



**JOHN ROBERT MANNIX**

**In First Person: An Oral History**

**Lewis E. Weeks  
Editor**

**HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION  
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REMARKS OF THE AMERICAN HOSPITAL ASSOCIATION  
ON THE OCCASION OF THE DEATH OF  
JOHN ROBERT MANNIX  
MAY 15, 1968  
CHICAGO, ILLINOIS

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John R. **Mannix**

## CHRONOLOGY

1902	born in Cleveland, June 4
1921-1926	Mt. Sinai Hospital, Cleveland, Supervisor of Services
1926-1930	Elyria (Ohio) Memorial Hospital, Superintendent
1930-1939	University Hospitals, Cleveland, Assistant Director
1933-1934	Cleveland Hospital Service Association (now Blue Cross of Northeast Ohio), Chairman of Organizing Committee
1933-1939	Cleveland Hospital Service Association, Chairman of Hospital Advisory Committee
1939-1944	Michigan Society for Group Hospitalization (Blue Cross), Chief Executive Officer
1944-1946	Chicago Hospital Services Corporation (Blue Cross), Chief Executive Officer
1946-1948	John Marshall Insurance Company, President
1948-1965	Cleveland Hospital Service Association (now Blue Cross of Northeast Ohio), Executive Vice President
1959-1961	AHA-USPHS Areawide Planning for Health Facilities committee, Member
1965-1972	Blue Cross of Northeast Ohio, Vice President for Research and Planning
1965-	Consultant

## AFFILIATION & MEMBERSHIPS

American Association of Health Data Systems, First President, 1971,  
Honorary Charter Member

American College of Hospital Administrators, Charter Life Fellow,  
Vice President, 1935-1936

American Hospital Association, Life Member, 1924

Blue Cross Association, Board of Governors, 1956-1966; Executive Committee,  
Member, 1957-1962

Blue Cross Commission, Vice Chairman, 1941; Commissioner, 1941-1946;  
Chairman, 1945-1946

Case Western Reserve University, Lecturer in School of Medicine and School of  
Library Science, Visiting Committee, Member, 1960-1965

Chicago Hospital Council, Member, 1944-1946

Cleveland Athletic Club, Member, 1952-

Cleveland Catholic Counseling Center, Advisory Committee, Member 1958-1971

Cleveland Chamber of Commerce, Member, 1948-

Cleveland Citizens Hospital Study Committee, Member, 1955-1962

Cleveland Health Council, Member, 1958-1967

Cleveland Health Goals Committee, Member, 1961-1967

Cleveland Jennings Home, Advisory Committee, 1960-1970

Detroit Hospital Council, Member, 1939-1944

Greater Cleveland Hospital Association, Member, 1921-1939; 1948-

Health Forum of Northeast Ohio, Organizer and Conductor, 1973-

Health Service, Inc. Hospital Advisory Committee, Member, 1941-1945

Illinois Hospital Association, Member, 1944-1946

Kellogg Foundation, Hospital Advisory Committee, Member, 1941-1945

Metropolitan Health Planning Corporation, Cleveland, Member

Michigan Hospital Association, Member, 1939-1944

Minnesota, University of, Lecturer in Hospital Administration, 1946-1968;  
Honorary Alumnus, Hospital Administration, 1965

Modern Hospital, Editorial Board, Member, 1939-1946

Northeast Ohio Regional Medical Program

Ohio Department of Health, Committee on the Feasibility of Central Statistics,  
Member, 1966-1967

Ohio Governor's Insurance Advisory Committee, Member, 1963-1964

Ohio Hospital Association, Honorary Member, 1924; Executive Secretary,  
1927-1932; President, 1933-1934

Ohio State Advisory Council, Hospital and Medical Facilities, Member,  
1963-1972

Ohio State University, Lecturer in Hospital Administration, Honorary  
Alumnus, 1972

AWARDS

Academy of Medicine of Cleveland

Distiguished Service Award, 1979

American Hospital Association

Justin Ford Kimball Award, 1972

American Hospital Association

Trustees' Award, 1964

Cleveland Clinic Foundation

Distinguished Fellowship, 1972

Greater Cleveland Hospital Association

Distinguished Service Award, 1976

Ohio Hospital Association

Distinguished Service Award, 1978

Ohio Public Health Association

Certificate of Honor, 1971



MANNIX:

I was born here in Cleveland June 4, 1902. When I finished high school, I took a position at Mount Sinai Hospital in Cleveland. Frank E. Chapman was hospital administrator there at that time. He tended to take me under his wing. He was one of the few business-oriented people serving as a hospital executive, although I was not at all aware of this at the time.

In the 1920s the larger hospitals of 300 beds or more were generally administered by doctors of medicine who for one reason or another had given up the practice of medicine. Many of the medium-sized hospitals of 100 to 300 beds were religious hospitals. If they were Catholic hospitals, they were administered by Catholic sisters. The Protestant hospitals were often administered by ministers. The smaller hospitals of 100 beds or less were, for the most part, administered by nurses. I am generalizing, but it is surprising in looking back on it later, how true that was.

I worked at Mount Sinai a couple months during the summer and then told Frank Chapman I was going back to school. He said, "I want to talk to you about that."

He was a very persuasive man. He called me into his office and talked to me about a career in hospital administration. As far as I was concerned,

hospitals were operated by doctors, sisters, ministers and nurses -- and he was the very, very rare exception. I felt the future of hospital administration was in the hands of physicians. I also felt that anyone other than a physician without a knowledge of medicine would not have much success in the long run in hospital administration. Incidentally, I continued to feel that way until World War II, which I will discuss later. This situation, in my opinion, changed in World War II.

I finally agreed that I would stay at Mount Sinai one more year. I felt that if I still wanted to go to college then, I would not have lost much time by this trial. I stayed another year, and although I was only 18 at that time, I moved from one position to another at Mount Sinai. I actually did some work in most every department. This type of exposure is not possible in a hospital today. By the time another year rolled around, I had the title of supervisor of services. Today we would call it vice president of the hospital in terms of duties I was responsible for.

#### HOSPITAL PRICING - INCLUSIVE RATES

During the part of the first year I worked in the accounting department. I had no previous knowledge of accounting, but I have always had a natural mathematical bent. I had observed that the concern about the cost of hospital care was generally regarding the cost of the ancillary services. A patient at that time would occupy a private room for five dollars a day for ten days and expect to get a bill for \$50, but get a bill for \$100 because there would be operating room, x-ray, laboratory, drug, and other ancillary services. Very often, particularly with laboratory and drugs, the patients did not even know

they had had these services. Next, I observed that two-thirds of the hospital income was coming from the room rate rather than from all the ancillary services. There would be one charge for the room rate and ten or twelve others for the ancillary services. So, there would be one charge for the room rate and ten or twelve others for the extras.

I decided that this did not make any sense, that we should raise the daily service charge and eliminate a lot of these extra charges. I did a lot of work on this to demonstrate the facts and then talked to Frank Chapman about it. I proposed, to begin with, to eliminate the charges for x-ray and laboratory services and increase the daily service charge. The pathologist was on a salary basis and therefore he was not concerned about this. However, the radiologist received a percentage of the fees, and he did not want any change.

