. He wasn't responding except when he had artificial help. That bill ran up. They were covered by Blue Cross of New York. Somebody has to pay.

You mentioned taxing hospitals. How about the question of taxing fringe benefits, particularly taxing refunds that come from the employer because of some good health picture they have.

SIBERY:

Well, Lew, I guess I am basically a conservative and therefore that shows itself on occasion. My fundamental thought is that there should be a fair taxation system that is not regressive. I would like a taxation system that applies to everybody fairly and equitably. I don't think we have that in this country now and I don't know that we will ever get it. I can tell you that it disturbs me a great deal with the high income people and the wealthy people

paying less income tax than I am paying, and I don't think I am overpaid -- or paying none at all, as many of them do. I think we have not found the answers to appropriate taxation in this country. I think it is about time that we come to grips with it. I think the taxation of refunds, as you say, because of wellness programs, things of that kind, should be taxed. I really do. Then if an individual is not making sufficient income, the tax rate at which they are taxed ought to recognize that and not penalize them.

WEEKS:

Do you offer dental insurance?

SIBERY:

Yes, we have Delta Dental Plan of Iowa. That, again, because of the unique state law, has to be a separate corporation. I am president of that corporation as well. We just started a capitation program that we are excited about. I think we have one of the better run, statistically, of all of the Delta plans around the country. We are among the very best on performance and cost.

WEEKS:

We don't have a very good program here except for dental cavities and cleaning.

SIBERY:

We cover orthodonture and the whole works.

WEEKS:

You mentioned that you were a member of Iowa's Governor's Commission on Health Care Costs. Do you wish to say anything about that?

SIBERY:

I think it was a very meaningful commission. I suggested this to the

governor. Shortly after I went there, he called me and welcomed me to the community and asked me to come over and talk to him. So I did. We talked about health care costs. I told him that the extreme variation in inpatient utilization rates around the country were of concern to me. We, in Iowa, were experiencing far more than the national average. We reduced our inpatient days over a three-year period by forty percent. We got it down to the national average. I said to the governor, "That will not be enough to meet the challenges that we are facing in the marketplace." I told him of our experience here with the Governor's Commission on Health Care Costs and the Greater Detroit Hospital Council staff. He was intrigued by it. So I wrote him a white paper at his request. He appointed a commission, and we did some good work in the state of Iowa. It pointed out our problems. It was a small commission, but a good one. The Health Policy Corporation of Iowa was set up to help implement the decisions that were reached there. As I mentioned earlier, that's a broadly representative group of all interests in the community. I think more states ought to use that approach.

WEEKS:

I have another item I am not familiar with, Hospital Research and Education Reserve.

SIBERY:

I think the reference there is to the one that the American Hospital Association had. I was asked to serve on that, and did serve for several years.

WEEKS:

The Hospital Society of New York. Is that different?

SIBERY:

Yes. The Hospital Society of New York was a group of think-tank people. We got together and I was privileged to be invited to join that. While I was there we would get together once a month every month. We would talk about big issues. It was one of the most challenging experiences I have ever had.

WEEKS:

That is another good item. I don't see how you have had the time and energy to do all of these things.

SIBERY:

My days start early and end late. I have a very understanding wife.

WEEKS:

I think that is the important thing, to have an understanding wife. I am fortunate too.

The Institute of Medicine study on developing a policy statement for general acute beds. Was this before we realized that we had too many beds?

SIBERY:

Yes, it was.

WEEKS:

I can remember the day when we needed more beds.

SIBERY:

That was prior to that finding.

WEEKS:

Have you been active in the American College?

SIBERY:

Not really. I give oral examinations every year just to keep in touch. Frankly, you say how do I do everything, my feeling is that I have to keep my

finger on the pulse of things in Iowa. My staff gives me magazine articles from publications that they think are highly relevant, or brief me. I am a Fellow of the American College of Healthcare Executives, and I really believe in that program. I think it's a great institution, doing a marvelous job, but I have restricted my activities largely to giving oral exams once a year.

WEEKS:

That's a good contribution too.

You are either vice president or chairman or member of the board of various subsidiaries of Blue Cross. This is BCA?

SIBERY:

When I was with BCA I was involved in a number of subsidiaries. BCS Financial is wholly owned by participating Blue Cross/Blue Shield Plans, a wholly-owned separate stock company for the purpose of providing insurance, casualty, life, things of that kind to the Blue Plans that they can't provide for themselves because of state laws, regulations.

WEEKS:

Do you mean to their employees?

