HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Ernest W. Saward

ERNEST W. SAWARD

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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Lewis E. Weeks
2601 Hawthorn Road
Ann Arbor, Michigan 48104
(313) 662-4298

Ernest W. Saward, M.D.

CHRONOLOGY

1914	New York City, born October 19
1936	Colgate University, A.B.
1939	University of Rochester, School of Medicine and Dentistry, M.D.
1939-1941	Barnes Hospital, St. Louis, House Officer
1941-1942	Peter Bent Brigham Hospital, Boston, Resident
1943-1945	Hanford Engine Works, Chief of Medicine
1945-1970	Permanente Clinic, Kaiser Foundation Hospital, Portland, Oregon, Medical Director
1964-1970	Community Health Foundation Medical Group, Cleveland, Ohio, Executive Committee, Member
1966-1970	Kaiser Foundation, Portland, Oregon, Office of Economic Opportunity Health Project
1970-1980	University of Rochester School of Medicine and Dentistry, Associate Dean for Extramural Affairs
1970-1985	Professor of Social Medicine and Medicine
1978-1979	Center for Advanced Study in the Behavioral Sciences, Stanford, CA, Fellow
1978-1979	Stanford University School of Medicine, Visiting Professor of Medicine and of Family, Community and Preventive Medicine
1985-	University of Rochester School of Medicine and Dentistry, Emeritus Professor of Social Medicine and Medicine

MEMBERSHIPS and AFFILIATIONS

American Association for the Advancement of Science, Fellow

American Board of Internal Medicine, Diplomate

American College of Chest Physicians, Member

American College of Preventive Medicine, Member

American Federation for Clinical Research, Member (Emeritus)

American Medical Association, Member

American Public Health Association, Member

Association of Teachers of Preventive Medicine, Member

Blue Cross, Rochester Plan, Board Member

Caldwell B. Esselstyn Foundation, Technical Advisory Board, Member and Consultant, 1978-

Committee of 100 for National Health Insurance, 1968-

Comprehensive Health Planning Agency, Portland Oregon Metro Area, Charter Member, 1968-1970

Congressional Prospective Payment System Assessment Commission, Member, 1983-1985

Davis Institute for the Care and Study of the Aging, Member of the Board of Directors, 1976-1978

Edinburgh, University of, School of Medicine, 250th Anniversary Symposium, 1976

Finger Lakes Health Systems Agency, First Vice Chairman, 1975

Foundation for Medical Care, Monroe Plan, Member of the Board of Directors, 1973-1978

Genesee Region Health Planning Council, Review and Planning Conference, Member, 1970-1978

Genesee Valley Group Health Association, Board Member of the Finance and Executive Committees, 1981-

Group Health Association of America, Chairman of the Board, 1970-1972

Group Health Foundation, Member 1968-1972; Chairman 1971-1972

Harvard University Health Services, Visiting Committee to the Board of Overseers, Chairman, 1975-1981

Harvard University Visiting Committee for University Central Services, 1978-1981

Health Insurance Plan of Greater N.Y., Member, Board of Directors, 1972-1973

Hospice National Advisory Countil, Member, 1975-1978

Institute of Medicine of the National Academy of Science, Member

John E. Fogarty International Center for Advanced Study in Health Science.
Task Force on Theory, Practice and Application of Prevention in
Personal Health Services, Member 1975

Kaiser Foundation Health Plan, Consultant, 1971-1977

Kaiser Foundation Research Institute, Portland, Member, 1967-

Medical Society of the State of New York, House of Delegates, 1973-1978

Milbank Memorial Fund Health Society, Editorial Board, Member, 1973-1976

Milbank Memorial Fund, Technical Board, Member

Monroe Community Hospital (chronic disease hospital), Member Board of Directors, 1973-1979; Chairman 1973-1976

Monroe Plan (Foundation for Medical Care) Member Board of Directors, 1970-1976

National Academy of Sciences, Board on Medicine, Member, 1967-1970

National Academy of Sciences, Institute of Medicine, Member 1970-; Council Member, 1970-1973

National Academy of Sciences, Panel on Health Status of the Disadvantaged, Member

National Professional Standards Review Council, Chairman, 1973-1976

New York State Governor's Advisory Council, Co-chairman, 1975-1976

New York State Hospital Review and Planning Council, Vice Chairman,

Member of Executive Committee and Fiscal Policy Committee, 1976-

Oregon Regional Medical Program, Member, 1968-1970

Oxford University, Christ Church College, International Symposium on Organization of Health Care, Member, 1974

Physicians' Committee for Health Insurance for the Aged Under Social Security Administration, 1962-1965, Member

Plan de Salud para la Communidad, Cordoba, Argentina (CEMIC)

Rochester Area Hospital Corporation, Long-Term Care Capitation Task Force, Member

Rochester Blue Cross/Blue Shield, Consultant, 1970-

Rochester Regional Medical Program, Regional Advisory Group and Executive Committee, Member, 1970-1976

University of Rochester School of Medicine and Dentistry

Advisory Board, Member, 1970-1980

Dean's Committee for the Veterans Administration Hospitals (Batavia, Bath, and Canandaigua, NY), Chairman 1970, 1978

Rockefeller Foundation

Bellagio, Italy, Resident Scholar, 1983

Critical Choice for Americans, Subcommittee on Health, Member 1974-1975

National Genetics Foundation, Technical Advisory Board, Member 1981-

Royal Society of Health, Member

Salzburg (Austria) Seminar in Health Economics, Chairperson, 1979

Strong Memorial Hospital, University of Rochester Medical Center, Executive Hospital Committee, Member 1970-1980

U.S. Department of Health, Education and Welfare

Ad Hoc Committee, Independent Practitioners Under Medicare, Member 1972-1973

Health Insurance Benefits Advisory Council, Member 1970-1974;
Chairman 1972-1974

National Health Insurance Council, Member 1977-1980

Task Force for Evaluation of Status of Appalachian Regional Hospitals,
Chairman, 1977

Task Force for Public Health Service Hospitals, Chairman 1977-1978

U.S. Department of Health, Education and Welfare-Social Security Committee
on Study Methods of Reimbursement of Physician Services Under Medicare,
Member 1972-1973

Xerox Center for Health Care Research, Member Board of Trustees, 1971-1975

AWARDS and HONORS

Secretary of War Stimson

Citation, 1945

Secretary of DHEW, Casper Weinberger

Citation for Service to the U.S., 1974

Secretary of DHEW, Joseph Califano

Citation for Service to the U.S., 1977

Governor Hugh Carey

Citation for Service to New York State, 1977

Group Health Association of America

Distinguished Service Award, 1976

Bertha and Henry Buswell

Distinguished Fellow

American Association for the Advancement of Science

Elected Fellow

WEEKS:

Someone has said that it is best to begin at the beginning. I have a note here that you were born in New York City in 1914. We are now about two days from your birthday.

SAWARD:

That's correct.

WEEKS:

You are a graduate of Colgate. What was your major there?

SAWARD:

At Colgate as I entered as a freshman, I knew very little about higher education. I had, shall we say, a bent towards science, and at the start intended to major in science without having any clear idea of what I was going to do with it. By chance, I had a roommate who was determined to be a doctor. His father was a doctor. I found it difficult to live with my roommate unless I became a doctor too. Indeed I did take the premedical courses as they came up at Colgate. When I went back to start my third year at Colgate -- we had a system there where we had a faculty member who was sort of a tutor to us that we visited three or four times a year to see what we were doing.

As I started my third year, he said, "You are wasting your time at Colgate. When this year is over, why don't you go to that new school that is starting in Rochester, the new medical school?"

Not having any yardstick of comparison I took his word for it and went there. I enjoyed the medical school in Rochester very much.

WEEKS:

Rochester itself is quite an interesting city, isn't it? Are there two major employers?

SAWARD:

Rochester in the days when I was in medical school in the period 1935-1939 was very much dominated by the Kodak Company. When I came back there in 1970, there had been a new element injected in the community -- the Xerox Corporation. Those two industries and various others what I would call technological satellites of them were the main employers.

WEEKS:

It is nice that you don't have a lot of heavy industry. I am thinking of Detroit, full of heavy industry.

SAWARD:

We have two GM plants there, Delco Products and the other called Rochester Carburetor. In normal times -- the auto industry is sometimes up and down -- they employ five to six thousand people, which is an industry in itself.

WEEKS:

One thing I noted which I have not seen in any other school of medicine is the name: The University of Rochester School of Medicine and Dentistry. Is that an unusual combination?

SAWARD:

Yes. The title is a real quirk, because we do not train dentists. The University of Rochester School of Medicine was a product of the General Education Board and the Rockefeller Foundation in an attempt to remodel medical education according to the Flexner Report. The School was founded in 1920 with an endowment from the General Education Board for that purpose.

As this came about -- it's a long story -- Mr. Eastman became much more interested than he had been in that particular subject. He wanted to have a

school for dentists. He had already started Eastman Dental Centers in London, and somewhere else in Europe, and in Rochester. He had great interest in dental health. As a concession to his endowment, the school was named that and never had a dental school but trained graduate dentists in research. At one point it was one of the main training centers of the late 1920s, at least to World War II. The training program there, the doctoral program in dentistry beyond clinical dentistry, trained a very large number of people who became deans of dental schools in the United States. It was a research school.

The whole objective of the Flexner pattern was, of course, to be heavily involved in medical research, which all schools became after World War II -- that type of school. It was indeed the aim of Flexner to have that model.

My faculty advisor at Colgate told me to go there. He knew this; I didn't know it. He detected that that was the place for me to go. So I went.

WEEKS:

I had to ask that question because it struck me as something different.

I have a note that you were at Barnes Hospital as a house officer. I can remember a house officer in a hospital in Detroit some years back. That was the first time I ran across that title.

SAWARD:

That's what they were called. I don't know the origin of the title, per se.

WEEKS:

It wasn't an intern or a resident?

SAWARD:

I was an intern in fact, but the title was house officer.

WEEKS:

One name I associate with Strong Memorial and Barnes in St. Louis is Dr. Lawrence Weed. Wasn't he the man who devised the new medical record format?

SAWARD:

The problem-oriented medical record? Yes.

To my knowledge, Weed had very little to do with Rochester. If he had something to do with Washington University in St. Louis, it was not while I was there.

I'll just say a word about the selection of Barnes Hospital and Washington University as a place to take the first training after medical school in internal medicine. I didn't choose it. One of the faculty members said this is where you ought to go. This was before the days of the matching system we have now in choosing this kind of thing. It was a matter of his writing letters, and there I went.

When I had been there something over a year the chief of the service at that time, Dr. David Barr, whom I'll refer to later, asked me what I intended to do when I finished my training. I said that I would like to stay there at Barnes.

He said, "You ought to go to Boston."

I said, "That sounds all right with me."

He arranged for a post at Peter Bent Brigham. Things were done then on a much more interpersonal basis, hardly possible considering the large numbers in the selection process now. Then, again, I didn't pick the Peter Bent Brigham. I was very happy to go there. He picked it and arranged the appointment.

WEEKS:

In my oral history interviews I have come across several persons who acted in an informal way to become part of a network of advice. I think this has proved to be very satisfactory in most cases. A lot of aspiring persons have been steered in the right direction when they had no basis of making a selection themselves.

Peter Bent Brigham, isn't this a part of a coalition of hospitals?

SAWARD:

Yes. It's now part of what is called the Brigham and Women's Hospital, which is a building about a decade old now, an entirely new physical structure from the days I was there. The structure I was in had been built in 1913, built by Harvey Cushing. By the time it was built it was, I am sure, somewhat antiquated in style. It was a pavilion style hospital with large spaces between the buildings so contagion wouldn't spread from ward to ward. Not exactly the current thoughts in hospital design. The experience at Brigham was excellent. The people, both colleagues in the residency program and the faculty, of course, were very stimulating. I enjoyed it. The intent was that I would have probably gone on and been there in pulmonary medicine which at the time didn't really have any permanent occupant of that particular function. I already had an interest in pulmonary medicine but the war upset things that were going on.

In January of '41 I was at the Brigham and, of course, it was later in that year that we became immediately involved in the war through Pearl Harbor. At the time my interests were that of academic medicine. They were not involved with what you would call organization of medical care. It was only through my experience at Hanford -- the Hanford Engineering Works -- where one

of my medical school teachers at Rochester, Stafford Warren, who headed the medical part of the whole Manhattan project -- Oakridge, Chicago, Los Alamos, and Hanford -- insisted that I come and be the chief of medicine during the war, and I did. The essence of it was that he was recruiting from people that he personally knew to be reliable to head these things.

I was confronted with a situation where there were 70,000 people, mostly living in barracks, 9,000 of them living in trailers of one sort or another.

WEEKS:

Did this include families?

SAWARD:

Just in the trailers. The rest were mostly men who lived in these barracks. There were some women's barracks for subsidiary workers, and kitchen help, and what not.

It was a matter of organizing medical care for them. There was no hospital building as yet, despite these people being there. They simply designated one of the barracks as a temporary hospital. My job was to build a hospital, organize medical care and oversee what went on. Coming out of academic medicine, that was a new assignment.