In late 1923, we eliminated the laboratory charges and increased the room rate. The laboratory income was averaging about 35¢ a patient day. We raised the room rate service charge 50¢ a day and eliminated the laboratory charge. This was a very simple thing in itself, but it led to many other considerations. I realized the potential here and started talking about an all-inclusive rate system of having a single daily rate for all hospital services eliminating all ancillary charges. At first, I did not quite know how to go about this because of the great variety of services the patients received. I finally decided that we should do this for patients with a couple of typical diagnoses.

ELYRIA - 1926-1930

While I was working on this in May 1926, I had a call late one Saturday

at home from Chapman. He asked me if I could come out to his home that evening. I kept the appointment wondering what I had done wrong. This was prior to my twenty-fourth birthday, by the way. He wanted to know how I would like to run a hospital. I could not believe I was hearing this. He told me that Elyria Memorial Hospital, twenty-five miles west of Cleveland, had a medical administrator who was leaving to become administrator of a hospital in Chicago, and they wanted a new administrator. They had contacted Chapman, who had done consulting for them. He wished to recommend me for this position. I was actually scared to death to take on this responsibility, but I went out and talked to the board of trustees and was employed. I became the administrator of Elyria Memorial Hospital in June 1926.

I wish to come back now to this inclusive rate idea. One of the early things I did in Elyria was to decide that for two typical diagnoses we would have one rate for the complete stay of the patient. I chose the two most frequent diagnoses: maternity care and tonsillectomies. I established one rate, incidentally it happened to be \$55 for ten days of maternity care including the care of the mother and the infant, delivery room, and anesthesia. The tonsillectomy rate was \$15; this included all necessary services for one day of care.

I realized that I was taking the charges for extras and dividing them up equally among all people who were hospitalized and that I could extend this to all patients regardless of diagnosis.

UNIVERSITY HOSPITALS - CLEVELAND - 1930-1936

Four years later, in 1930, Frank Chapman became the administrator of

University Hospitals in Cleveland. This, incidentally, was one of the first multi-hospital systems in the country. University Hospitals included Lakeside Hospital, which was a medical and surgical unit; Maternity Hospital, which was a maternity hospital; Babies and Children's Hospital, which was a pediatric institution; and Rainbow Hospital, which was a convalescent children's hospital. Lakeside, Maternity, and Babies and Children's were all located in different parts of the city, although they all had affiliations with the Western Reserve medical school. New buildings were built on the university campus. We talk about multi-hospital systems in the 1970s and 1980s -- this really was a multi-hospital system. Chapman became the administrator. He called me and invited me to become his associate, which I did in July 1930.

In July 1932, I established a complete inclusive rate system at University Hospitals, eliminating all charges for ancillary services. We had one rate system which varied only by the type of accommodation, whether it was a private room, semi-private, or ward accommodation. To begin with, we offered the patients the choice of the day rate plus extras or the inclusive rate. It is very interesting that 92 percent of all patients from the first month chose the inclusive rate. This system was in effect at University Hospitals for close to 50 years, although they made some changes in this about two years ago.

In this process, I realized that I was taking the cost of all extra services and dividing it among all persons hospitalized regardless of the use of these services by the individual patient. It occurred to me while I was still in Elyria that I could carry the law of averages two steps further. Instead of just taking the day rate plus extras and dividing it among people

hospitalized, I could take the day rate plus extras and divide it among all people, whether they were hospitalized or not. This is the Blue Cross of today.

Incidentally, with that point I thought I had an entirely new idea for financing hospital care on a periodic payment plan basis. Since that time I discovered that the history of health insurance goes back to the seventeenth century.

I attempted to establish a prepayment plan for hospital care in Elyria in 1929. I had all of the details of this worked out and presented it to the board of trustees of Elyria Memorial Hospital in November 1929. They decided to delay this temporarily because of the stock market collapse in October of that year.

Six months later when I returned to Cleveland, I again attempted to develop a program for prepayment of care. I was only twenty-eight then and got the reaction from hospital administrators and physicians that this John Mannix was a nice young fellow, but he had a wild idea about financing hospital care, so don't get him on that subject! The interesting part of this is that when we started the prepayment program in Cleveland in June 1934, I was considered by some as a Communist out to socialize medicine. The detail of this is most interesting.

#### EARLY HEALTH INSURANCE PROPOSALS

WEEKS:

Did Ohio enter into the American Association of Labor Legislation model bill that they were trying to get through state legislatures for compulsory

health insurance? It must have been about that time, wasn't it?

MANNIX:

That actually occurred before World War I, roughly between 1913 and 1918. I got into the health field in 1921, but it wasn't until some years later that I heard about that. Before World War I, I was only fifteen and this type of activity had no interest for me. One of the interesting aspects of this early movement was that many of the leaders in medicine were much interested in the proposed legislation, including Dr. S. S. Goldwater of New York, who had been the City Health Commissioner in New York City and later became the head of Mount Sinai Hospital in New York and still later president of Blue Cross in New York City. There were many other health leaders interested in this, but this interest prior to World War I seemed to be forgotten during the war period.

There was one other interesting historical situation that I learned of later. I believe it was in 1919 that the House of Delegates of the American Medical Association passed a resolution advocating national health insurance. Very reputable physicians supported this.

The attitude of the AMA House of Delegates later changed. In 1922 the House of Delegates rescinded the 1919 action. There is some reason to believe--this is historically interesting--that the young doctors coming back from the war opposed the earlier action and had it rescinded. It seems that it was the older physicians who were liberal at that point and the younger physicians who were more conservative, which is just the opposite of what is normally true.

The American Medical Association continued to be opposed to national health insurance for many years following that.

There is one other piece of history that is important. In 1928, a Committee on the Cost of Medical Care was established. Rufus Rorem was a member of the staff. It was financed by foundations. They ultimately published twenty-eight volumes; the final volume was published in 1932. This covered the recommendations of the committee, including among other things experimentation with prepayment for hospital care. There was a minority report of physicians which opposed this.

EARLY BLUE CROSS - 1934

One of the strong members of the Committee on the Cost of Medical Care was Dr. George Follansbee of Cleveland, who also was the surgeon for American Steel and Wire, a division of U.S. Steel. He supported the minority section of the report, however, he helped more than any other physician when I became interested in starting a prepayment program in Cleveland. When I was developing the program in 1933, I went to Follansbee, who was then chairman of the Finance Committee of the Cleveland Academy of Medicine. He was a very much admired progressive physician. He was also chairman of the Judiciary Committee of the American Medical Association. I told him I would like to develop an experiment in connection with financing hospital care. I did not want the Academy of Medicine to approve it, but I hoped they would not oppose the experiment. The Cleveland Academy of Medicine Board of Directors approved an experiment in the financing of hospital care on a periodic payment plan basis with the provision that the principle not be extended to medical care.