SIBERY:

Not for their employees. For instance, we are using them in the chiropractic area because of our inability in the past to provide that service. So they would actually write the coverage for us. It is a large mechanism. I was privileged to serve as chairperson of the committee that decided to remove that from BC/BSA direct control and have it as an independent stock corporation. I have been chairman of that board now for over five years. A great opportunity. I have been chairman of the board of its subsidiary corporations.

In Des Moines we have two HMOs, we have a third-party administrator called Benefit Administrators of America Incorporated. We have Cross/Shield. We have Delta Dental Plan of Iowa and we have a freestanding prescription drug program, Iowa Pharmacy Service Corporation. I happen to be president and CEO of all of those organizations. Keeping them straight is difficult at times.

WEEKS:

The Interplan is still handling the national accounts?

SIBERY:

Yes.

WEEKS:

What is the Medical Indemnity of America?

SIBERY:

That was the predecessor to BCS Financial. HSI-MIA, Health Services Incorporated Medical Indemnity of America. One wrote casualty, the other life programs. We phased those out into BCS Financial. That again was back in the days when you had the Cross and Shield separate, doctor and hospital separate.

WEEKS:

You did mention something about the Iowa Business and Labor Coalition.

SIBERY:

Yes. I was instrumental in setting up the Iowa Business and Labor Coalition. We sit on that largely as an advisor to them. I sit on it representing Blue Cross and Blue Shield of Iowa. I think it has done a good job. You see, hospitals get together with their state hospital association, medical societies represent physicians, but who is going to speak for business and labor? We have many organizations in Iowa, but none of them really focused on health issues. With the leadership of some of my friends in the

business and labor community we decided to set up the Iowa Business and Labor Coalition.

WEEKS:

Doesn't this add to the general good feeling to have them sitting down together other than at a bargaining table?

SIBERY:

Oh, absolutely.

WEEKS:

It seems to me that this would be preparing the ground for better relations.

SIBERY:

It does indeed.

WEEKS:

You mentioned that you were a member and vice president of the Michigan Hospital Association.

SIBERY:

Yes, I was. I received their key achievement award back more years than I like to think.

WEEKS:

That is one thing I don't think you have on your c.v. is your awards.

SIBERY:

Oh, I haven't had many, but there are a couple.

WEEKS:

You talked about your ad hoc study group on comprehensive planning. Probably what you accomplished hasn't helped much now.

SIBERY:

Not too much.

WEEKS:

You also talked about the Michigan State Board of Education and the Committee on Education for Health Care. Was this for recommendation of curriculum or licensing?

SIBERY:

Oh, no. This had to do with state funding. It was set up by the Board of Education. The question was state funding for health education, primarily medical education. I commented earlier about the osteopathic, the first time that education was being financed. I guess the osteopaths weren't happy with me as chairman of that because we insisted that it be affiliated with a university with mature programs. The M.D.s weren't happy because they thought that they weren't getting enough for their own allopathic education programs. Maybe when no one is happy it is the best decision that could be made.

WEEKS:

I think that suggestion of yours was good and probably brought good results. I was in East Lansing about three or four years ago attending a meeting of the deans of medical schools established after 1960. Most of them were like the MSU program. Many of them were not affiliated with a university hospital for clinical experience and this kind of things. I was surprised at how well they -- at the dinners the osteopathic faculty was there and all these deans from different medical schools, including MSU, were there. They seemed to get along pretty well.

SIBERY:

Well, they really do. In there somewhere you will see reference to



Michigan Association of Regional Medical Program, MARMP. When that legislation was set up I was privileged to sit on the national advisory committee and I also served as the forming executive director here in Michigan to get the thing organized while I was here at the Greater Detroit Area Hospital Council. I bring that up because the concept I had then was networking, where you take a hospital like Oakwood and they would relate to the smaller hospitals around it, send medical staff out for purposes of bringing information down to the local level. I have felt for far too long that we didn't do enough networking of our medical education. Michigan has done more than many places have. But so often they wanted to build that big empire, to have their own facility, and forget the fact that maybe networking could be done to the advantage of everybody.

WEEKS:

The National Commission on Productivity.

SIBERY:

That was a government commission that was set up on productivity. An interesting experience again. I worked with Walt McNerney on that and sat with that group. A lot of hard work was done, but you don't see much in the way of long-term tangible results.

WEEKS:

So often these government studies end up in a report that was put on a shelf somewhere.

SIBERY:

I fear that's where that ended up too.

WEEKS:

Do you want to say something about your tenure on the advisory council at

Northwestern University?