At less than thirty years of age, I had very few restrictions. When I went to the head of the project and said we have to have a hospital and I think we will need so many beds, the answer was, "All right, how do you want it built? Go tell the engineers." It was that open.

If my experience had matched it, it would have been very clear. I simply tried to replicate what I knew. I think that is what one does under those circumstances.

In doing this I organized what was, in fact, a hospital-based group

practice with the essentials of it being prepayment. I won't go into what was going on there before. Having done that and not realizing that I was doing something different fundamentally — it was simply a feasible way to work with these people who all had their eligibilities as workers on the project in health care.

I then started to look around to see what was going on — this was while war was going on. I looked in Seattle, I saw the new hospital in Bremerton that had been built at the naval stations there during the war. I went down to Vancouver, Washington and saw what the Kaiser Shipyard was doing. I related what I was doing and I heard what they were doing. Their response was, "When the war ends, come down and we will try to start a program together for the community rather than for a specific shipyard."

WEEKS:

Did you find that the employees of this wartime project had more health problems because they were people who couldn't be drafted, who were 4Fs?

SAWARD:

The project had many employees who in ordinary civilian life wouldn't have been employed. They recruited people from... Remember the recruitment started after the war was under way. The draftable people had been drafted. We were getting a very remarkable set of problems. People came by the trainload. They would be off the train into barracks and then the sifting and sorting would go on between what I would call medical care and the military police. It was perfectly clear that they had recruited people who were in no way capable of performing ordinary work.

WEEKS:

Were they rejected then?

SAWARD:

Some of them had been in mental institutions immediately before the war. Many of them were alcoholics who had simply been rounded up by recruiters and put on the train. It would usually take several weeks before what I would call sifting would make up a train to go back.

The initial problem at Hanford was quite different from that. They were having an epidemic of meningococcus meningitis with no public health principles at all. They had about eighty deaths. That was enough to panic the place and that was why Stafford Warren was so anxious for me to come and to be immediately involved in medical care, to try and stop that epidemic.

We had the sulfonamides which were quite effective in prophylaxis in meningococcus meningitis at that time. I think we were up to the sulfapyridine stage of sulfonamides at that point in time. They were concerned about it depopulating the reservation by panic. That's why it was necessary and I'm sure why they were so permissive in letting me organize medical care in any way I wanted.

WEEKS:

How about the recruitment of physicians and other health personnel?

SAWARD:

It was a difficult group. Many doctors had come there as a refuge to avoid being drafted. It was a very mixed lot of physicians. I would say there were forty-five or so that I dealt with on the reservation as full-time. Mind you, coming out of a university background, it was something of a shock to find this level of practice going on. There were six or seven that would be acceptable normally as colleagues. What I did was take them out of individual practice, and, after making an assessment of what they could and

couldn't do, assigned them to what I felt as appropriate for the talents they had. Perhaps not ideally suitable, suitable to do what we had to do.

By establishing a clear triage system and responsibility for those admitted to hospital in the hands of those who were truly colleagues, and having the understanding that "if you don't know what it is, admit it" -- then we had a good service and brought things under control very promptly.

WEEKS:

You talked about this being a prepayment plan.

SAWARD:

Their eligibility...the DuPont Company was the prime contractor. Through working for the DuPont Company they had the fringe benefit of hospital insurance and surgical fees. What we decided was: we wanted no barriers to people coming in for care. We came to what was a $2.00 charge for an office visit. It was not a barrier. We collected the rest from the insurance the DuPont people had. The gap between the two was the cost of building plutonium. So it was relative prepayment. The fees did not go to any individual physician.

WEEKS:

They were all salaried?

SAWARD:

They were all salaried. The fees all went back into a pool which was the property of the DuPont Company, which was making up the deficit under the prime contract.

Establishing this kind of a system was not greeted with enthusiasm by many of the doctors who had practiced fee-for-service medicine. In as much as this was wartime and we had the authority to command the system, this is what

I did. I heard from some of the physicians later that they hated me and hated what was happening at the start, only to come around and say, "This is the best way we ever practiced. We really don't have to do anything beyond our limits. We are happy with what we are doing." The level of satisfaction of that group was reflected in conversations.

It was rather great. Granted they were there because of the war. I am sure nine-tenths of them dispersed themselves at the end of the war. Nevertheless, they were happy with the experience they had.

Now, having these ideas in my head, I went in the summer of 1945 to join the group in Vancouver, Washington to form what would be called, at the time, Northern Permanente Foundation, to form a community health plan. Obviously, I was already into the structure and ideology of this form of practice.

WEEKS:

May I interrupt? we have said something about families of the people at Hanford. From the very beginning were the families covered?

SAWARD:

Yes. They had to be.

WEEKS:

Kaiser had that trouble at Grand Coulee when they first opened up, as I remember hearing.

SAWARD:

At first they were not. The project at Hanford was absolutely full stead ahead. War time.

WEEKS:

Let nothing interfere!

SAWARD:

Let nothing interfere. It was quite clear that if there were families there, they had to be cared for. Or for workers off the job.

I don't mean to exaggerate but the way the very large structures for plutonium piles were built during the war must very much resemble the way the pyramids were built. It was a hard, driving task for which no excuses for not going ahead were acceptable. It was work fourteen hours a day, every day, seven days a week. The people who were knowledgeable about the project were also knowledgeable that they were in competition with Germany to develop the technology. The state of knowledge of how the enemy was faring was not very great. The Allies did go and sabotage the heavy water plant in Norway, and that sort of thing, so there was indeed knowledge of what they were doing. It was a contest. If Nazi Germany had gotten this weapon first, it would have been a catastrophe. That was the thing that was in the heads of the people driving the project, so there was no reason for us not to do whatever needed to be done. And keeping the work force reasonably content. It was very important, all of it.

WEEKS:

How was the morale of the work force?

SAWARD:

One of the things I was involved in will illustrate that to you. You have 50,000 men living in barracks. We had no recreation essentially. The liquor store was thirty miles away. You can sort of imagine things. The labor force was worked very hard.

One of the things I thought, and a couple of my colleagues thought, was that there should be some sort of recreational facility for these people. We

talked to the head of the DuPont Company there, Mr. Church, told him this, and told him we thought there should be some sort of recreation facility.

He said, "We will never get it approved, so we will start building it tomorrow. We will start building the same day we ask permission, because we won't hear back for about three weeks. We can build a recreation hall in three weeks." And he did.

WEEKS:

Those were heroic times weren't they?

SAWARD:

I cite that to give you some flavor of the atmosphere.

WEEKS:

That must have been a very unusual situation.

SAWARD:

Yes.

WEEKS:

Probably many of the people didn't know what the project was doing.

SAWARD:

Only a very small number knew. It was very security oriented. Very compartmentalized. This is one of the things that is interesting about wartime projects that are compartmentalized. They don't realize how a physician goes across compartments. All the top hierarchy became my patients. Everyone had to tell me all his difficulties. I wasn't in any sense oriented to atomic energy. I had a certain amount of physics background that anyone would have going through medical school. You could put the project together very nicely, and that was the case. But it was very security oriented.

There was also a group of physicists from Princeton, and their families.

It was a very diverse group on the project.

WEEKS:

How did you organize your medical staff? Did you assign...

SAWARD:

Assigned people departmentally then assigned certain functions within the department.

WEEKS:

Were the workers assigned to a certain doctor?

SAWARD:

No. We ran an appointment system but the vast majority of the workers didn't and wouldn't use an appointment system. Again, the upper echelon, the visiting physicists and so forth, would use an appointment system. They were used to such a thing. The work force that had labored in Arkansas fields didn't know anything about an appointment system, it was purely a walkin service for them.

Where there were public health measures to be taken, that was directed from the top down.

WEEKS:

That must have been a wonderful experience for a person...

SAWARD:

It was the orientation for starting a community program in Portland for Kaiser. I certainly could not have been medical director there starting in the summer of 1945 without it.

WEEKS:

Maybe we should say something about Dr. Garfield here, and how this all came about. My understanding is that he had his beginning in the desert back

in the 1930s when they were building the aqueduct for the Los Angeles water system. He ran a health service as a proprietorship in a capitation plan in the sense that the employers gave him so much a day per capita of workers. After this project was done -- it was finished sometime in the middle 1930s -- he then went back to the Los Angeles General Hospital where he had been before this, but was contacted by Kaiser representatives to come to Grand Coulee to put in a medical system on a proprietorship basis again. That worked out successfully and then when the war came along they extended the same idea to the shipyards and steel mills that Kaiser owned on the west coast from San Diego all the way up to...

SAWARD:

They had steel mills in Fontana, California which is about fifty miles west of Los Angeles, the shipyards were in Richmond and Vallejo in the San Francisco bay, and in Portland, and in Vancouver, Washington, which are on the two sides of the Columbia River.

WEEKS:

As you say, after the war was over, all these people were dispersed -- all those who had had membership in the health plans. People went their way.

SAWARD:

Exactly.

WEEKS:

Many of the doctors and others who had been in the proprietorship scheme felt that it should be continued. The communities wanted it also, didn't they?

SAWARD:

It was very hard to tell what the community wanted. Who would be the

voice of the community?

WEEKS:

This was in turmoil too.

SAWARD:

Exactly. The situation in each of the areas -- Fontana, the San Francisco Bay area, Oakland, in fact, the focus, Portland, Oregon region including Vancouver, Washington was different in each instance.

First of all, the people who worked in the shipyards in a very considerable number stayed in the San Francisco Bay area following the war. The ones who were in the Vancouver, Washington shipyard dispersed almost totally because Vancouver, Washington was a town of 13,000. Even though it had had a work force of 40,000, there was nothing for them to do when the job was taken away. Whereas the San Francisco Bay area could absorb, and did absorb, many times the number of people by migration anyway. Fontana steel mill went right on producing steel. That was a very stable situation, in fact. For a long time the Fontana membership really was involved with just the steel mills, whereas the San Francisco Bay area rapidly became a community plan. It had significant membership. The membership where I was -- Vancouver is the community -- went down to less than 3,000 members. At that time we had a 300 bed hospital. With 3,000 members you have quite a disparity in needed beds. Obviously we had to find something to do. The community made no response to this. They fully expected the program to shut down in response to the shipyard shutdown.

Two aspects to it. One, in September of 1945, I as the medical director and the only one that belonged to the county medical society, received a letter telling me that what I was doing was unethical and they disapproved.

That was one part of the story. We took it through the AMA judicial council and had that reversed. That is a story apart. An interesting one. Not immediately germane.

The other thing was that we had to find something to do that produced the volume needed to keep the facility open. In about March of 1946 we got a contract with the Veterans Administration to take care of people being discharged from the service, largely from the Navy, largely who had been prisoners of war in the Pacific -- with tuberculosis. I think I told you a few minutes ago that my interest had been the subspecialty of pulmonary medicine. So suddenly by serendipity the thing came together. We had anywhere from 75 to 150 of these discharged tuberculosis patients in that hospital in Vancouver. That's what kept the hospital open while we set about building a community health plan. There was no spontaneous response from the community. As a matter of fact, from the medical community it was adverse. From the community as a whole it was indifference.

WEEKS:

You were also faced with a problem, I assume, in that you couldn't publicize too much because of the trouble you were having with the medical society.

SAWARD:

It was not in our heads to publicize it. Today we see an HMO advertising. It was an absolutely unthinkable thing. Unthinkable to me as well as to anyone else. We didn't try to do that. We did -- and I cite this because it was a subject of considerable dispute -- put a sign at the entrance to the hospital grounds -- the "Northern Permanente Foundation Community Health Plan." That was very much frowned upon to even put a sign up saying

our name and saying that we were a community health plan.

The health plan grew slowly. It did in the next five years become self-sufficient. As the Veterans contract ran down, as patients passed through into new Veterans hospitals which were being built across the country and the supply of patients stopped, we were out of the Veterans contract after about five years. We had enough sustenance from our small health plan to keep the services operative.

It was a long, long tedious struggle getting an understanding of what indeed it was, what the principles were, a considerable struggle in what I would call the practice of the administration of such an organization and, if you can remember the times, there was a considerable ideological struggle in what we were trying to do. To some we were some variety of communists, for having an organization of this kind. Indeed, it took much interchange to work out what it was that we were doing. Different people emphasized different aspects of it. It is all very simple and clear today. I must say this because Dr. Garfield had very little to do with the operation after the war ended with the community program that sprang up in the Vancouver-Portland area. He may have visited a half a dozen times in five years.

WEEKS:

Was it still a proprietorship?

SAWARD:

No, it was a foundation, 501 (c) (3) Northern Permanente Foundation, in which the physicians were employed by the Foundation.

WEEKS:

Did you have the three divisions, the hospital, the physicians, and administration?

SAWARD:

No, it started out all as the Northern Permanente Foundation which included the hospital and owned the clinical facilities, and employed the physicians. Simultaneously it promoted the health plan.