The Plan in Cleveland was started and has been very successful. An interesting aspect to me when I review the history of Blue Cross is that I



have always thought of seven Plans starting at about the same time: one in Newark, New Jersey; one in Washington, D.C.; Durham, North Carolina; New Orleans; the Cleveland Plan; the St. Paul Plan; and the Plan at Sacramento, California. These Plans were all started within about eighteen months of each other. While I later got to know all six of the individuals who took the leadership of the Plans, none of us knew each other at that time. That was a perfect demonstration of an idea whose time had come. I think the report of the Committee on the Cost of Medical Care accelerated this, but all of us were working on the idea without any particular knowledge of what the Committee was doing or what they were likely to recommend. I do not believe that the six men who were interested in developing the other Plans had any more knowledge of the earlier history than I did. We all thought we had come up with a new, logical, and sound idea by independent actions in seven widely separated parts of the country.

Rufus Rorem was at the Julius Rosenwald Fund at that time. The foundation decided to make a contribution to the American Hospital Association to support the development of prepayment. Rufus joined the AHA about 1937. I can remember very well back in the 1934 to 1936 period when a group of us, probably not more than ten or twelve people, who were attending the annual meetings of the AHA and who were interested in this idea of prepayment of hospital care would get together in a hotel room during the course of the AHA meeting and talk about what we were doing. This led to the Commission on Hospital Service Plans.

The Commission was to be a coordinating agency for these Plans. There was strong opinion that there should be some approval of Plans which met certain standards. In 1938, I believe, they asked the AHA to set up the approval

program. It was decided they should have some kind of symbol the approved Plans could use. E. A. van Steenwyk, who was the executive of the Plan in St. Paul, had been using a blue cross on its stationery, however he did not use the term "blue cross." Someone decided, and there apparently is no record of who suggested it, that the AHA should adopt the blue cross as a symbol of approval and superimpose on it the seal of the American Hospital Association. I cannot find anywhere, although the action was taken in 1938, that anyone used the term "blue cross" until about 1942. They had been using the Blue Cross symbol without actually referring to it as Blue Cross. The original publications of the American Hospital Association indicate that the first time the term "Blue Cross" was used in print was about 1942. The switch to the corporate name of Blue Cross is fairly recent. Many Plans were using the term Blue Cross in the late 1940s and 1950s but still using their original corporate name.

#### CLEVELAND BLUE CROSS

In 1931 and 1932, I attempted to have the hospitals take some official action here in developing a prepayment plan. I was not making much headway. However, in November, 1932, and I think only because I continued to press this, the Cleveland Hospital Council, which was the local association of hospitals, now known as the Greater Cleveland Hospital Association, decided to appoint a committee to study the development of a program for the prepayment of hospital care in Cleveland. As so often happens, as much as I agitated this, I was appointed chairman. We had a committee of three people. The other members were Dr. Woods, who was the administrator of St. Luke's Hospital; and Dr. Rockwood, the administrator of Mount Sinai Hospital, who had

succeeded Frank Chapman when Chapman went to University Hospitals. The three of us worked for eighteen months, from November 1932 until June 1934, establishing the Plan. I had no intent or interest at that point in becoming connected with Blue Cross as a paid employee. My interest was in hospital management; I thought of this as my future.

We had the problem of finding an executive for this new organization. With a large number of Americans out of work during this depression period, there was no scarcity of applicants. I felt this idea was so new that we should hire somebody who knew not only something about the hospital and health field, but someone who had promotional ability.

At that time John McNamara was editor of Modern Hospital magazine. I recommended him for this position, which he ultimately accepted, and he was very successful. In a very short time the Plan became the largest in the country from an enrollment standpoint. From 1934 to 1939, because I was chairman of the committee that started the Cleveland Plan, I was called upon by a great many people around the country, mostly hospital people, to help them with something along these lines. I had some part in starting all the Ohio Plans; Akron, Youngstown, Toledo, Columbus, and Cincinnati. In every one of these places, I met with key people at their request. I paid my own expenses in most cases because I was interested in the idea.

I also met with people in Rochester, Chicago, Des Moines, and Indianapolis and had some part in the development of those Plans. This was during the time I was associate administrator at University Hospitals. I did this on a gratis basis and in most cases paid my own expenses.

I ran into many interesting things in those local meetings. It was not unusual to have somebody get up in the audience and say "What are you getting

out of this?" There was disbelief that someone was just interested in the idea.

Frank Chapman died in 1931, less than a year after I went to University Hospitals. I was in a key position there and only twenty-nine at the time. His death momentarily threw a great responsibility on me at the hospitals. The board of University Hospitals appointed Robert H. Bishop, M.D. as the administrator. Dr. Bishop had been the administrator of Lakeside Hospital ten years previously. He was a son-in-law of Samuel Mather, who financed the building of Western Reserve medical school and Lakeside Hospital. Bishop became the hospital administrator, and I continued as his associate from 1932 to 1939.

Bishop, incidentally, was very helpful to me, granting me time to develop the prepayment idea. He became extremely interested and was willing to grant me an endless amount of time the 1930s to work with others in this connection.

Bishop was responsible for the development of many very original health activities in Cleveland. He always insisted on taking a background position; he never wanted to be out in front on any of these activities. In my opinion, he believed he was much more effective in the background, and I think this was true. There are scores of developments in the health field in Cleveland Bishop originated and saw through which hardly anybody in the town ever associated with him.

#### PIONEERING IN CLEVELAND

WEEKS:

As I remember from some of your previous conversations, Cleveland in

particular and Ohio in general were way ahead of the whole hospital field for a long time, weren't they?

MANNIX:

Yes, before I entered the hospital field in 1921, there had been a number of interesting early developments in Cleveland. First of all, the American Hospital Association was formed here in 1899. It had its first meeting at the Colonial Hotel, which is just a block from my present office. There were only eight persons at that first meeting; four of them were Clevelanders. There were also representatives from Detroit and Pittsburgh at what was when called the Association of Hospital Superintendents. The name was later changed to the American Hospital Association. The leader was Dr. James S. Knowles, who became the first president of AHA (no relation to Dr. John Knowles, by the way), He was the administrator of Lakeside Hospital, which later became a part of University Hospitals of Cleveland.

In 1916, the first state association in the country, the Ohio Hospital Association, was started. The first meeting was held at Cedar Point, which is a resort west of Cleveland. In that same year, a group of Clevelanders started what they called the Cleveland Hospital Council, which is now the Greater Cleveland Hospital Association. It was some years before any other state association was started and still later before any local group of hospitals started.

I remember my earlier years in the field when the talk around the country at meetings of the AHA was about things we were doing at the Cleveland Hospital Council. I hesitated to elaborate because other hospital executives did not seem to believe that extensive cooperation among hospitals in the public interest existed in Cleveland. There was a time when the Cleveland

Hospital Council had a greater full-time staff than the AHA.

WEEKS:

Is this the proper place to bring in your idea about the auto accident fund?

MANNIX:

We will discuss that later.

One action in Cleveland is interesting in light of the development of Health Systems Agencies (HSAs). In 1919 a study of health facilities in Cleveland was made by Haven Emerson, who was with the School of Public Health at Columbia and a book of over 1,000 pages was issued outlining a plan for hospital facilities in the area. I am quite sure this preceded any other facilities plan for a metropolitan area by several years. My point here is that there was a great deal of leadership in the health field in the Cleveland area, particularly in cooperation between institutions as reflected in the development of the American Hospital Association, the Ohio Hospital Association, the Cleveland Hospital Council, and this very early planning document. This happened thirty years before most people elsewhere started thinking about planning on a communitywide basis.