SIBERY:

Yes. I found that a very interesting experience. When I was at the Blue Cross Association, I was asked by the faculty to join that advisory group. They dealt with broad issues, largely in the business school. It was not particularized to their program in hospital administration which was high during the MacEachern years and low in subsequent years. It was another opportunity to reach out and to help educate some people who were giving advise and council on what the health implications are of many of the educational programs. I found it a very rewarding experience. I was sorry when I moved to New York to have to give it up.

WEEKS:

Walter has a faculty appointment there now, doesn't he?

SIBERY:

He does indeed. One-quarter time.

WEEKS:

He must be busy doing consulting work, isn't he?

SIBERY:

He is very busy. He does a lot in Iowa, interestingly.

WEEKS:

Here is another I have never heard of, the Department of HEW's Division of Direct Health Service, Program Plans and Facility Requirements Review Committee.

SIBERY:

I was asked to sit on that. It was largely reviewing grant applications from grantees back when it was Hill-Burton, the planning was under the Hill-

Burton Act. That is the technical name of the group. I was on that panel and I was very much involved in going out and doing site visits and recommending whether applications should be viewed favorably or without favor.

WEEKS:

You have done a lot of legwork here.

SIBERY:

I tried to do my part, Lew.

WEEKS:

You have enjoyed doing some lecturing I can see.

SIBERY:

Yes, I have.

WEEKS:

You spent quite a while here at Michigan.

SIBERY:

Yes, I did. I still do quite a bit in Iowa.

WEEKS:

Sam Levey is running a good program now, isn't he?

SIBERY:

He is running an excellent program. That program has grown in stature markedly under his leadership. The university is a good, sound university. Unfortunately we are without a president now with Dr. Freeman going to Dartmouth. The medical center is an excellent one. The school of medicine is very good. I think Sam is running an excellent program.

WEEKS:

Do they still have a doctoral program?

SIBERY:

Yes, still do.

WEEKS:

I know several graduates from the doctoral program. Several of them have done very well, haven't they?

SIBERY:

Yes, they have.

WEEKS:

Larry Prybil, who is now down in Indiana with the Daughters of Charity group used to live a couple of doors away. I knew him when he was in Virginia, but one day we were driving home and I saw a jogger, as we all see joggers, and lo-and-behold it was Larry Prybil. He had moved in and didn't realize I lived right here.

SIBERY:

Dr. Jim Cavanaugh is one of the more famous of the doctoral program.

WEEKS:

Dick Knapp, too, at the Council on Teaching Hospitals.

SIBERY:

Yes, indeed.

WEEKS:

Would you like to say something about the YMCA?

SIBERY:

I have been very active in the YMCA over the years. I am a great believer in that program. I guess the two programs for young people that I have been most active in are 4H and the YMCA. We had a combined program in Dearborn when I was active on the board for so many years because we did not

have a YWCA. It was called the YMCA, but it was certainly coeducational in every regard. We are just in the throes of considering a possible contribution to the Ys in Iowa. It is interesting that you mention this because I feel that we are duplicating a lot of costs and programs by having separate Ys in communities. So our contribution to the Ys is not to build bricks and mortar, but to insist upon a study of how the two can get together. I am a firm believer that they are uniquely good programs.

WEEKS:

They have done very well here in Ann Arbor.

SIBERY:

Is that right?

WEEKS:

I felt very badly the other day when I was talking with Stanley Nelson. I drove along West Grand Boulevard past the Fisher Y, and it is no longer a Y.

SIBERY:

I didn't know that.

WEEKS:

Remember that beautiful building?

SIBERY:

Yes, yes, indeed I do.

WEEKS:

I have been depressed since I drove around Detroit. I go into Detroit to the east side, but I go in on the expressway and don't get off.

SIBERY:

I haven't been back to Detroit very often since I left. I hope the community spirit which spearheaded things when I was there will once again

revitalize Detroit.

WEEKS:

I hope so too. For years I lived on the east side and I knew East Grand Boulevard intimately. I got on the thing the other day and drove up near Poletown where they built the new General Motors factory. I didn't know when I passed certain streets until I came to the overhead bridge that has been there for years. It was disappointing to me.

Is there anything you would like to add?

SIBERY:

I think the only thing I would add, Lew, is that we have difficult decisions to make in the future. We have had them in the past, and I just hope that those who are responsible for health policy making these difficult decisions will be mindful of the heritage that we have been left by a lot of great leaders, and I hope will be wise making those decisions. It's a great country in which to live. Health is terribly important to all of us, and I hate to see us face choices, but we do indeed.

WEEKS:

I have really enjoyed this interview. I know it is going to be one of the outstanding ones.

SIBERY:

It has been my pleasure to be interviewed, I assure you.

Interview in Ann Arbor, Michigan

July 23, 1987

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