I said there were a lot of ideological discussions. This was one of the things. Why shouldn't what we call the unitary system be the way? Why was it necessary to go to three organizations: a physicians' organization, a health plan organization, and a hospital organization? These things were all resolved by controversy. Sometimes the facts were extraneous to what I call the ideology. Let me illustrate if I might. The reason the physicians' groups split off and became a partnership was under the intense pressure of organized medicine. Before the Judicial Council I was told by many of its members that it is unethical to practice for a salary. One of the members of the council took very strong exception to that because he was from the Mayo Clinic.

WEEKS:

This Judicial Council of the AMA or the state society?

SAWARD:

The AMA. That was one reason why the Foundation split with the physicians' group. Why should the health plan be separate from the hospital? The basis for that -- and it didn't for a long time in Portland after California -- it stayed one entity for at least ten years in Portland health plan and hospital. It finally split because of pressure from the Internal Revenue Service who thought that the part that was the enrollment organization should be like Blue Cross a 5Ø1 (c)(4) organization. The hospital could remain a 5Ø1 (c)(3) organization. These kinds of things I would call both

practical and conceptual.

WEEKS:

You were stumbling, trying to find your way.

SAWARD:

Exactly. There is no road sign, no right way, no wrong way. Mind you, if you have a group of young, bright people running an organization they are going to argue interminably about what the right way to do it is. I won't deal with it at all in this interview -- the Tahoe conferences.

WEEKS:

I have heard of that.

SAWARD:

I am sure Dr. Garfield told you of that. As a matter of fact, that was a considerable period of turmoil in the whole Kaiser-Permanente organization. The essence of it was to work out these arrangements. This occurred between 1953 and 1956 or 1957. we had already worked it out in Portland, because we were essentially independent. The Northern Permanente Foundation was a separate legal entity from the rest of the health plans.

WEEKS:

Kaiser hadn't entered into this yet? In the sense of it being a Kaiser this or that?

SAWARD:

The name Kaiser? No. In Portland it wasn't legally named Kaiser until 1959. It was the Northern Permanente Foundation.

WEEKS:

This is when I have Dr. Garfield stepping out of it.

SAWARD:

Garfield stepped out of active control in 1953. That's what started the whole commotion and controversy. As long as he was there -- I am talking about the Bay area -- and running it and had been its founder in the Bay area, as long as he was doing that there was no controversy about what its organizational forms should be. Once he stepped out, then the whole thing opened up. All the ideas I just talked about and many others surfaced, were thought out, argued out, worked out, compromised between the board of trustees, the physicians, and others.

WEEKS:

When you started out in Portland, you had a capitation plan.

SAWARD:

Yes.

WEEKS:

How were decisions made? Physicians always entered into decisions, didn't they?

SAWARD:

Let me outline the organization as it started between 1945 when I came as medical director at the end of the war and started the plan and certainly 1950 -- the first five years of the organization. It was the Northern Permanente Foundation. The chief operating officer of that Northern Permanente Foundation was the medical director. The physicians were employed by the Northern Permanente Foundation. The Northern Permanente Foundation operated the hospital, therefore I was the chief hospital officer. The health plan was within that structure for promotion and enrollment. In fact, I directed that.

As it grew it had to have some structure. We appointed somebody to be

administrator of the hospital, somebody to be administrator of the health plan, and the medical group which was a partnership with an executive committee. All three of these interacted all the while. As the chief operating officer of all three I was involved in decisions in a crosswise fashion.

In 1948, as the medical group settled off in a partnership, we did a precedent setting thing on how the medical group should be paid from this organization. I am talking about the group as an entity, not the individual. we decided it should be paid a percentage of the health plan dues. That in effect was capitation because as the plan grew we got the same percentage. It was not until the mid-fifties that these arrangements were really put in place in California.

We had started it in April of 1948. I asked this of the board of trustees which didn't meet except on an ad hoc basis when there was a crisis. There were no regular meetings of the board. They didn't know what I was trying to do. Fortunately one of the lawyers who was present understood at once what I was trying to do. He explained it better than I could, to the rest of the board, of which he was a member. He said, "I think that is a good idea."

Before this they didn't have a fixed amount coming to the medical group. They would want more. They would want more people employed, they would want more salary. Once they saw their share of it to operate the clinic facilities was forty percent, or whatever it was, they then knew what they had to spend and how best to spend it -- that was their decision on what was cost effective to do.

WEEKS:

Your partnership didn't start until about 1948?

SAWARD:

Partnership from the standpoint of being an effective partnership may have started about a year before.

WEEKS:

Who was the leading spirit in forming Northern Permanente at Portland?

SAWARD:

The shipyards started right at the time of Pearl Harbor, as a matter of fact. There was a startup period before that. The spring of 1942 the medical program for the shipyards was in place. That endeavor was done by the Kaiser Shipyards Corporation exactly parallel to what happened at Richmond and Vallejo in the Bay area by Dr. Garfield and the Kaiser executives. Edgar Kaiser ran the Vancouver shipyards and one in Portland. At Swan Island.

Edgar Kaiser was the dominant figure in that community at that time. He left in 1946 or 1947 to go to Willow Run, his first defeat, so to speak.

It was run in exactly a parallel position to the Bay area during the war, but just for the shipyard workers.

WEEKS:

Somebody had to say, "We will have to continue this. Shall we continue this?"

SAWARD:

In September of 1945, five other physicians and myself -- and Edgar Kaiser who lived there at the time -- met around a little fire on the beach on the north side of the Columbia River and discussed whether we should go on with this or not. The five physicians were five of the forty-five, the five

who wanted to go on. I was their leader.

Edgar said to us, "Yes, go on if you would like, but don't expect any financial support from us."

Edgar actually was a very generous man, a very generous spirit. What he actually was doing was warning us there would not be any substantive support. The times were very turbulent. Three-fourths of the forty-five or forty-six doctors left at the end of the war. A number had been at Grand Coulee, by the way. But they all left.

WEEKS:

Were you already hired before you sat around that fire on the beach?

SAWARD:

Yes, shortly before. From my experience at Hanford I had these things in my head. Anxious to do them. Here was a place to do them. I have five other physicians, good physicians who I knew were going to be dedicated to the idea. In my mind it was an important thing to do. How I made this transition from academic medicine to doing this kind of thing was really the magic of what had happened to me at Hanford.

WEEKS:

This is what I was trying to get clear in my mind. After the experience you had at Hanford it was natural for you to go into the Permanente, but I was wondering how the transition came.

SAWARD:

I was invited down to be medical director.

WEEKS:

By that time at least a part of the physicians were sure they were going to continue, at least try to make it work.

SAWARD:

I think we may spend too much of this interview on that subject. I think it was in July or maybe August there was what was called a staff meeting of the group leaders during the war. It was quite clear from the process that they were going to vote to dissolve the corporation. There were a few of us who were trained in parliamentary law and made a motion to defer this vote which was clear from the conversation around the room was going to result in the dissolution of the corporation. The motion would adjourn the meeting and reconvene it. When the meeting was reconvened two weeks later the staff were simply gone. It was by a parliamentary tactic that we kept dissolution from happening. What I think you can get out of this is that there was a small group that had become dedicated to a concept.

WEEKS:

I gather then that the Portland, Oregon plan was quite separate from the Bay Area plan, and from the Los Angeles plan.

SAWARD:

It was a separate legal entity too.

WEEKS:

They must have gone through something of the same sort of legal process in their place too.

SAWARD:

They didn't do this until 1953 when Garfield was essentially out of this, out of the chief executive officer role. The reason they didn't was because Sid had started it, ran it. He ran it in sort of a unique hierarchical way. They were content with that. It was very prosperous. It grew rapidly in the Bay area because of the large population. By the way, the hospital at

Broadway and McArthur in Oakland is located right in the middle of an urban area. An ideal location. The hospital in Vancouver, Washington was located three miles east of the village of Vancouver of 13,000, out in apple orchards. It had been built there because that is where the shipyards were. When the shipyards closed, it was nowhere.

So to recruit people to join our program in Portland, they had to not only come across the river and travel to it, generally a ten mile trip. When babies were born out of state, the mothers complained of the birth certificate..."Why don't they say Portland?" We had all sorts of trouble. Finally we built a hospital in Portland but that was a long time later. The program was already a success by then.

We have spent a long time about these early developments. They are important. The program, once it really started to go, became an astounding success so that we could do all the things that for years we hadn't been able to do: start home health care programs; start outreach programs; take on the OEO group as we did in 1966; start to enroll the aged when Medicare first came in -- all these things we had always wanted to do suddenly became possible. We started a health services research center which we did in 1964 with Dr. Merwyn Greenlick from the University of Michigan. All these things we wanted to do became possible as we grew and became a success.

We spent years having roughly twenty to twenty-five thousand members. A very difficult period. By the time I left in 1970 it was around 150,000 members. It's around 280,000 or 290,000 members now in the Portland community which is about a million people. That's one part of that story.

I left as medical director for a variety of reasons. The chief reasons, really, were that a very peculiar management and governance situation had

developed. Nobody would do anything unless I agreed. I had become sort of a great white father to the group. I had been the founder and had been in charge too long. This became clearer and clearer to me that this was an unhealthy management way of going about it. I know some people like that way of being in charge.

For example, I went to New Zealand at the invitation of the New Zealand Medical Association. I was gone about six weeks to go to all their district societies and so on. I had lined up any number of things to be done while I was away knowing that they wouldn't be done. That did it. This was before I had any idea of what I was going to do. I was going to leave on my twenty-fifth anniversary. I intended to take a leave of absence. My feeling was that if I actually, physically got out of the place for two to three years a new management would come about. I had even created a Young Turks society to have an opposition to the administration. Unfortunately when I did leave, for three and a half or four years the place went through a real turmoil. I had left them in very good financial shape. They really had to dissipate that until they got down to being really serious.

WEEKS:

That is a difficult thing to do: to replace a person who has been in charge that long.

SAWARD:

It did settle down, and, of course, it is operating well now.

WEEKS:

I want to ask you about when the Kaiser system was organized and took in all the elements: Portland, San Francisco Bay, Los Angeles, and so on. Also I want to ask you about the Permanente partnership arrangement, whether this

was automatic or whether there was a probationary period, what sort of control you had over physicians on your staff. I want to ask you about physician extenders. Possibly we can squeeze some of those topics in this interview.

SAWARD:

By 1950 we had a strong partnership. (All this relates to the Portland area, not the Bay area.) We had a strong partnership. I was still running both parts of the organization even though now nominally we had other managers in the hospital and health plan.

The medical partnership had an executive committee that was partly some of the founding partners -- three as a matter of fact -- the rest were elected so that there were roughly seven, as I remember it. This turned over slowly. So the fundamental decisions were made by the executive committee of the partnership which were then voted upon by all partners.

The use of the nurse practitioners was not started until 1962 or 1963. For an organization such as the Kaiser Permanente system, nurse practitioners are not in competition with the doctors. They are extremely useful, very well trained, generally those in other medical environments are under-utilized for their real talent. We could take advantage of this very directly. As a matter of fact in 1964, we introduced nurse midwives. Again, that's quite a separate story. There was turmoil first with the state medical board who wouldn't allow them. Once we wrote them a letter telling who they were and what their training was, they never responded again and let us operate. Yes, we were anxious to use that sort of thing. Developing all the ramifications, so to speak, of all ancillary personnel, it's simply just cost effectiveness in such a situation. In the fee-for-service world it is difficult to do because you can't collect the same fees for them, or any fees for them. We

had a slight difference in legally permitted utilization whether they were in Washington or in Oregon.

The physician partnership was paid -- we got switched off the percentage of health care premium in the 1950s into a straight capitation. That worked very successfully. We had quite good accountants who were very good at forecasting and estimating. There was very little difficulty about the level of capitation. That wasn't where the controversies were. Probably the greatest controversy always was about budget. We used to make budgets from what I call bottom up, having each department make up its budget for the coming year. They would submit them, and we would go over them, then forecast what the dues would have to be to equal this forecasted budget. Generally what would transpire was that we would get such a wish list that we weren't in competition with Blue Cross or Oregon Physicians Service schedules. You would have to make your own judgment of what is the market, and how to compete and set the dues, and then back forecast upon this original bottom up budget. That is simply the way we did it.

That was always, always much more of a controversy than the actual physicians payment per se. I don't mean there weren't some physicians who were difficult to deal with. I know physicians well enough to know they wouldn't be normal if they didn't give you a bad time. None of that was insuperable really.

WEEKS:

Doctors didn't enter as partners immediately, did they?

SAWARD:

No, they had two years of being employed by the partnership, and then became partners. There is always an element that comes, that is using this as

a stepping stone. They would come and it wouldn't matter if they didn't get voted in. They really didn't intend to stay. They were using it as a way to come west, or something.

There were very few that we had to say at the end of two years, "No, you are not satisfactory." Generally that would be detected at six months. Those who were not suitable for the program could be found out rapidly by working with their colleagues, you see. In the unit medical records you could see the character of their records. This would come about early in their stay with us, not at the end of two years.

WEEKS:

At the end of two years was there a vote taken?

SAWARD:

Right.

WEEKS:

Were all partners paid the same?