You asked about the automobile accident fund. In 1927, I became the secretary (on a voluntary part-time basis) of the Ohio Hospital Association. I continued as secretary for five years when I was elected its president.

One of the big problems at that time was payment for care of automobile accident victims. Hospital patients were very unhappy that they had been in an automobile accident in the first place. The persons injured felt that the persons responsible for the accident should pay for it. It was very difficult to collect at all for this care. I made a study of the cost of caring for

automobile accident patients in about 1930. This showed an annual cost of just under \$5 million, as I remember it, for all hospitals in the state. I felt there should be some way of spreading this cost over the people of the state. I proposed that the cost of this care be paid for out of the motor vehicle fund, which was a state fund of the automobile license tag fees. I developed a brochure at that time in which I argued that if the automobile license fund was used to repair roads which were damaged by automobiles, it was proper to use that same fund to pay for hospital and medical care of people who were injured on those same roads. This proved to be a very effective argument with the legislature, and the motor vehicle accident law which we originally introduced in 1932 was passed in 1934. This law is still in effect.

There is another interesting aspect of this that is related. In 1912 the Ohio Industrial Commission Act was passed in Ohio which provided for care of workers injured in industrial accidents. This is a fund administered by the Ohio Industrial Commission, a division of state government. Beginning in 1912, hospitals were paid \$3 a day for hospital care of injured workers, which was a reasonable rate in 1912. By 1918 and World War I, costs were running over \$5 a day, and hospitals were taking a loss on the care of industrial accident cases. The Ohio Hospital Association, after a series of negotiations with the Ohio Industrial Commission, persuaded the Commission to reimburse hospitals for the cost of care not to exceed \$6 a day. This required filing with the state department of health a uniform annual report in which the cost had to be certified. This, I am certain, was the first use of reimbursement for hospital care on a cost basis in the country.

I mention this in connection with the motor vehicle accident law because,

while that cost payment was a regulation of the Industrial Commission, the motor vehicle accident law provided for reimbursement on a cost basis. This cost method was later adopted by the federal government in connection with the Emergency Maternity and Infant Care Act during World War II and later in connection with Medicare in 1966. Again, this was an indication of the early pioneering.

AMERICAN HOSPITAL ASSOCIATION REORGANIZATION

As I mentioned earlier, I became secretary of the Ohio Hospital Association in 1927. This increased my interest in the American Hospital Association, which I had joined in 1924. As secretary of the OHA, I had an opportunity to observe the activities of the AHA first hand. We had a very active hospital association in Cleveland with a rather large staff involved in a number of cooperative activities. The staff at that time was larger than the AHA. As secretary of the OHA from 1927 to 1933, I would make suggestions to the American Hospital Association for the need of various association programs. I always received a lot of attention, but was told the association did not have any money to finance the suggestions. I felt that the American Hospital Association should be well supported so that it could carry out the many projects that were needed in the field nationally and that could not be performed by a state or certainly a local association.

In 1931 the president of the American Hospital Association was Paul Fesler, who was the administrator of the University of Minnesota Hospitals. I received real interest from Paul Fesler on the need of what I called the reorganization of the AHA and the financing of it when he was immediate past



president in 1932 and George F. Stephens was president.

I continued to press for some kind of action within the American Hospital Association. Dr. Nathaniel W. Faxon, who was administrator of Strong Memorial Hospital in Rochester, New York, and later administrator of Massachusetts General Hospital, became very interested in what I was proposing. I think he was influenced a great deal by my previous conversations with Paul Fesler.

Faxon agreed to appoint a Committee on Membership Structure to study the American Hospital Association. I was appointed chairman. He inquired who I wanted on the Committee, and I proposed three trustees of the AHA and three members representing state hospital associations. The original group of AHA trustees were: Dr. Robin C. Buerki; Asa Bacon, who was at Presbyterian Hospital in Chicago and treasurer of the AHA; and Harvey Agnew, who was with the Canadian Hospital Association. The three people representing state associations were: James A. Hamilton of New England; Graham Davis, who was with the Carolinas-Virginia Association and was in charge of hospital activities of the Duke Endowment and later executive for health activities of the W. K. Kellogg Foundation; and John Hatfield, who was secretary of the Pennsylvania Hospital Association. It was an excellent committee, and all of these people became better known nationally. Asa Bacon had been president of the AHA and Agnew, Buerki, Hamilton, Davis, and Hatfield later became presidents of the American Hospital Association.

That committee met from 1934 to 1937. During the 1934 to 1935 period, prior to the annual meeting of the American Hospital Association in 1935, we developed a report with certain recommendations. The bylaws of the AHA at that time provided that any change in the constitution and bylaws be cleared through the Constitution and Bylaws Committee. In many ways the leaders of

the hospital field were satisfied with the AHA the way it was and desired no change. Most members of our committee, particularly Hamilton, Graham Davis, Hatfield and myself, were young fellows then, all in our middle thirties. The term "Young Turks" was used to describe us on more than one occasion.

Attempts to contact the chairman of the Constitution and Bylaws Committee of the AHA were not successful. He did not answer our correspondence in advance of the meeting although we had submitted recommendations for changes in the constitution and bylaws. He was completely unavailable. We could not get an answer at his hotel room, although we knew he was in town. We spent from Monday until Thursday trying to reach him to arrange a meeting of the committee. This turned out to be impossible, so there was no action. Our committee was reappointed.

In view of later history, it was just as well that those recommendations were not acted on, although the final recommendations were not particularly different. We became a little more adept at association politics.

At the 1936 meeting, we had a report but we insisted that it be a progress report. We felt we wanted another year to acquaint the membership of the AHA with what we were proposing. We presented the progress report, and some of the leaders of the AHA, conscientious individuals, no question about that, insisted on voting on the report. We stated there was nothing to vote on, that this was just a progress report, and we were not making any recommendations. The chairman of the meeting finally ruled there was nothing to vote on. Actually, some leaders wanted to vote it down, and we knew this, and that they probably had the votes.

The committee continued to improve the recommendations. There must have been fifteen or twenty full-day and two-day meetings over a period of three

years spent on that report.

By 1937, whatever opposition there was to the report vanished because by that time we had met with a great many state associations, and we had contacted a lot of key people including trustees of the AHA, of whom there were three on the committee. They decided the committee recommendations should be implemented.

The recommendations included the establishment of a House of Delegates of one hundred people with representation from all the states with greater representation from the larger states. We recommended setting up what we called councils to coordinate committee activity. Prior to this time, it was customary for presidents of the AHA to appoint committees each year. A president generally would have some special interest and appoint a committee for this purpose. There was no sunset law; once a committee was appointed, it continued ad infinitum. This resulted in a lot of overlapping of committee functions. Incidentally, there was little committee activity. First of all, there was very little money to support any of them. We recommended six councils in what we considered six principal areas of association activity and provided that all committees in the future should report to one of the six councils. The councils were to coordinate committee activities. In addition, we recommended a coordinating council which consisted of the chairman of the six councils to coordinate committee activities.

#### FINANCING OF THE AMERICAN HOSPITAL ASSOCIATION

The Committee on Membership Structure also recommended quadrupling the association dues.

Dr. Bert W. Caldwell at that time was the executive secretary of the Association and chief executive officer. He was very concerned about the dues increase and felt that the Association might wind up with one-fifth of the members. Even though the dues were four times as much, the total income would be less than ever. He doubted hospitals would pay the increased dues, although the dues were very modest compared to the present AHA dues. The hospitals not only paid the increased dues, but the Association had a great increase in membership, and the total income became about five times what it had been previously.

For the first time the Association had the income to do the things we had been talking about for years. In my opinion, the work of that committee gave the American Hospital Association the kind of financing required to do the national job the hospital field needed.

One of the things we did at that time was study the budgets of a hundred national organizations. The American Hospital Association budget was ultra-small compared to most national associations. We showed that many national associations had income twenty times as much as the AHA.

The quadrupling of dues was approved in 1937, effective for 1938. This permitted enlargement of the staff and programs of the Association.

WEEKS:

Could we digress for just a moment? You brought up the need for more income. Where today and over the years has the income come from? I am under the impression that the annual convention is a big moneymaker. Also, just before this, wasn't this the time they bought the Boys' Latin School? Since then, I would imagine real estate has become -- 840 North Lake Shore -- a very lucrative thing.

MANNIX:

Not so lucrative; let us go back a bit. In 1928, the Association purchased the Boys' Latin School building on East Division Street in Chicago. This was the first headquarters building of the Association. Prior to that time, Modern Hospital publishing company gave the Association space in its headquarters in Chicago. Again, prior to that time the staff consisted pretty much of an executive secretary and a secretary. There was a lot of opposition of Association members to the purchase of this building on the grounds that they should not be putting their money into real estate when there were so many other needs of the Association. The Association did, nevertheless, purchase that building and remained there until the 1940s when the Lake Shore building was built during Dr. Edwin L. Crosby's tenure as Association secretary.

The Association had completely outgrown the old Latin School building on East Division. When the present building on Lake Shore Drive opened, a number of related associations moved into the building including the American College of Hospital Administrators, the Blue Cross Association, and the National Association of Nurse Anesthetists.

The Association has income from the space they lease to other organizations. This is pretty much on a cost basis. I do not believe there is any profit to the Association in that connection. The Blue Cross Association, which was using a great deal of that space, has recently moved into its own leased building a couple blocks away.

WEEKS:

They have income from publishing, seminars, educational programs, don't they? This brings up a point: when you had this committee studying structure

and recommending changes, were you also talking about the objectives and goals of the Association such as research, education, and representation, as they usually say?

MANNIX:

Yes, very much, but I would say to a lesser degree about research at that time, even though we recognized the need for it. This was only because of the financial situation. There were so many activities of a service nature that the Association, even with the quadrupling of dues, did not have enough income to provide for all the needs, and particularly did not provide much income for research purposes, the type of thing that HRET is doing today, which in turn has had a great deal of foundation support.

AMERICAN HOSPITAL ASSOCIATION

GEORGE BUGBEE ADMINISTRATION

Bert Caldwell retired in 1943 as AHA executive and was succeeded by George Bugbee, who had been at the University of Michigan Hospitals and Cleveland City Hospital (now Cleveland Metropolitan General Hospital).

George Bugbee is an extremely competent person and is so recognized by the field. He gave the Association real national stature, in my opinion. You could probably say that the Association came of age under George's leadership. I think for the first time in those years there was an important degree of recognition of AHA from the American Medical Association and the American College of Surgeons. It attained a professional status.

WEEKS:

Was that the time there was a crisis about the Joint Commission and AHA

stepped in?

MANNIX:

Yes. The College of Surgeons had established the accreditation program for hospitals way back in 1916 because the College wanted to admit to membership surgeons of proven ability. Deciding just who these surgeons were was very difficult. They decided they needed accurate medical records of surgery performed. Most hospital records were not too complete at that time. The College of Surgeons set up this hospital accreditation program and required complete medical records. The program became more and more accepted. Even today the program is voluntary. The hospital must apply for review for accreditation. The program gained important professional status. From the beginning there was greater and greater recognition of accreditation. The College continued to support the program financially from about 1916 until about 1943, about the same time that James A. Hamilton was president and George Bugbee executive of the AHA.

The College of Surgeons requested the American Hospital Association to operate and finance the program on the grounds that this was a hospital accreditation program and the hospital association was the logical group to operate it. There were objections on the part of the American Medical Association and the College of Physicians. Conferences were held for a period of over a year between the American Medical Association, the College of Surgeons, the College of Physicians, the American Hospital Association, and the Canadian Hospital Association that resulted in 1944 in the establishment of the Joint Commission on the Accreditation of Hospitals. It is more and more effective all the time.

Dr. Malcolm T. MacEachern was the executive of the College of Surgeons and

in that capacity in charge of its accreditation program. He made outstanding contributions to the entire health field. Among other things, he wrote a book on hospital organization which is still very popular. MacEachern was a Canadian and a very, very well liked individual.

George Bugbee, as secretary of the AHA at the time of the formation of the Joint Commission, gave great leadership from the hospital standpoint, as did Jim Hamilton. George resigned from the AHA to take a position with the Health Information Foundation, a non-profit research organization financed by the drug houses.

AMERICAN HOSPITAL ASSOCIATION

EDWIN L. CROSBY ADMINISTRATION

George Bugbee was succeeded by Dr. Edwin L. Crosby. Crosby had a background in administration at Johns Hopkins in Baltimore. He was very similar in many ways to George. He had an advantage in that he had an M.D. degree, which probably resulted in strengthening the relationship between the AHA and the American Medical Association.

Up until then, George Bugbee was the only AHA executive without an M.D. degree but, as far as I was concerned, this did not handicap him in any way. During George's service at the AHA a considerable number of administrators, particularly at large hospitals, had M.D. degrees. There are very few physicians serving as hospital executives now. I would be surprised if there are as many as twenty-five physicians who are chief executive officers of hospitals in the entire country today. For instance, in Ohio only the Cleveland Clinic, which was established by physicians, has a physician as its



chief executive.

Crosby had a very successful tenure with the AHA. Unfortunately, he died at a relatively young age while he was still Association executive.

J. Alexander McMahon was appointed to this position. Alex is an attorney by training and still is the chairman of the board of trustees of Duke University. He was on the board of one of the two Blue Cross Plans in North Carolina. When the two North Carolina Plans merged, he was appointed the first executive of the statewide Blue Cross/Blue Shield Plan in North Carolina. He held that position until he was appointed president of the AHA.

I think you can say that all the men who have held the position of chief executive of the AHA have done a very top job. It is not easy to keep 6,000 member hospitals happy. In many ways Caldwell, Bugbee, Crosby and McMahon had very similar personalities. All were very good executives, all personable, all well-liked by the field, although there will always be individual hospitals that believe certain things should be done differently.