SAWARD:

No, no. You are living in the real world in the market place. A pediatrician is not paid the same as an orthopedist. There were scales for each one of the specialties. They progressed in a seniority scale, one specialty to the other. You remember between the mid-fifties and 1970, we underwent a great escalation of physicians' incomes in the United States. So, we had to keep changing our scales. By and large, the community sets your pay scale. You can't do that arbitrarily.

WEEKS:

These were set, in fact, by the executive committee?

SAWARD:

Right.

WEEKS:

These may be little things but when we get into talking about HMOs things of this sort are still a problem that has to be faced.

SAWARD:

The name of the physicians' group in Portland, that region of the program, was Permanente Clinic. It has changed its name since I left. It is now Northwest Permanente, Inc. They are no longer a partnership. They are a professional corporation. In the days when I was there it was called the Permanente Clinic. Permanente Clinic was self-governing, but the capitation it received was negotiated across the organization, health plan and hospital.

WEEKS:

So in the middle fifties when Kaiser Foundation came in did this draw together all of the...

SAWARD:

Yes. Actually the Portland region was attached to the California regions in 1959. You see the time span. So, from 1945 to 1959, fourteen years, we operated legally separate but not without contact.

WEEKS:

But separate as a legal entity.

SAWARD:

As a legal entity, and name, and so on.

WEEKS:

How about service, cross service, between localities and units?

SAWARD:

You mean people belonging to the health plan getting service in the other areas? That was sort of automatic, no problem. They never had a real distinction about that. Very small fraction of the service.

WEEKS:

I suppose the same thing applies to emergency service, for nonmembers who might come to one of your hospitals.

SAWARD:

The only region, and, of course, this is later in the history, that really had a problem with servicing members from other regions was the one in Honolulu. Many of the Californians go to Honolulu. There is a disproportion between the huge size of the program in California and the small size of the program in Honolulu. It put an abnormal burden on Honolulu servicing the members from California. I don't remember the details of how that was adjusted but they were compensated for that some special way. Otherwise, the shifting around was so small.

Honolulu brings up another aspect of it, probably more interesting to me than others in the program. Early on in the program, I thought the program should be generalized in different geographic areas. Two things happened that got me involved in this. One was that in 1959 Mr. Kaiser -- his first wife had died -- was remarried and went to Honolulu ostensively for a honeymoon but stayed there. Made his home in Honolulu. He started building a hospital then sent up a cry, "Why isn't anyone helping me?" He got involved in a mismanaged program in Honolulu and in the summer of 1960 I got a phone call would I please come over and form a new medical group. Mr. Kaiser had fired the medical group! The essence of it was that I spent a significant part of my

time going between Portland and Honolulu for the next couple of years, getting that region settled and organized.

Concomitant with that in time, Kaiser started an automobile industry in Argentina at Cordoba, in the center of the country. There was a cry that there wasn't organized prepaid medical care in Cordoba, believe it or not! I started a Kaiser type program in Cordoba for the community down there. That required many visits to Argentina. Once we got started and going, we started one in Buenos Aires but the turbulence of Argentine politics intervened. It's still going in Cordoba quite well; but it stopped being anything I would continue to call the Kaiser program in Buenos Aires. A real difficult situation for them.

Then in 1963 I volunteered to help a labor organization in Cleveland start the Community Health Foundation in Cleveland. initially I was serving as the medical director of it overlapping the one in Portland, you understand, making 65 trips from Portland to Cleveland. That is the program that is now the part of the Kaiser in Cleveland, though founded in 1963-1964 by labor, it became part of the Kaiser organization in 1969.

So, I was involved in multiple endeavors all through the sixties and, as I indicated to you, through the sixties starting the health services research center dealing with the OEO population of Portland, reaching out in a variety of ways for people's needs. All of this was going on at once so it was a very busy period.

The principles of the program, certainly in the atmosphere of the sixties, were extensible to doing other things. I don't know whether you are familiar with the experiments now going on called the social HMO. It's a developmental program out of HCFA and Brandeis. Brandeis contracts with four

centers: one in Brooklyn, NY; one in Long Beach, CA; one in Minneapolis; and one to Kaiser in Portland. The social HMO is to bind all comprehensive services in one package, this for the Medicare population.

The savings that are characteristic of HMOs in hospitalization can be used to fund chronic care services and home health care services to the elderly, in an integrated package. 1986 is the first year of the national program, through a special act of Congress. One thing this administration is not anxious to do is extend Medicare. My point is that we had engaged in almost all of these things back in the sixties. We had the fun of innovating this. With an organization turned to that kind of thinking it is not surprising that the social HMOs project is being formally demonstrated.

WEEKS:

I should say not.

SAWARD:

These were the kind of things that we were interested in doing. Not everybody agrees that these kinds of things should be done by the Kaiser programs. I would say there would be considerable dissension in the house. I tried to make my advocacy of them general. This is the way we in Portland were oriented, to do these things.

WEEKS:

In your whole career, I can see, you have looked at the social side of problems. All the way through. That's one thing that impressed me as I read your credentials.

SAWARD:

I will give you another example. You lived through the period so you know it very well. In the early sixties the medical profession were dead set

against the King-Anderson bill which was part of the three-layer cake that became Medicare finally. I almost immediately took the opposite side. In April of 1962 I was part of the small group (not more than twenty) physicians who went to the White House to see Jack Kennedy to advocate the bill, and to see Lyndon Johnson. We were very hospitably treated. The essence of this is that my initiative was not warmly greeted by the Kaiser organization, for taking this stand on King-Anderson. These very individual activities. Kaiser as an organization took no position.

My taking on the OEO group (resulted in): "My God, what are you doing, Ernie? Taking on 7,000 impoverished people and letting community action boards pick who the members would be! That's an invitation to disaster."

WEEKS:

But you did all these things and remained competitive?

SAWARD:

Oh, yes.

WEEKS:

Somewhere in this interview I want to ask you about the care of the aged, the care of the nursing home population. Does that enter into...

SAWARD:

In the new social HMO activity, that demonstration group is covered for a certain amount of nursing home care. It's the first time that HMOs have done that. It is a demonstration project, the outcome must be evaluated.

WEEKS:

Did you do anything at Permanente?

SAWARD:

You must remember that we are always responsible for the professional

care of our members. Even when in nursing homes.

WEEKS:

That is what I was wondering about.

SAWARD:

We are always responsible for the professional care of our members, whatever laboratory tests they needed, and so on. Being in a nursing home didn't exempt us, but we didn't pay the cost of the nursing home.

WEEKS:

You did absorb the cost of the medical care.

SAWARD:

Let's see if I can say this succinctly and not take too much time with it. Obviously we would have liked to cover the nursing home care. Home health care, by the way, comes rather easily to an organization like this. At the time it was something like seventeen cents a member per month, as the cost of having the home health program.

The nursing home care put us in this dilemma: If we ran one ourselves, which we came several times close to doing for our members, the members automatically would see this as a contractual benefit, so we couldn't charge them for it. On the other hand, if we didn't charge them for it, this very small group of the membership would raise the dues to an extent that our program would be noncompetitive for the bulk of the membership who came from different age groups. So, we were always in that dilemma. We can't have one of our own. Therefore, we just helped people through our social service agency to arrange placement for people and then provided supervision.

I'll tell you a little about what I think lies in the future. Almost all of the talk about nursing home care by the HMOs is hypothetical for they have

not come to deal with the aged population yet because they deal mostly with employed people, as HMOs start out all over the country.

We found the physicians were very bad performers in supervising our members in the nursing homes. So we had a cadre of nurse practitioners that were trained to do that, write in the same medical record with a carbon copy of everything they wrote to the attending physician. They were glad to and eager to go out to supervise these people. To the doctor it was always a nuisance to go out there. Basically we developed a separate oversight system for our members who were in nursing homes, in addition to what the nursing home itself provided. I think HMOs will come to that across the country as they mature into dealing with that population, which in time they will.

WEEKS:

HMOs at present are having difficulty absorbing Medicare patients, aren't they?

SAWARD:

Yes and no.

WEEKS:

Some of them are trying to get out of their contracts to care for Medicare recipients.

SAWARD:

I understand that is about five percent that are trying to get out of their contracts.

Let us say that the risk contracts, the TEFRA contracts, dealing with HCFA is a big pain in the neck. That's number one. Secondly, if you are in a relatively small community, the better you do, the worse you will get paid. So, it's a self-defeating thing. A crystal clear example of it is the

Marshfield Clinic. Everybody in Marshfield, elderly or not, gets their medical care through the Marshfield Clinic group of doctors. So they know the Medicare population, and they reduce their use of hospital care drastically, as they did under a demonstration contract. As much as they reduce it they get 95% of what they reduced it to next time! It's sort of a self-defeating game. We have had that experience in Rochester also. Rochester is the lowest per capita age/sex adjusted metropolitan statistical area Medicare payment in the United States. This couldn't happen by accident. When it comes to capitating these people to get 95% of the lowest rate in the United States isn't exactly a reward for virtue!

WEEKS:

I suppose the same thing applies to Medicaid.

SAWARD:

Medicaid is just coming into capitated programs. This is its first year in which everybody on AFDC and on home relief categories are capitated in Monroe County, New York, roughly 66,000 people.

On to Rochester.

WEEKS:

One thing before we leave Kaiser. Is there any likelihood of it becoming a national operation?

SAWARD:

They have gone into the area between Washington and Baltimore, into North Carolina, dipping their toe in the water in Atlanta, toe in the water in Dallas, in Hartford, Connecticut, Westchester County, and in Kansas City. Those are the areas of expansion after the initial Denver, Honolulu expansion, and taking over Cleveland once we had the labor program under way. I don't

think it will be a national program. As a matter of fact, I really am in no position to prognosticate. I think with the exception of the Washington, DC area, each of these plans in Connecticut, and Westchester County, and North Carolina, and Georgia, Dallas, Kansas City have been subsidized by the California regions. I think that the period of startup subsidy will be so great that it will take some of their enthusiasm.

WEEKS:

We heard rumors a few months ago about their approaching HIP in New York City.

SAWARD:

Yes, that was true. It didn't occur. The HIP board voted it down.

One of the things I did while I was at Kaiser is perhaps of some interest. You see I was very much involved in what I would call health policy at the time, through these various programs. Having had the international experience of Argentina, and having visited Scandinavia, in fact, having gone to school at the University of Oslo, and having gone through the whole Medicare struggle and advocacy when it was a very unpopular thing for a physician to do, I thought there should be some new organization developed in health policy. I was one of the founders of the Institute of Medicine of the National Academy of Sciences as a policy making body. It somewhat miscarried. A lot of members think it is an honorific thing. What we had in mind was a working thing. I suppose that was too optimistic to think we could get these honorific people to stop and work at the policy initiatives. I don't mean to say it failed, but it hasn't been exactly what we had in mind.

Walsh McDirmot and Rashi Fein and others were really much more in favor of being actively involved in health policy making. It turned out that by the

time it has done a study, everyone else had also done a study. The lag between perceiving a problem and publishing a report is great.

The period between 1967 when we started meeting and 1970 when it was formalized as the Institute of Medicine, we met every month. I took a trip from Portland, Washington and back. Usually it was a two day meeting, hard, controversial discussions on how to organize and set it up. We were quite sure we didn't want members to be all MDs by any manner or means. We made provisions in the charter so it wouldn't be. Now it is so categorized, you in effect vote only on people like you, your category. It's pompous.

WEEKS:

After deliberation, how do you get policy in effect?

SAWARD:

Actually somewhat better than we anticipated. If you are quick on the take up of issues the federal government will usually put up most of the cost of it, of pulling the study together and in publishing it. It will go back to the ones putting up the money. Obviously some of these things stay on the shelf. As a matter of fact it is one of the devices of the Congress which you are only too familiar with to put up a study committee for something they want to put on the shelf. You really never know what is going to happen. But the IOM is well respected.

I served on Carter's national health insurance committee, for example, which never got anywhere but the shelf. What I am saying is: We had hoped through the publicity we could get through the National Academy of Sciences to get public engagement on health policy issues much more quickly and strongly than has come about. Serving on the organization of the IOM those three years, and then two years on the council, was a very active period of being

involved in Washington affairs.

Sort of overlapping that in a way was when Medicare was set up, the Health Insurance Benefits Advisory Council (HIBAC) was created. I served on that and finally became its chairman.

WEEKS:

Did HIBAC actually have any teeth?

SAWARD:

It wrote regulations. You understand staff would propose regulations; they would be debated on, argued, and changed. Yes, it had teeth in it.

WEEKS:

Why was it terminated?

SAWARD:

That's a complicated story. Some didn't want any second-guessing of the bureaucracy, frankly. Having a public body review their work was not always a happy experience.

Following immediately on that activity was the 1972 legislation creating PSRO. I chaired that national council. It was an interesting struggle because for the first fifteen months the AMA wasn't going to do it, finally gave in and did do it. Again it was an interesting struggle to participate in. Recently here, I served with the first year and a half of ProPAC, the Medicare prospective payment council. Most of the conceptual issues were pretty well argued out in the first 18 months of ProPAC -- where we were going with the DRGs and all they implied. So these have been what I would call a continuous involvement in trying to do better. We thought by setting up something in the National Academy of Sciences that we would get some better health policy. That was in 1967 when we started that. We still have quite a

melange in health policy. Our optimism was probably naive.