There is no question in my mind that the AHA, particularly in the past 40 years, has gained greatly in national stature. It is an extremely effective national organization today, well-recognized by the medical profession and other organizations in the health field. A large part of this is unquestionably due to these four top executives. I had not thought of this before, but McMahon is probably the first executive that has not had direct hospital service, although he served with Blue Cross and Blue Shield. Crosby and Bugbee had been administrators of hospitals, and Caldwell had been administrator of American Hospital in Paris during World War I. However, I do not see that lack of actual hospital experience in any way has limited or interfered with McMahon's administration. He has given and continues to give

the Association an outstanding performance.

HOSPITAL ACCOUNTING

WEEKS:

You were quite interested in uniform accounting, weren't you?

MANNIX:

As a matter of fact, that is where Rufus Rorem and I first became acquainted, although there was no direct connection between our accounting interest and Blue Cross.

Some accounting history goes back to Ohio. I mentioned earlier that in 1919 the Ohio Industrial Commission agreed to pay hospitals their cost, not to exceed \$6 a day, provided they would file a detailed statement annually on costs. This resulted in the passage of an Ohio Hospital Registration Act by the Ohio legislature. The act was simply for registration, not licensing. This required hospitals to record their expenditures on a uniform basis, because it required the filing of expenses by department such as administration, housekeeping, x-ray, laboratory, etc. There was also a breakdown between salaries, supplies, and other expenses.

This probably was the first time in the country that hospitals were required to report uniformly. Up to that time there probably were as many kinds of accounting systems as there were hospitals. Once they were required by Ohio to report uniformly, they were forced to keep books uniformly. There is no evidence that this result was foreseen when the registration law was passed.

This resulted in the appointment of a committee of the Cleveland Hospital

Council to develop a uniform accounting system. Frank Chapman, with whom I was associated at Mount Sinai and later at University Hospitals, chaired the committee and developed the original report, which at that time was called the uniform chart of accounts. His work resulted in the American Hospital Association deciding in about 1923 that this should be done on a national basis. One of the early things I did with Chapman at Mount Sinai was to work with him -- he was chairman of the AHA committee on accounting -- on developing a uniform system. Frankly, we copied pretty much what we were doing in Ohio.

He made a mistake in that connection because he felt that it was necessary not only to have a uniform system, but if the hospitals were going to use it uniformly, they should be supplied with typical printed forms for the accounts receivable ledger, the accounts payable ledger, the general ledger, and so forth. He developed a very complete set of accounting forms in 1923. The report was sent to the AHA in 1924. The trouble with this was that those forms were so detailed that just the stack of forms scared the hospitals out. In many of the small hospitals at that point their accounting system -- and this is literally true -- consisted of a spindle for bills and a checkbook. They paid bills if they happened to have the money.

Later, in about 1930, the AHA decided to revive that accounting committee, the original 1924 committee, which had not been effective outside the Ohio area. Rufus Rorem and I were on the committee. He was with the School of Business at the University of Chicago. I think that was the first time I ever met Rufus. Ultimately it developed that we had two common interests: uniform accounting and prepayment of hospital care. We developed another report on accounting for the AHA in about 1934 which received more and more acceptance

throughout the country. It was used in Ohio extensively, in North Carolina with the encouragement of the Duke Endowment, and then by the United Hospital Fund in New York. We had a whole series of accounting committees throughout the 1930s. Both Rufus and I were on all those committees.

#### ASSOCIATED DEVELOPMENTS

I am reminded of how many of my interests tied together: the Ohio Hospital Association, the American Hospital Association, the interest in accounting and prepayment. My interest in all these things was overlapping, of course. They did not seem very important at the time, but they have influenced a lot of developments in the hospital field.

WEEKS:

You didn't realize how long the shadows were?

MANNIX:

It was particularly true in Blue Cross. I remember when we finally started the prepayment plan in Cleveland, Guy Clark, who was the executive of the hospital council, bet me a straw hat we would not enroll 10,000 people in the plan within five years. We did that in less than a year.

Incidentally, very few people -- as recently as 1940 -- had any conception of how large Blue Cross would become. There were many articles saying that while voluntary prepayment for care was a good idea, you could never expect to reach more than a small percentage of the population.

AMERICAN HOSPITAL ASSOCIATION - BLUE CROSS RELATIONSHIP

The relationship of the American Hospital Association and Blue Cross went through a series of stages. At the annual meeting of the AHA in 1932, I was a member of the Resolutions Committee. One of the resolutions we offered suggested American Hospital Association activity in what was then called group hospitalization, or periodic payment for hospital care. This resolution resulted in action by the AHA trustees in January 1933, to establish approval standards for hospital prepayment plans and recommended the study by hospitals at the local level of periodic payment for hospital care. This came immediately after the issuance of the final report of the Committee on the Cost of Medical Care which had operated from 1928 to 1932. The Committee issued 28 volumes on health economics, probably the most extensive study of health economics ever done anywhere on earth. The majority report of the Committee on the Cost of Medical Care recommended experiments with financing of hospital care on a periodic payment basis. A minority opposed this.

During the next two years, 1933 and 1934, there were seven plans established, which later became Blue Cross Plans, and in my opinion were the basis of the whole Blue Cross and Blue Shield development.

Following this action of the trustees of the American Hospital Association in January 1933, the AHA established a group hospitalization committee of five: Dr. Basil MacLean, Dr. S. S. Goldwater, Monsignor Maurice F. Griffin, Dr. Robin C. Buerki, and C. Rufus Rorem. They strongly advocated local hospitals establishing programs of prepayment for health care.

In about 1937, the Julius Rosenwald Fund agreed to finance an executive for the commission. Rufus Rorem, who had been very much interested in the

idea and had worked with a number of plans established during the 1933 to 1937 period, was appointed executive. The Julius Rosenwald Fund, as I remember it, financed Rorem's position for about five years. The position was later supported by the plans themselves.

There always were several plans that were not comfortable under the banner of the American Hospital Association. I always felt that their concerns were not justified and took a stand for a very strong AHA relationship. I felt that the plans were offering hospital services to the public on a monthly payment basis, and the success of this type of program necessitated cooperation between the plans and the hospitals.

In the very early 1940s a group of plan leaders was interested in complete separation from the AHA. That resulted in a weekend meeting in about 1941 at the headquarters of the AHA. Nearly all the plan executives were present and a large representation from the AHA. The result of this meeting was to continue under the aegis of the American Hospital Association, and probably a stronger interest than ever on the part of the AHA in prepayment for hospital care.

However, there continued among plan executives interest in having their own separate organization and having more autonomy. Actually, in my opinion, the individual plans were separate corporations and had complete autonomy. The American Hospital Association activity was primarily strong support of the plans without any dictation about their operation.

Further discussions resulted in the establishment of a new type of AHA membership called Type IV. Types I, II, and III were institutional and personal memberships. Type IV memberships were for Blue Cross Plans.

Concern again flared up in the late 1960s and early 1970s regarding the

AHA-Blue Cross relationship. This resulted in the establishment of the Blue Cross Association as a separate corporation. This was promoted on the basis of a partnership of the Blue Cross Association and the American Hospital Association. Even though the term "partnership" was continually used, it meant further separation of the plans from the AHA, although the Blue Cross Association continued to occupy space in the AHA headquarters building until last year when Blue Cross acquired a separate building.

I always felt the Blue Cross program of financing hospital care would be much more effective with a strong AHA relationship. While my background was in the hospital field, I do not think this had anything to do with the way I felt.

A corollary to this is that I have always felt that the American Medical Association would be wise to maintain a strong relationship with the Blue Shield Plans. At one time the headquarters of the Blue Shield Plans was in the AMA building.

In the last few years people raised questions regarding this relationship, but I have always believed that a maximum degree of cooperation between Blue Cross and Blue Shield on one hand, and hospitals and the medical profession on the other, was in the public interest. I agree that there could be certain dangers in this, but after watching the development of Blue Cross and Blue Shield for fifty years, I think these programs have been operating in the public interest, and the record shows that.

VOLUNTARY VERSUS COMPULSORY HEALTH INSURANCE

WEEKS:

Before we digress, I was going to ask you about how you happened to leave Cleveland to go to Detroit. I also wanted to ask you about McNamara. Apparently he and Rufus had conflict later on. As I remember from some of your other conversations, McNamara was in and out of the Blue Cross Commission.

MANNIX:

Let me see if I can describe John A. McNamara and also give you my impression of his relationship with Rufus Rorem. McNamara was unquestionably a very competent individual. He made terrific contributions to the health field generally and to Blue Cross. He was also very difficult to get along with. I probably was closer to him than anyone in the field. There would be periods of as long as twelve months when McNamara would not talk to me at all because of something which occurred. Ultimately, out of the clear blue sky, I would get a telephone call from him. I did admire his ability. He did an outstanding job, in my opinion, as editor of Modern Hospital prior to the time he came to Cleveland, and an excellent job in the development and management of the Cleveland Blue Cross Plan, which was then called the Cleveland Hospital Service Association. He had some difficulty with the local hospitals and with his board of trustees. He also had problems with corporation officials in Cleveland and with Rufus.

He took such strong positions for what he thought was right that he created a lot of difficulties. In 1948, at a meeting of his board of trustees, he announced that if the board did not do such and such, he was going to resign. They accepted his resignation.

McNamara felt Rufus Rorem's real interest was in a governmental program to finance health care, and that many of Rufus' actions and statements indicated this. I think if we go back to the late 1930s and early 1940s, very few



people ever thought that Blue Cross on a voluntary basis would enjoy the success it now has. McNamara was an exception to this. He believed that Rufus' position was that Blue Cross was a very excellent experiment that demonstrated the soundness of prepayment, but did not feel that this was going to do the job of financing health care for most of the people in this country. As a result of this, McNamara resigned from the Blue Cross Association, or the Blue Cross Commission as they called it then, about three times.

There was no question at all about McNamara's sincerity and the soundness of his beliefs, but he was a difficult individual. He had an excellent sense of humor, very often to the point that he made enemies.

The conflict with Rufus was basically because McNamara felt that down deep Rufus did not believe that voluntary financing could really do the job and that the only answer was a government program which McNamara completely opposed.

WEEKS:

I think I. S. Falk had this idea also. Falk and Rufus had worked together. It was fine to try out the voluntary idea, but eventually they would have to go to compulsory insurance.

MANNIX:

A great many people still feel this way. Many people in the field in the late 1930s said that at best -- and I think this is stated in some of the journals -- you could not hope to enroll more than ten million people on a voluntary basis. This was at a time when we had three million enrolled. At the end of the war in 1945, it was sixteen million, and now it is over eighty million.

WEEKS:

Talking of semantics, at the APHA meeting in Detroit this week, somebody made the statement, at least it was reported this way, that there are twenty million people who do not have insurance.

MANNIX:

I noticed that statement. It ignores the fact that over 200 million are protected by Blue Cross, Blue Shield, private insurance companies, Medicare and Medicaid.

#### NATIONAL HEALTH INSURANCE

WEEKS:

Going back, I wonder if you remember during the Eisenhower years, when there was quite a change from Truman's ideas. It seems to me that Eisenhower policy was pretty much that if anything was done about health insurance, it would be in the form of a subsidy to private insurance, which Teddy Kennedy is getting back to now. Do you remember whether during those years the Association took any stand on that?

MANNIX:

Thinking back to Roosevelt, then Truman and then on . . . the original Social Security Act had a Chapter V on national health insurance. This was dropped at the last moment in 1936 before the legislation was finally presented to Congress. We had, of course, through the late 1930s and during the Roosevelt administration and continuing into the Truman administration, Wagner, Murray and Dingell bills covering national health insurance. Generally, the Democratic party and the liberals of the country favored some

form of national health insurance and took the position that you never could solve this problem in a voluntary way.

I remember Truman speaking to the American Hospital Association annual meeting in Philadelphia some time probably in the late 1940s. I had not been a Truman supporter by any means, but when he spoke to that meeting on national health insurance, I was very, very much impressed with Truman, though I came in as a doubter. What impressed me about him was the obvious sincerity of the man. He made, of course, a big point that he was absolutely against socialized medicine. He was not talking about socialized medicine, but about a system where the government would finance this care. There was no question about his sincerity in this connection.

During the Eisenhower years from 1952 to 1960, the interest in national health insurance and in federal intervention in the system dropped off markedly. We went through a very conservative period. Eisenhower tended to believe in a minimum amount of regulation. We heard very little during his term about Wagner, Murray and Dingell. That changed with the election of Kennedy and his succession by President Johnson and the final enactment of the Medicare and Medicaid legislation in 1965.

While the American Hospital Association could not be considered a strong supporter of those bills, they did not oppose the legislation. The hospitals of the country, particularly in connection with indigent care, were facing major problems. It was becoming more and more expensive. The local governments, the state governments, were finding it more and more difficult as they are today to finance the cost of this care even on a matching basis. My feeling was that the AHA and the American Medical Association were favorable to Medicaid. I do not think there was that same feeling as far as Medicare

was concerned. The AMA did not favor Medicare. They thought care of the elderly should be financed on a voluntary basis. The AMA also felt that if you had that degree of financing of health care, it would mean more and more regulation of the health field.

The AHA has always taken a much more liberal attitude on this than the AMA. Even in the early days of the Blue Cross, the AHA took a leadership position. The AMA raised many questions about the development of Blue Cross and Blue Shield Plans.

#### CARE OF THE ELDERLY

WEEKS:

Would you care to say something about the Blue Cross attitude toward the elderly? That which predated Medicare and so forth?