WEEKS:

When I first noticed your involvement in PSROs, I wondered if you had not already had some experience at Permanente on looking at the quality of care on your own. Your own self-policing.

Do the Kaiser hospitals in general ask the Joint Commission on Accreditation of Hospitals for examination toward accreditation?

SAWARD:

All of them.

As a matter of fact, way back when the American College of Surgeons were examining, we had all our hospitals approved then. Yes, we have always been in the system.

WEEKS:

I talked with Dr. Affeldt. You probably know him, until lately president of JCAH, now retired to California.

I think I have asked all my questions about Kaiser, but before we move on to talk about your professional career in Rochester, NY, we could speak about HIP, the Health Insurance Plan of New York City.

SAWARD:

Yes.

WEEKS:

HIP was a brainchild of Fiorello La Guardia, wasn't it?

SAWARD:

Yes. Exactly where the ideas came from... It came out of George Baehr. George Baehr was La Guardia's physician. It is awfully hard to put ourselves back now on the conditions as they were before World War II. New York City

employees had no health insurance coverage as was characteristic of many other municipalities, states and other bodies. Their credit union had 60% of their requests for credit in health related loans. These conditions were very well known. George Baehr suggested this sort of scheme to Mayor La Guardia, who was all for it.

I am sure you are going to get somebody else to tell you the HIP story. It had some very difficult beginnings. To start a plan for New York City employees which was 300 to 330 thousand people all at once in all five boroughs when, in fact, there hadn't been developed medical groups in the five boroughs to serve them. It produced almost a catastrophe for HIP in that some groups were not dedicated to the HIP program. They were, in some cases, organized groups and in others loose affiliations of individuals who made themselves available like our IPAs today. In some instances the groups' main business was with HIP, such as the Montefiore group. In other instances it was only a small part of the doctor's business to take care of HIP people. They were much more concerned with their fee-for-service practice. They regarded the HIP patients as second class citizens.

With that kind of start, which was radically different from the Kaiser start, where we wanted to do prepayment from the start. We had only members joining to the extent that we could serve them. Starting with 330,000 without any service organization was damn near disaster. It did survive.

There was a tremendous controversy within the organization. The various city unions and others had very great voice in it. At times they were disruptive. It was a very stormy course. Along in the late fifties the dilemma was well understood as to what the problem was and the solution. A sincere effort was made to right the wrongs of HIP. In part they were able to

do it. They started the group called the East Nassau Group on Long Island which was started as a model group, dedicated to that purpose. The inter-group...the divisiveness between the groups serving HIP was profound, the raising of membership issues that had nothing to do with health care was disruptive. It's amazing the place ran as well as it did. With the blueprint they were given in the early sixties, with Jim Brindle and Marty Cohen coming aboard they made heroic effort to right the ship. In part they did. I don't know exactly what year it was that Brindle went there but it was between 1961 and 1965.

The program now is under Bob Biblo -- and Bob has been there, I would say, about four years and is forming a very good organization. There is no longer any of the old turmoil that was HIP. They are forming medical groups that are dedicated to what they are doing and they are becoming a true group practice organization. They are also getting away from what I call the internecine warfare between some of the consumer groups.

I was on the Board there for a while. The board met with lunch and following the lunch, the meeting. I don't think I ever went to a board meeting without the lunch having pickets going around the lunch table. You can imagine the atmosphere of a place like that. It was really rough. You would hear arguments at the board meeting between the old union founders of HIP (mostly from families that had immigrated from Poland in the generation before) and the blacks, the Puerto Ricans and others -- as to who the consumers were! It was wild. So you would seldom get down to what I call the service issues.

In regard to consumers, I want to say one more thing about Portland. I had a great tutor while I was in Portland in this sense: In 1950 we enrolled

Harry Bridges' longshoremen. We had 95% of them. I guess this was three or four thousand people. The secretary of Local 8, at least five days out of every seven throughout the many years, 1950-1970, was on the phone to me about something. That was a great lesson in consumerism. It started out with total antagonism and became, in the course of time, total collaboration. They were hostile to medicine, they were hostile to institutions -- they were just hostile to the point where they had no confidence or trust. That sounds trite, doesn't it?

WEEKS:

Once you had demonstrated it...

SAWARD:

Working together every day. I would get repeated phone calls. I practiced medicine and my office nurse was informed that I always would take the calls from that business agent. Trivialities at times, critical at others. I couldn't imagine why at times he would call, but we developed a relationship. He would laugh after he made one of these calls.

WEEKS:

But he knew he had access.

SAWARD:

That's right. So, I say, I had a good tutor, a tutor in consumerism. It was a very militant union. consumer feedback varies all over the lot. I don't know that I recommend that everyone be taught by a militant union, but it helps. It really does.

WEEKS:

A couple of questions about HIP. One is about the physicians. Were they hired on a salary basis? Capitation?

SAWARD:

All over the lot. There was no one thing. East Nassau, which was the group developed to represent the new model was essentially on the Kaiser model. The other groups were highly varied as to how they functioned. Basically, yes, it was capitation. The capitation for the group may have ended up by going fee-for-service for the individual physicians.

WEEKS:

As I understood it, there were about thirty different groups. Were there that many?

SAWARD:

That's right. Thirty-two, I think, at the maximum.

WEEKS:

If a physician was connected with a group, then the physicians in that group decided what they were going to do about their percentage of the capitation?

SAWARD:

Let's say a physician sees twenty patients a day in his office and three of those people on average are HIP members, what are you going to pay him? The group may get a capitation for 30,000 members, shall we say. But how are you going to pay the fellow who sees on an average of three and some days none, and have it vary up and down? It becomes very difficult. So the group is going to have to turn around and pay him for what he has done. Unless you have full-time groups, as East Nassau was, devoted to taking care of HIP members, then you really can't work out a system. So, they had every range of activity. Montefiore, by the way, was a salaried group that was full-time, or reasonably full-time.

WEEKS:

Martin Cherkasky was there?

SAWARD:

Yes, and George Silver. George Silver ran the Montefiore group under Cherkasky. What I am saying is that HIP was all over the lot. There was no such thing as a standard anything.

WEEKS:

Then the next question is: How about the hospitals? Did they have a free choice of hospitals?

SAWARD:

HIP didn't cover hospitals, Blue Cross did. There was a subcontract by Blue Cross to cover HIP members in hospital. If HIP doctors functioned cost effectively in the hospital it benefited Blue Cross, not HIP. All of this was obvious by the fifties. All of this was laid down in a new plan by the early 1960s. The metamorphosis between then... This is what Brindle and Cohen tried to do. In part they were successful and in part they weren't. They even got their own hospital, La Guardia Hospital, but that would serve only a fraction of the HIP members. It couldn't possibly service the whole metropolitan area. The metamorphosis has gone on now so that under Bob Biblo, who has been there about four years, that the thing is now down to being a functioning group practice HMO, with good quality controls, true capitation. It has been a long, difficult struggle.

What was the problem? The problem was trying to start, and service five boroughs all at once, on day one, with people who were in no way dedicated to HIP.

WEEKS:

Was this financed entirely by the city or did the employees have to contribute a certain amount?

SAWARD:

I don't know how it started at the beginning but the bargaining power of the city employees was such that they had full coverage from the city. It may not have started out that way. I can't really show you day one. The city employees' union in New York City is a very powerful union.

WEEKS:

It looks to me as though HIP is quite a headache.

SAWARD:

HIP has been a great headache. The fact that at present that it really has been reformed and is doing as well as it is, I think is remarkable. It shows a very great talent of the team that is in charge now as well as the great efforts the Brindle-Cohen team put into it in the past.

WEEKS:

Did the East Nassau group serve as a model?

SAWARD:

The East Nassau was set up in the fifties to be a model group. The warfare between the groups serving the HIP was such that many of them considered the East Nassau group an anathema.

WEEKS:

As you say, when you consider the problem of the New York City employees and on top of that consider the New York City municipal hospitals, I would hate to have an administrative position there.

SAWARD:

It has taken very thoughtful, progressive management to manage HIP. My hat is off to the people who are there now. They have done well.

WEEKS:

Shall we move along to Rochester?

SAWARD:

Yes.

WEEKS:

I think this is where you can contribute to the present stage.

SAWARD:

Let me say that in my own mind it was perfectly clear that the program in Portland wouldn't develop the strong kind of managerial talent and initiative unless I got out. What was happening was that everybody turned to me for every kind of decision. I am not talking about medical decisions. Whether they should have reserves in treasury bills or CDs! I had to decide that kind of question. What next piece of real estate should we buy for the next clinic? Obviously some of that is programmatic. There was every conceivable kind of decision. It was coming to an impasse. Quite an anomaly in a way.

As you can see, having been engaged in a lot of the broad front health policy as it was developing -- and the background of having done programs in Honolulu, in Cleveland, in Argentina, having traveled abroad and spending time in the Scandinavian system, having been involved with the Washington politics of the Johnson years -- I just thought there must be a change in management in Portland. As I said, I planned on going on my twenty-fifth anniversary, although I didn't know what I was going to do.

Now again, I think you have seen the coincidence in the choice of my

medical school, the choice of my internship and so on. One of the persons I had had considerable interaction with was Dick Weinerman, who was in Berkeley. Did you know him?

WEEKS:

No, I don't know him.

SAWARD:

Richard Weinerman was a leading figure in health policy in the medical care section of the APHA, in a variety of union programs and others. He was nationally known. He had gone from Berkeley -- he was not faculty of the University of California as such, but he was involved with Berkeley as a community -- to Yale as professor of, I guess, health administration as Ig Falk was retiring from that job in the Department of Public Health and Epidemiology, as it is called at Yale. So Dick Weinerman, who was ten years younger than I, was succeeding Ig Falk in that job. He had been at Yale about three years, had considerable impact at Yale-New Haven Hospital's organization of ambulatory care. I don't remember exactly how it occurred -- he knew the Kaiser organization well for having been at Berkeley. When he heard that I was leaving he said, "Why don't you come with me?"

I thought that would be a good idea. It would be a real change of scene. So, I interviewed at Yale both in pulmonary medicine -- because I still considered myself primarily an internist -- and in public health and epidemiology. After a set of interviews, with Kingman Brewster and everybody else, I was offered a job with a dual professorship in internal medicine and epidemiology and public health. It was just about set to go. This is sort of the trigger of how I got to Rochester.

At that time, quite unknown to me because I hadn't followed affairs in

Rochester, Rochester was having a real deep look at the cost of medical care, and what could be done about it under the auspices of Marion Folsom.

WEEKS:

That resulted in the Folsom report?

SAWARD:

Yes. They had a committee, chaired by Mr. von Berg who was chairman of the Sybron Corporation, looking at alternatives. One of the alternatives was what today we call HMOs. They hadn't been named that yet. In fact, I think they were calling it an alternative way to finance care.

That committee asked me to come and be a luncheon speaker. In as much as my late wife's family lived near Rochester, I was delighted to come back to Rochester to make a luncheon speech. I was quite surprised to learn that my colleagues at lunch were heads of not only Sybron, but Xerox and Kodak and some others. There was a serious industrial effort to look at the cost of medical care. You can imagine the kind of speech I gave them about Kaiser -- what its cost effectiveness had been. Coincidentally I had been asked to come and make a talk at the medical school. I understood it to be sort of a courtesy because many of my contemporaries in medical school were now professors in the medical school, former classmates.

I went back to Portland and I thought that was the end of that. Two days later the dean of the medical school was on the phone to me saying I must come back. he had been instructed that I must join the faculty. What had happened was that Mr. Marion Folsom, who was on the board of trustees of the university, said, "Recruit Saward to do these things in Rochester."

I had known Rochester, the university was my alma mater, my wife's parents lived nearby. I did give it serious consideration as opposed to going

to Yale. There were attractions in both directions. I did go to Rochester and was immediately involved in Rochester's community affairs. It became perfectly clear that one of the things I was to do was start a prepaid group practice program in Rochester under Blue Cross auspices. Remember in 1970 Blue Cross was just beginning to get into the alternative systems. The usual sort of controversy started. The medical society decided it should start its own, which at the time had not yet been named an IPA, because it wasn't named until a couple of years later. Concomitantly the OEO network which had been started in Rochester wanted to enroll as a prepaid group practice, as well. I worked on all three: served on the board of the medical society plan, organized the prepaid group practice plan with Blue Cross, was on what was called Task Force Number One of the Rochester Health Network community program. Gave all three the best advice I could, and was not responsible for running anything in actuality.

The curious Rochester decision made by industry since it all came to the surface and was worked out was that all three programs should start their program on the same day, with the same dues premiums, with the same sales force. That's a recipe for disaster.

WEEKS:

But still be separate?

SAWARD:

Still be separate, yes. Competing with the same sales force, the same dues structure, same benefits.

Mr. von Berg of the von Berg Committee was the person who was active in insisting on this, but with others. He was a nice person; I liked him very much. He publicly apologized for this subsequently to me. The essence of it

is that all three programs got off to a very shaky start. People were confused about what they were signing up for. There was no individual promotion of anything.

WEEKS:

Did each one give...

SAWARD:

They all had the same benefit set. The benefit set was the federal HMO statute benefits by the time they started up in 1973. I tell you this to give you some idea of how Rochester functioned. It took them a year and a half to break out of that pattern. The medical society plan went belly up in a couple of years. The prepaid group practice plan acquired several million dollars of debts. We finally got the whole thing righted with new programs up and going. We'll come to that in a minute.

I had stressed the community aspects of my activities in Portland. I was active in Portland on the hospital planning council, which again was no real part of the Kaiser activity. I was an active member of their Regional Medical Program board. We incorporated a community health planning agency in Portland.

So, when I came to Rochester and the regional medical program was run by the medical school in Rochester, the dean said, "I wish you would look into the regional medical program. I don't understand it."

I said, "Fine." And took it over. I was also involved in the health planning body there. It immediately became apparent to me and others that the regional medical program and the comprehensive health planning agency should be combined. One had the planning funds and the other had the implementation funds. They were running two separate boards that were at cross purposes.

We first went off to Rockville and said can we do this. They said that one or the other of the programs would not be funded if we did that. So, if we want to continue funding of both, we should overlap the boards. We did.

That had quite far-reaching effect, quite apart from Rochester. That led to the drafting -- on the Rochester model -- of the Comprehensive Health Planning and Resource Development Act. The resource development part was never implemented of the Comprehensive Health Planning Act, but you remember the name.

Something else came about in Rochester that was very unsettling at the time. I must have been quite an annoyance to the medical school at first. I was associate dean as well as professor of social medicine at the time. The dean was very kind. He really didn't have any idea of what I was doing, but he was sympathetic. He was quite frank that he was a pathologist. These community activities were not in his experience. An honest, sincere, and good person in every way. Very tolerant. All medical school faculties are not terribly tolerant of these community innovations, shall we say. Mr. Folsom and David Stewart, who was president of Blue Cross, and I often worked together on these activities. One couldn't have a better friend than Stewart, really. A great guy.

WEEKS:

He is coming in two or three weeks.

SAWARD:

Is he? You will enjoy him. Very lively, full of fun. As I say, you couldn't have a better friend than David Stewart.

We kept talking of this business of cost containment. In the 1970s it was a very popular, national subject. One of the things -- and I think you

can see how I got there -- was: Why do you have these hospitals competing with each other? What Blue Cross really wants is to ensure hospitalization. Why should it be bothered with inter-hospital competition? Why should the community go at it that way? An example of the cooperation is the twelve Kaiser hospitals in the San Francisco Bay Area which certainly are not in competition with each other. It was a crystal clear model in my head, as well as that of the Swedish counties. That's one of the reasons I point out my period in Scandinavia -- they have multiple hospitals but they don't compete with each other. The county has to come up with a budget for the hospitalization of the people of that whole county.

I give you this background so you will have some sense of where these notions came from. You will remember the American Hospital Association at the very end of the sixties was coming up with "Ameriplan". The culmination of these things was: Why don't we have a health care corporation for Rochester in which the hospitals will be paid by the health care corporation, and the payers pay the health care corporation? In other words, Blue Cross, Medicare, Medicaid pay into the health care corporation. The health care corporation pay the hospitals, and have enough authority over them so they will not duplicate services, not everyone have a lithotripter shall we say. You know what I am talking about. There was a considerable element of duplication back in the seventies. Somehow or other this idea escaped into the community before we were ready to surface it. There was a big public meeting that filled an auditorium. I outlined the idea. The medical society was totally against it. The black community thought I was trying to take their OEO grants away from them, which was farthest from my thought. I hadn't really conceived that they would react. The blacks were very vociferous against the idea.

Basically I got tarred and feathered and sent back to the medical school. So, that idea stopped in its tracks at that time only to come back in 1976-1977.

New York State, because of the looming bankruptcy of New York City, had mandated a drastic regulation of hospital costs in the State of New York.

Rochester hospitals, which had been managed on lean budgets, were all forced into deficit financing by these measures which were designed to take the "fat" out of New York City hospitals. Hence, when escape from this regulation could be obtained by the proposed demonstration of pooled funding surfaced by the Blue Cross proposed MaxiCap, it became the hospital experimental payment plan of Rochester.

It started January 1, 1980. It was exactly that: a pool of funds from all the payers; the hospitals paid out of the pool; not in competition with each other; the overall governance of all hospitals having to decide who got what in technological advance. We surfaced this in 1970-1971 and because we had innoculated the concept then the hospital administrators could bring it back themselves.

WEEKS:

How did the physicians act then?

SAWARD:

They were very quiet. They had a board member physician and an administrator from each of the eight hospitals in Rochester meet together once a month for lunch. I sat through those lunches. I represented one hospital as a board member and Strong Memorial as its most atypical staff member! I sat on that committee for several years of this. The physicians were as quiet as though it would never affect them. They didn't perceive what it might amount to.

WEEKS:

Was there any question of staff privileges for physicians extending to all member hospitals?

SAWARD:

Not at that time. However, Rochester has a lot of overlapping privileges. So, it isn't very much a bone of contention. It is fairly open in that sense. There are exceptions.

I mention that because one of the great happenings in Rochester that has made it different is the hospital experiment payment plan. The Rochester Area Hospital Corporation, as I mentioned to you at the beginning of this talk, has made Rochester have the lowest per capita, age/sex base adjusted cost for Medicare of any metropolitan statistical area in the United States, seventy-one percent of the national average.

That is the result of a variety of things, but very largely this hospital experimental payment plan and the fact that Rochester has 330,000 members in health maintenance organizations out of a total population in the county of 700,000.

What we are seeing in Rochester is a concomitant of a set of interventions which has produced very low cost care. I am sure that if you have David Stewart coming in that he will tell you all about it in detail, because it is in many ways his accomplishment as the Blue Cross president.

WEEKS:

Rochester Blue Cross and Blue Shield recently merged, didn't they?

SAWARD:

They didn't legally merge. They are under a joint management. They will merge. There had been a lot of friction between the two organizations,

basically between doctors and hospitals.

WEEKS:

As to HMOs: Blue Cross has one...

SAWARD:

Blue Cross has a group practice HMO called Genesee Valley Group Health Association which has a little over 40,000 members; Blue Cross has an IPA named Blue Choice which has over 100,000 members; there is another organization called Preferred Care which has about 100,000 and is not connected with Blue Cross. Blue Cross and Blue Shield should have merged earlier and didn't. Another organization is called Rochester Health Network which has 60 some thousand. At any rate those are the organizations that are operating in Rochester now.

We also embarked on a Medicaid experiment. Since the first of this year (1986) all Medicaid, i.e., home relief, and AFDC people are in one of the HMO arrangements, capitated at 95% of the previous year's cost. We have a considerable involvement, I guess of the 70,000 Medicare people in the county there are about 12,000 who are enrolled in HMOs. Again, it isn't a big percentage, but if you look at it nationally it is far more than the national enrollment in risk contracts.

So, we are well advanced in all these fields and still have this hospital experimental payment plan.

Employers in Rochester don't realize how well off they have been, and Stewart will tell you that for sure. Compared to their costs in other areas, other regions of the United States, Rochester health insurance premiums have been very modest in their escalation. Rochester has a very strong planning agency, and it has been quite effective. In most places in the United States

planning agencies haven't been. In my opinion there are not over 20 out of the more than 200 that have been effective. In Rochester -- remember the Comprehensive Health Planning and Resource Development was based on our Rochester plan, in the first place. So naturally we followed it. Between the health planning agency, the hospital experimental plan, the penetration of the HMOs into the population, and, indeed, over Blue Cross being the chosen instrument of the employers. There aren't competing indemnity insurance companies in any significant way. The perpetuation of community rating in Rochester -- the only Blue Cross plan to continue community rating in the country -- those five intervening variables have meant much more control than other communities have had.

WEEKS:

How have they been able to continue their community rating?

SAWARD:

It's beginning to unravel, frankly, but the essence of it was -- if you look at the situation ten years ago -- penetration through community rating was something like 82% of the employed population of Rochester belongs to Blue Cross. It was an industrial agreement that they all paid the same dues. Xerox, which started as a new company in 1964 with essentially young people has a much younger than average work force. The difference between the two is such that Xerox could save itself a lot of money by not community rating. Nevertheless, for example, up until recently, the agreement has been that they would pay their share because all the community will benefit because there will be no uninsurable groups. That is a definite philosophy of the industrial management council. It has held together so far but it really is rapidly unraveling.

WEEKS:

What is the community doing for the aging? Not just the nursing home care but also retirement living and...

SAWARD:

We have the highest concentration of chronic care beds of any county in the United States. This, again, was part of the health planning effort through Mr. Folsom in the sixties. As you know, to curb hospital bed construction, we had to have more less costly chronic beds. That was all done really before Medicare had any impact on the community and certainly before any prospective payment system had any impact. Home health care has been a Blue Cross benefit since the mid-1960s. Evaluation and Placement Centers for patients before being admitted to chronic home health care are a Rochester creation and the work of T. Franklin Williams who now directs the National Center for the Aging in Bethesda. He ran the program in Rochester for some years.

The program called Access which does evaluation and placement for all Medicaid patients is a grant program in its eighth year in Rochester. So we have had a plethora of this kind of thing developing through the years. We have a 48 bed demonstration unit in Strong which is neither nursing home nor a hospital, but is a place where people are evaluated as to how they can be improved enough to go on home care. They get very intensive evaluation and rehabilitation which is a special program under the New York State Health Department.

I was at HCFA last summer wanting to do a demonstration program for Medicare. They said, "You folks from Rochester come around wanting another waiver. You have got more waivers than you have people." We have had a great

number of demonstration programs.

We have had, as you know, in the Monroe Community Hospital, which was until up to 1966 or 1967 the typical county nursing home, 700 beds -- not terribly admirable. It has been changed into a model institution of progressive care and rehabilitation. When the Moreland Commission evaluated these throughout the state, they said it was the best one in the state.

WEEKS:

Isn't that marvelous.

SAWARD:

Again, Frank Williams was medical director of it and put the program in effect.

Rochester has a great deal going on. Very interactive, and it hasn't stopped. It's not over. It doesn't have the great leaders it had in the late sixties and early seventies. Joseph C. Wilson, the founder of Xerox Company, was absolutely open to all kinds of ideas about improved health care, and would push them. His pushing them made them go with other industrial leaders. Marion Folsom, of course, played that role for many years. Both of these men are gone. Nobody stepped into their shoes. We don't have what we had, but we have a lot more than most communities.

WEEKS:

Was Folsom dead by the time you came back?

SAWARD:

No. I worked with him the first couple of years I was back. I can give you the correct dates. I came back July 1, 1970. He had a stroke in 1973. He functioned beyond that, but he certainly was not able to be the aggressive community leader. He died, I think, in 1976.

WEEKS:

Can you give me a little profile of Mr. Folsom? He is one of the persons I would have liked to interview.

SAWARD:

He came from Georgia and never lost the southern gentleman aspect. I don't mean by accent, I mean by manner, his southern gentleman style. He went to the Sloan School of Management at MIT. He joined Mr. Eastman as sort of a personal assistant, I guess in the late teens of the century and by the mid-twenties had put in fringe benefits at the Kodak Company that we would regard as contemporary fringe benefits. He was one of the pioneers of that sort of thing. There was a good article in the Atlantic Monthly in 1927, I believe, outlining the philosophy of fringe benefits in corporate life. Way ahead of his time. He served on the advisory committee that created Social Security. Obviously very community oriented all along. He was Eisenhower's Secretary of Health, Education and Welfare. When he came back to Rochester, the hospitals wanted to start a very large fund drive for the hospitals. He produced the methodology to evaluate their need, which resulted in cutting the fund drive in half. He was instrumental in creating the health planning committee, first in Rochester, then getting the State of New York to pass the Metcalfe-McCloskey Act which created the first state health planning commission in the country. Then the Partnership for Health Act by Congress in 1966 which incorporated the comprehensive health planning agencies. He was very active in all those things.

I found him to be a dignified, serious, dedicated person to the community. For me, that was a great find. I enjoyed him very much. I didn't anticipate that he wouldn't be around, or I would have devoted a great deal

more time to him. That's how life is, I guess. You expect people who were there to be there.

WEEKS:

When you see all that has come out of Rochester, you know there has to be a man or some men behind it who are original in their thinking and are willing to make the effort to implement these ideas.

SAWARD:

Let me give you an example about Blue Cross. Blue Cross, as you know, got started in the early thirties as a practical matter, first with the Dallas school teachers. It started in '35 in Rochester. By 1940, five years later, 44% of the working population of Rochester had Blue Cross, while the nation had less than 10% having any health insurance. Before the war 44% had Blue Cross. Why was that? Mr. Folsom saw this as a good thing, persuaded the other industrial leaders that it was a good thing. The way it came about was very formative in the idea of community rate persisting during the fifties when many Blue Cross plans were forced into experience rating.

WEEKS:

You said previously that you would speak about research and research procedures both at Permanente and at Rochester.

SAWARD:

Like every academically oriented physician -- trained in the academic environment -- obviously the original ideas I had had were for clinical research. In fact, in less than three years out of medical school, I published an article in the _New England Journal of Medicine_ all by myself. That's the way we were brought up. If we were going to have an academic career, that's the direction we must go. When I was working in chest

diseases, tuberculosis, I did a large cross-sectional study of pneumothoraxes and complications. That kind of research was essentially the mode of the day and how we were trained to look at research. As I really involved myself in medical care rather than patient care I became more an more curious as to what epidemiologically consumed resources in medical care, how these things were distributed, how they might be distributed better, what people's attitudes were towards medical care -- we were always being told they were one thing or another, never really knowing, dealing with opinion rather than any kind of quantification of information. In the early sixties I had a series of contacts, one within the Kaiser organization with the late Arthur Weissman who was not only a good economist, he was a good teacher. He would always ask you the questions that made you think about what you had been asking him. Between his influence and others it had become clear to me that having unit medical records, having a limited number of professional staff that would be compiling the medical records, having a defined population to serve, we had mechanisms to start to dissect for the use of medical care by populations.

After spending a year or more looking for candidates, through friends at the University of Michigan I was told about an about-to-be granted Ph.D. candidate by the name of Merwyn Greenlick. I met him in 1964 and recruited him to come to the Kaiser program at Portland to set up a research center. Dr. Greenlick was more than I ever contemplated. He was the kind of man who could play all the kinds of instruments in the band and play them well, ambitious, full of energy, and who recruited a very loyal staff, and has gone on to this day producing good work.

Very shortly he set up data systems that were in that day at least, and to a considerable extent I think still, unique in HMOs in that we had very

detailed records of all our hospital discharges including their functional status on discharge. He had drawn a random 5% sample of our membership on whom we studied all health care utilization on ambulatory visits, laboratory use, pharmacy use, telephone calls -- every other service parameter of the group on this 5% sample. In addition we did detailed attitudinal and medical care and sociological studies on the same 5% sample which could then be correlated with the utilization tapes. From these data sources a wide variety of studies have been done. When we took on the Office of Economic Opportunity program, we did the same thing with the 7,000 enrollees we had there on a 100% sample basis so we had a disadvantaged group to compare with our usual health plan population. The center has done many other projects since then which I won't detail because most of them were done subsequent to my being at Kaiser. The production of health services data in the early and mid-1960s was rather unique. There were very few places doing studies at this time. As a matter of fact, with the sole exception of Sam Shapiro of the Health Insurance Plan of New York, I know of no other HMO that is really doing significant health services research. Today very few of the HMOs are doing any kind of health services research. The Harvard Community Health Plan is one of the exceptions. Most of them simply have their operational data, nothing else. Some of them, as a matter of fact, make it very hard to get their operational data, as to what they are doing. I feel that if you are going to represent a new kind of organization of health care, you have an obligation, it seems to me, to furnish fundamental data about it, explore it in every way. Fortunately between being recipients of grants from the National Center for Health Services Research and grants from various Public Health Service entities in the course of time, Kaiser Portland has managed to pursue this

kind of work. The research unit has basically a core funding of 2% of the health plan dues supporting it.

WEEKS:

Did you make your connection with the National Center while Paul Sanazaro was there?

SAWARD:

Paul Sanazaro was the first head of it and the person who came with his colleagues to make the site survey when we received the initial grant.

WEEKS:

I think he did a very good job as head of the National Center.

SAWARD:

Indeed he did.

WEEKS:

I have a few general questions. I may be hopping around a bit but I hope you will respond to some of them.

Do you care to say anything about your work at Stanford as a Fellow at the Center for the Advanced Study in the Behavioral Sciences?

SAWARD:

The year there was a difficult year for me in one respect in that simultaneous with my being there my wife was being treated for metastatic cancer in a variety of experimental chemotherapy programs. I didn't have what I would call the usual freedom to pursue things. While I was there I wrote several papers. In addition I prepared material for a meeting that occurred in May of 1979 at the Leopolds Kron in Salzburg, Austria where there was an international symposium. I was the chairperson at the international seminar and spent a good deal of time organizing that material while I was at the

Center.

WEEKS:

Was this at Salzburg?

SAWARD:

The Salzburg Center for Studies. It was a very pleasant occasion, but, again, it required quite a bit of preparation. Between that and the article that was published in the Scientific American and two lesser articles that were published elsewhere is the way I spent most of my time at the Center.

The Center for the Advanced Study in the Behavioral Sciences is an interesting place for a physician to go in that physicians are, indeed, the exception there. Most of the fellows are doing studies in much more specific discipline oriented areas of the behavioral sciences. Having a group of colleagues with intimate scholarly relationships at lunch every day is a very educational experience, seeing what their attitudes are about a variety of subjects in the behavioral sciences. The Center takes one or two physicians a year who have been involved in medical care.

WEEKS:

You were also a visiting professor, weren't you?

SAWARD:

Yes, at Stanford. I did some minor things for the department of preventive medicine.

WEEKS:

The Fogarty International Center Task Force on Personal Health Services. Is that something you would like to speak about?

SAWARD:

That's quite a while ago. Fogarty had several meetings. Two of them

were about medical curriculum and its structure particularly during the period when the so-called student revolt was occurring across the world. The interactions between the students and their faculties and the public during those times, and the effect of making relevant curriculum were heavy agenda items. There was another Fogarty meeting, two other Fogarty meetings, on the development of position papers on preventive medicine and the general government effort in preventive health care, what role it played, and how to teach these subjects in medical school.

WEEKS:

I don't know whether you have said all you want to say about the Monroe Plan, The Foundation for Medical Care. I think you did mention something...

SAWARD:

The Monroe Plan was one of the three plans that started simultaneously in Rochester. It was sponsored by the medical society. It was what today we would call an IPA, but the term hadn't been invented then so it was called The Foundation for Medical Care.

WEEKS:

I wasn't sure of the nomenclature there.

We were talking about the National Academy of Sciences, on the panel of the disadvantaged.

SAWARD:

The Institute of Medicine in its formative period and in its early years, just as it does now, commissioned a variety of studies on what were at the time relevant health policy issues. I participated in the one on the disadvantaged -- what the health care needs were and what the most cost effective means were of ministering to the health needs of the disadvantaged.

WEEKS:

Among the disadvantaged did you include the uninsured and the underinsured, or the unemployed?

SAWARD:

No, the targets were those emphasized in the late 1960s.

WEEKS:

Do you have any thoughts on how that might be managed?

SAWARD:

Yes, indeed. The panel that started in 1968 ended in about 1971. The National Academy of Sciences took a strictly economic definition of the disadvantaged at the time. Today the problem is quite different with 35 million uninsured or significantly underinsured, or that can't meet their needs because of either employment or entitlement.

We have backed away from facing the problem by any legislative entitlement, as a matter of fact, the entitlement is shrinking from the legislative and regulatory standpoint all the while as both Medicare and Medicaid are progressively cut back. So we turn around and devise other means. During the first few years of the 1980s we covered a great deal of the disadvantaged by cost shifting. As the business community and the business coalitions for health care became disillusioned with this indirect tax upon them by cost shifting they demanded accountability. Cost shifting becomes progressively unsatisfactory as an answer to taking care of the disadvantaged. In New York State, for example, we are now taxing the health insurers, taxing the hospitals three and one-half percent of their gross revenue into a regional pool, and a statewide pool as well, for the coverage of the disadvantaged by hospitals. Again, mandatory. The point is you don't face up

to the problem and legislate entitlement. We regulate hospitals in a manner that produces funds. That can only be a temporary expedient. The employers are progressively concerned with having anybody else's insurance experience intermingled with those of their employees. These costs are stratified in society so that we have more and more people left out. It's all very well for the good risk employer to insist on experience rating, but for the bad risk employer to find a place to insure when he doesn't have a very profitable business in the first place, it become such that they are dropping out of the insurance pool altogether. Hence, the growth of the uninsured.

Self-insurance, as I understand it, now takes up roughly 35% of all employers who have more than a thousand employees. That takes a big chunk out of the community for risk taking. One has to understand that risks vary tremendously. In a program, such as the Kaiser program, one finds some groups -- all of them being insured at a community rate -- use five times the services that other groups do. If there is not a community rating these people will be progressively uninsured. This is what the problem of our time is: Whether the ERISA program has a beneficial effect by exempting employers from state regulation. I think is very doubtful. HMOs must community rate to be federally qualified.

WEEKS:

Have you read any data on the percentage of companies that have an ERISA program?

SAWARD:

As I said, the self-insured are exempt from state regulation so whatever they want to do... For example, mental health benefits are being progressively dropped by self-insured employers. They may not be dropped

entirely but they have dropped to a minimum benefit. So, they are having people left on the fringes again as far as mental health is concerned. For example, a state like New York legislates that all insurers in the state must provide a certain mental health benefit. Self-insured employers are exempt from that state regulation through ERISA. The more the state mandates, the more self-insurance occurs. We are splitting society apart instead of pulling it together as was the original intent of Blue Cross with its community rating program as it started out.

WEEKS:

There are many varieties of self-insurance.

SAWARD:

Yes. For example, HMOs are running into an interesting development from employers who are self-insured. Suppose, for example, that one-third of the employees of the ABC Company elect coverage in an HMO and the employer makes, as the federal law demands, equal contribution to that which he makes for the rest of his employees to the HMO. Some employers are saying that all the good risks join the HMO and leave the bad risks in the other two-thirds. Whether that is so or not they then want to experience rate the few that are in the HMO alone. This divisiveness of stratifying society to every possible subclass only paying for the risk experience is driving society apart as far as paying for health care. While I do believe competition does make for efficiency, competition at the present time is not only making for efficiency, it's making for a great lack of equity in our health care system.

WEEKS:

This competition should be on an equal basis?

SAWARD:

Alain Enthoven, who is one of my friends, started in 1977 trying to not only promote competition but promote a national program to have equity built into it. That is, that there would be a nationally recognized set of benefits. Those benefits would be provided across the board. Without a standard set of benefits, to have competition on nothing but price, just leads to progressive deterioration in the quality of health care coverage. You see equity going down the chute. At the present time it does not seem to be the primary concern either of state or federal bodies to insist on equity of coverage in health insurance.

WEEKS:

We just had an HMO bought out by MaxiCare, in Michigan. Recently the Michigan HMO had been acquired by an HMO in California which in turn was purchased by MaxiCare. (This is in addition to the acquisition of HealthAmerica, an HMO of Nashville, by MaxiCare.) The sellers are losing money on each deal. This is coming out of somebody's pocket. It seems to me that competition is going to get so keen among HMOs that many of them will bow out or fail and that all of them will be keeping their eyes on the profits at the cost of the benefits. This may be a case of seeing who survives. Am I wrong, do you think?

SAWARD:

I think you are quite right. I wrote an article that was published in the New England Journal of Medicine about this. I believe it was in April of 1982 about what eventuates from a for-profit HMO. They must be profitable. Because it must be profitable if the stock is to be attractive, the source of capital financing.

WEEKS:

Do you think the not-for-profit HMOs are going to be the survivors?

SAWARD:

It is very hard to tell at the present time. We are dealing in a situation where standards are held in abeyance. It is my understanding that this administration wants to do away with the HMO Act, and is actively pursuing that course. If the federal HMO act goes and we are without any standards, it is going to be quite a jungle.

WEEKS:

All HMOs do not operate at federal standards, do they?

SAWARD:

At the present time, the majority of people in HMOs in the United States are in federally qualified HMOs.

WEEKS:

This is the important thing.

Incidentally, we were talking about data banks. Are you familiar with the data bank of the HCA, the Hospital Corporation of America?

SAWARD:

Yes, in general.

WEEKS:

That is for their own hospital?

SAWARD:

That's right.

WEEKS:

I talked with Dr. Frist, Sr. a couple of years ago and he said that at that time they had not extended it to all their hospitals but they hoped to

have a data bank complete on every patient, inpatient. I don't know what they were going to do about data on outpatients.

What is going to happen with all these separate data banks that are being developed unless they can be interchanged or made available to each other?

SAWARD:

Let me speak of data banks in the hospitals, in hospital systems. Let me contrast the kind of information that's in them, compared to what can be had in HMO data banks. For example, Strong Memorial Hospital has detailed information on all admissions on tape for the entire process for the patient's care in hospital, as well as the costing -- by price, not by cost -- by price in the system. In as much as Strong Memorial Hospital's patients come from a diverse and unknown population, you can find out a lot about the hospital, you can find out a lot about certain morbidities that are in the hospital, but you cannot find out community-wide data, let alone anything beyond that. Nor can you find out anything about the incidence of those morbidities, because you don't know what population they have come from. This is true of all hospital based systems. They don't have a backup of a denominator. In other words you could study the numerator of the equation with a great deal of detail but if you had no denominator you can't get rates.

WEEKS:

This is the CPHA type of approach.

SAWARD:

To have anything meaningful as to population you have to have the denominator as well, not just the numerator. The Hospital Corporation of America has hospitals over a wide area, has no idea who it has or who it doesn't have from the population from which it draws. That is where the

usefulness of that kind of material is. We have had hospital data for a long time -- since we have had computers. I can remember going to Billings in Chicago in the fifties and watching them handling the punch cards. In those days it was a punch card, IBM. That kind of information has been around a long time -- no denominator. Until it has a denominator it doesn't tell us about utilization, rates, it doesn't tell us about the cost of populations, it really doesn't give us epidemiology at all. That's what an HMO can do because it has a finite population. To do that you have to set up your basic population data system. Once you have it set up, the maintenance is relatively straightforward.

WEEKS:

I shall pose a question you may wish to respond to. In many of these health care plans, the member of the group covered by insurance may receive a bonus in return for not having used facilities. Should that bonus be taxed? Should Blue Cross be taxed?

SAWARD:

You are posing a series of problems. Let me see if I can clarify the first one. Are you asking, for example, should non-smokers get a lower rate or some sort of bonus?

WEEKS:

I know that has been attempted but I don't know how it can be controlled.

SAWARD:

In truth it hasn't been a very feasible set to activate because it assumes the individual being individually insured rather than group insured, which is the dominant way of insurance in the United States.

The question of whether Blue Cross should be taxed. I don't quite

understand the politics of what has happened here. It seems to me that Blue Cross was performing a particular service. The Blue Cross plans with which I am most familiar (New York) do take individual members regardless of risk in an open enrollment. In doing so they perform a public service. I think, indeed, not taxing them has been an offset against that particular actuarial risk of having individual open enrollment. My own personal feeling is I don't understand -- I understand the necessities of budget to come under the Gramm-Rudman ceilings but quite apart from that I don't understand their picking on a nonprofit program such as Blue Cross to have its premium taxed. If I understand correctly, these things seem to be unsettled yet until I read it in print and it is all over and signed. They are not taxing the reserves they have, they are only taxing additions to reserves. To the extent that Blue Cross has three months of reserve, for example, and maintains that, simply maintains it, if I understand the present compromise, it won't be taxed. Additions to reserves would be taxed. I understand it is on a 20% rate for the first additions and then the second step beyond that would be to the maximum corporate rate under the new tax law.

WEEKS:

You are talking about a tax at the federal level. Michigan has had Blue Cross trouble. The plan has a director who is quite pugnacious and gets into the news quite often. I think it has gotten to be a political question rather than a question of good policy.

I think your argument about the enrollment of individual members or people who might be a bad risk is to the credit of Blue Cross.

SAWARD:

Certainly they are performing a public service when you take the

individual enrollment and compare it with the balance of the Blue Cross plan it is 60% more use in hospital days.

WEEKS:

Did the Kaiser plan cover the retirees?

SAWARD:

Before Medicare we had the same coverage for everyone regardless of age. Since Medicare we have had, as Blue Cross does, a medigap policy and we take care of them. We have had demonstration programs in the last five or six years now, demonstrating the risk Medicare contracts. The only program that has a contract now is Kaiser Portland. They have in the neighborhood of 25,000 people on the risk contract.

I would like to say a bit more about Rochester. While the Kaiser experience is fascinating, in a sense the Kaiser experience is not as absolutely a typical experience as today's HMOs. Today's HMOs are a different breed of horse from what Kaiser was, or what Group Health Coop of Puget Sound was, or what Harvard Community Health Plan was, or some of the others. We have had a good deal of deviation from the original prepaid group practice model of what is now called an HMO. This is very deliberate policy making. Paul Ellwood wanted this from the start of HMO policy, to make it as diverse as possible. He couldn't be any more happy, I believe, in the diversity he has gotten. The question is: Is all this diversity of the same coinage, or isn't it? Are we dealing with Gresham's law, or not? Bad currency drives out good currency. I myself have concerns about that in HMOs. When I say what Kaiser has done, I have tried to explain some of the motivations that we had in Kaiser Portland. It certainly is not typical of what is going on now. They are being run as profitable businesses essentially. There is quite a

distance between those two objectives in running, as I have said repeatedly, something that is for the benefit of the members as essentially a consumer cooperative contracting with a producer cooperative. The format of the Kaiser plan has been very stable and very successful as we see it in the Pacific Northwest, California, et cetera. The essence of it is there are many variations today on what an HMO is. I don't think they all will be successful survivors. I think some of them are hazardous to your health.

In Rochester we tackled things not from the standpoint of any institution. I think you know that I am based in an institution, the medical school and Strong Memorial Hospital. We almost never talk about that. When we are talking about Rochester, we are talking about it as a community! Rochester's emphasis, and repeated emphasis, on trying to make community decisions on health care, and including everybody in our decisions, has not only had this result of low cost as I detailed before, but the very high penetration, and the very low number of people who come in as uncovered patients to our institutions. Between that and our spreading the safety net of very extensive home care, our hospice, and institutional beds of every kind in our community is, I think, the way I would like to see the country go. I don't think I can think of one national solution for every region, every town, everywhere. I would like to see regions do what our Finger Lakes Health Agency has done for its region, really work out a system that applies to that geographic area in a real sense of community so the people are not left out. We have had relatively few unmet health needs in our health planning area, and we have managed to do them at costs less than the national average, and provide much better coverage. That's the kind of program I would like to see us engage in. That's what the Comprehensive Health Planning Act was, though

very premature, trying to get at. The second thing that was wrong with the Comprehensive Health Planning Act, aside from the fact that it didn't have teeth because they were all taken out as part of legislative compromise, the second thing that was wrong was it started to be over regulated by the federal government with what they would and wouldn't accept. It can't be that and be regional at the same time. The strength of the thing is the title of Mr. Folsom's book, Health is a Community Affair. I believe the concept that health is a community affair is very important. I had it brought home to me again in England last fall when I was there as a visiting professor for the fall semester. To be sure there is a national medical system and that there are fourteen regions of the National Health Service. The Trent region, which I visited, had five million people. The Trent region and its districts are very busy making programs for the region and its districts of that health system that are within the rules of the National Health Service and within its funding, but adaptable to that region. They have done very well at that. Those are not cross-sectionally uniform across the United Kingdom. I don't mean that the entitlement isn't uniform, but the local way they have adapted to providing services shows how they have reached out even within a national system to do it.

The Swedish counties -- except the most northern ones which can get a central subsidy from the national government -- are self-financing. The county council makes the rules. Believe me, that makes for a very great focus of local interest in what they have and what they haven't. I do think the regional approach with great local involvement and truly community participation is essential to giving health care. Without it you have great misfits. You can't have all people wear size eight shoes though that's the

average size.

WEEKS:

I am sure if one traveled about our country he would find out how diverse some of our areas are. As an example, we have a friend who went with Health America in Nashville. A young woman with the university. She has been down there two or three years and still doesn't feel at home because she is a northerner. They have different ways of doing things, and different ways of accepting persons from outside the region. Too, if they have different ways of doing things at that level, they must have at operational levels in anything. You have to atune your program to that sort of situation.

SAWARD:

I had a fine example to that in 1978-1979, the year when I was at Stanford. The Western Center for Health Planning located in San Francisco, knowing that I had been instrumental in helping get this planning act, and knowing that I was an active leader of Rochester's agency, sent me around to the health system agencies, mostly in the southwest part of the United States -- San Diego, Phoenix, Denver, various health systems agencies. I nearly got lynched! What was community cooperation in Rochester was communism in Phoenix. Getting people to involve themselves and cooperate in doing things -- they weren't buying that at all. The fact that we had in Rochester some control of our health care costs in '78 and '79, I assure you that they didn't at all in Arizona. I had members of their board of directors come up and put their fingers on my chest and say, "You mean there are some health things we shouldn't vote for?" -- with the greatest skepticism like voting against the American flag.

WEEKS:

When you stop to think about it, after nearly twenty years, Arizona just recently adopted Medicaid.

SAWARD:

That's right. It's Access program is only four years old.

I emphasize local and regional heavy input into health systems design, obviously with some standards. And obviously with equity in resource commitment. There has to be some sound kind of equity of resource commitment.

WEEKS:

Also competent staffing. A friend and I were talking the other day about planning agencies. Are there some 200 in the country?

SAWARD:

There used to be. There are about seventy left.

WEEKS:

The question I asked my friend was: Were there 200 persons who were capable of directing programs such as that? With suitable background, and that sort of thing? The answer was necessarily no.

SAWARD:

Obviously not.

WEEKS:

You are off on a collision course right away.

Do you want to say something more about Rochester?

SAWARD:

In doing our health planning agency as it came into being at the end of 1974 through the legislation, the goal we had in mind in helping write the act was that of a regional health authority -- to call it that so not to confuse

it with what actually happened. To have a regional health authority to control hospital reimbursement, that could decertify beds as well as add on, that had some power with it, was what our intent was. But the intent was lost in the legislation and the rules that came with it. That's why we had to go back into the hospital experimental payment program which gave us reasonable local authority, that gave hospital control and could decertify beds and could stop unnecessary duplication of equipment. We got to carry out our plan of community planning. We feel, regardless of how other people feel, we feel that is what has given us control of a cost-effective, high quality system. Nobody has ever complained that the quality of care in Rochester was anything but above average. First of all we have a relatively small town, 700,000 people, and with a medical school that has 900 staff and dominates the town completely. You have to control costs when you have a medical school dominating the community. It's difficult, to say the least. But we have done it.

WEEKS:

What is the connection between the medical school and Strong Memorial Hospital?

SAWARD:

The university owns Strong Memorial, wholly owned. The way it was set up until just recently was that the dean of the medical school was the director of Strong Memorial Hospital. He delegated that to a hospital administrator, but he had the final say.

WEEKS:

The administrator reports to him. We have gone through this here in Michigan. We still have the dean of the medical school and the administrator

of the hospital and the director of the nursing school all trying to work together -- let's say it that way. There is always likely to be a conflict over sources of power, regulating residents, and this sort of thing where education enters into the operation of a hospital.

SAWARD:

We have gone from what I call the simple fundamental titles that prevailed for fifty years and now there are vice presidents of various things.

The top of the health care side is held simultaneously by the dean of the medical school and the vice president for medical affairs, one and the same person.

WEEKS:

Do you have a group of health science schools? Is there a division including dentistry, pharmacy, and public health?

SAWARD:

We don't have any of those schools.

WEEKS:

That solves the problem.

SAWARD:

That solves the problem. We do have a nursing school.

WEEKS:

You explained the dentistry school earlier.

I want to say just a word about Dr. Esselstyn. He was active in the group you were in of physicians who wanted Medicare under Social Security.

SAWARD:

He was the leader of it. First of all, Dr. Esselstyn and I were close personal friends over a long period. Dr. Esselstyn published in the New

England Journal in 1953 an article about the Rip Van Winkle Clinic which embryonically was a prepaid group practice. It didn't have more than a couple hundred members. Really just an embryo. The arguments for it were stated very clearly in his article. Obviously I was operating such an organization. A much larger one at the time. I immediately communicated with Essie. Essie and I became friends. We engaged in starting what is today the Group Health Association of America together, and a whole variety of other activities together. He was president of it at one time and I was president of it later. All of that kind of thing.

Throughout his life -- I forget what year he died, but around 1975 -- we were close friends. Interestingly enough, I had never really had other than the most casual contact with his wife during his lifetime, and really didn't know her as a person. Since he died it has turned out that I am probably the chief consultant for the Esselstyn Foundation. I am on the telephone once a week to Lillian, his wife, who runs this foundation. We have these conferences at Claverack, New York and publish the results. It's a very minor foundation, not a grant giving, but it's a very worthwhile endeavor that perpetuates the diverse health interests that Essie was involved in. For example, last May we had a very distinguished group of Canadians down, obviously people who were very knowledgeable of what the Canadians can learn of what is going on in the United States and make themselves more efficient. For example, by our standards they are overhospitalized. How can they bring that under control? We had a very nice conference and published a nice paper from it -- maybe 70 or 80 pages. So, I have been very much involved with the

Esselstyn Foundation after Essie died. It has been a pleasure to me to do this. In fact, I loved Essie. He was a great guy, a marvelous raconteur. He could tell stories all night long. Did you know him?

WEEKS:

I didn't know him. The reason I asked you about him was that I had heard so much. I think his son married a daughter of George Crile, Jr.

SAWARD:

That's right. He is at the Cleveland Clinic.

WEEKS:

After the death of his first wife, Dr. Crile, Jr. married Carl Sandburg's daughter Helga.

SAWARD:

So I have had a lot to do with the Esselstyn Foundation, at this stage of my career because Lillian more or less relies on me to help run the thing, if you know what I mean. She is not a professional and she doesn't know the people around the country. I do it mostly by telephone.

WEEKS:

It is nice that she has you to lean on.

SAWARD:

She lives at the farm. The farm has been in the family for 300 years -- near Claverack, New York -- an original Dutch land grant. Esselstyn, of course, is a Dutch name. She is either there or she is in Cleveland to be near her son. Right now I think she is in Cleveland for the winter.

WEEKS:

We are getting down near closing time.

SAWARD:

I am ready to quit if you are.

Interview in Ann Arbor

October 16, 1986

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