MANNIX:

I was very much interested in Blue Cross and Blue Shield offering a program for the care of the elderly and advocated a program in the Blue Cross field which I called the Golden Age Program. I also tried to develop such a program in the Cleveland area in which the individual would pay a somewhat higher premium during his working years which would be adequate to cover the cost of his care after he retired. I did some work on a plan which would pay 75 percent of his cost of care during retirement years with the subscriber paying only 25% at that time. The premium was on a graduated scale depending on his years of membership as a subscriber. One of the interesting things about this that I had opposition in Cleveland from labor. In the early 1960s, labor was very much in favor of a federal health insurance program. When I

presented this program to the Ohio Insurance Department for approval, labor opposed it. I believe this was a mistake. Medicare came a couple years later, and I think it leaves a lot to be desired. Medicare is paying only approximately 40 percent of the cost of health services of the elderly. Blue Cross and Blue Shield and private insurance companies supplement this with what is generally referred to as fill-in programs where they cover the benefits Medicare does not cover. This is a problem for the elderly.

Many people who have Medicare feel that they have very good health coverage. When they find that they are paying about 60 percent of the cost of care out of their own pockets, unless they have supplemental coverage, there is a great deal of unhappiness.

The unfortunate thing about Medicare is that people over 65 and eligible for Medicare still are paying more money out of pocket for health care than they were before Medicare started, partly because of increase in costs due to inflation. The Medicare program is so written that as the costs increase, the benefits decrease. As Medicare has developed, deductible amounts have continually increased requiring the individual to pay a greater part of the cost unless he has supplemental coverage.

The American Hospital Association became interested at an early date in the care of the elderly and made a detailed study of the problem.

WEEKS:

Would that be back in the 1950s?

MANNIX:

I would say at least the late 1950s or early 1960s. This study revealed the much greater cost of health care for the elderly compared with younger age groups. First of all, the elderly used a great deal more care. Secondly,

very often, although this is changing, they do not have employer contributions once they are retired. Now, a great many of the national corporations continue to contribute to the cost of health benefits after retirement.

Elderly people are using about five times as much hospital care as people under 65. People under 65 receive about 800 days of hospital care per 1,000 people per year. People over 65 receive over 4,000 days of care per 1,000 population per year. More and more health care cost is becoming the problem of the older population.

I quite often quote these facts: In 1900, the average life expectancy at birth was 47 years. At the present time 60 percent of all hospital care, and probably 60 percent of all medical care, is rendered to people over 47 years of age.

One of my principal criticisms of Medicare--although I have many criticisms of it for its inadequacies--is the need of the elderly for nursing home care and the very limited nursing home benefit in the Medicare program. The cost of nursing home care is tremendous. It is difficult for anyone except the federal government to meet this cost.

WEEKS:

Even when there is a good Medicaid program, and of course, all states do not have good Medicaid programs.

MANNIX:

As far as Medicaid covering the indigent and medically indigent where you have matching of federal funds with state funds, I do not see any answer to the problem of caring for the indigent except a program where the entire cost is met by the federal government without requiring state matching. Even the wealthiest states, California and New York, have a hard time matching federal

funds in the Medicaid program.

FUTURE FINANCING OF HEALTH CARE

I think when you look at financing of health care for the balance of this century, four things are likely to happen. First of all, I think we may well have federal legislation that will mandate that all employers provide some type of health insurance for their employees with the employer meeting some part of this cost, maybe two-thirds or three-fourths. This actually would not result in much change for the employed population which, with their dependents, represent over 75 percent of the people in this country.

I think it is going to be necessary at some point for the government to broaden Medicare coverage for the elderly. The recent Medicare legislation is unbelievably complicated. First of all, there is the separation of coverage into Part A, the hospital portion, and Part B, the medical portion, with deductibles and co-insurance on both of them, limitations on both of them, no coverage for dental care, no coverage for prescription drugs, and very limited coverage for nursing home care. It is pretty hard to conceive of writing any more complicated legislation. In addition to that, as costs go up, the benefits decrease. This results in the elderly paying a larger and larger amount of the cost out of pocket or purchasing supplementary coverage which many of them find hard to pay for. I expect much broader coverage for the elderly to be paid for by the federal government.

Health care of the elderly is becoming one of the biggest social problems in the country. Illness itself is becoming more and more a condition of the elderly. The younger group is getting to the point where people under 45 do

not have much health care except maternity and accident cases. We have the opposite problem at the other end of the age scale.

Medicaid, care of the indigent, has much greater problems than Medicare; very severe problems. The principal problem is that Medicaid is on a federal-state matching basis, the wealthier states meet about 50 percent of the cost; some of the poorer states meet as little as 16 percent of the cost. But most states, regardless of their relative wealth, find it very difficult to match the federal funds.

About 12 1/2 percent of the people in the country are eligible for Medicaid benefits. Take 12 1/2 percent of the present 230 billion dollar bill and you are talking about 30 billion dollars. It is a lot of money. Many of the wealthy states cannot do a good job of matching. We have fifty types of state Medicaid programs; no two of them are alike. For all practical purposes, all fifty of them are inadequate. The state of Ohio, for instance, has fair matching for the true indigent and no matching at all for the medically indigent. It is a problem that creates financial difficulties for some of the biggest and best hospitals in the state. The care of the medically indigent is a greater problem than caring for the indigent. I do not see any solution to the problem except complete federal payment for the cost of indigent care. As far as I am concerned, it has been demonstrated that state matching is completely unsatisfactory. States themselves do not have the tax base to support the necessary matching.

The fourth part of the future, as I see it, the first three parts being some mandated program for the self-employed people, a much more liberal program for Medicare, and a complete federal financing of Medicaid, is some type of catastrophic coverage. I hope that this will be on a mandated basis,



that employers will be required to provide this. It would not be costly to the employer. While the cost of catastrophic illness is enormous to the individual, the cost when spread over the entire population is very small. Most hospital care is rendered in the first fourteen days. The problem is the occasional case that requires prolonged care. There should be some coverage for this. Incidentally, it would not cost a great deal more to provide unlimited coverage by Blue Cross/Blue Shield and private insurance companies. Some employers have extremely broad coverage with benefit limits up to a quarter of a million dollars or half a million. This could be mandated and if the cost were spread would not be a burden to most employers. It would solve a lot of problems for the occasional employee who does have such unusual expenses. We are likely to see some kind of catastrophic coverage, preferably on a mandated basis. I do not see any need for the federal government to finance this. Whatever money the federal government has ought to be used for care of the indigent and the elderly.

Many people worry that there are twenty million people in this country that do not have health coverage. They all should have it, of course. Most of the people who worry about this are the same ones who said forty years ago that you could never expect to cover more than ten million people on a voluntary basis. They do not want to talk about the 200 million with good coverage. Some want to talk about only those who do not have it. I am very sympathetic for the 20 million, and I think something must be done about it. At least for those who are employed, I think it should be a mandated program. The real need for federal help is not for employed people, but for the indigent and the elderly.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS

The person most responsible, in my opinion, and I do not think anyone would question this, for the idea of forming the American College of Hospital Administrators was a Chicagoan named Matthew Foley, who was editor of Hospital Management, a magazine in the field. He first talked to me in 1931 or 1932 about establishing a separate professional organization of hospital administrators. Frankly, I did not agree with him. I felt that while there was a need for a professional group, it should be under the aegis of the American Hospital Association. I had long association with hospital administrators and took the position that they did not need another organization to consider their professional problems.

Foley was a very dedicated individual and persisted in this. He finally interested a group of Chicago hospital administrators in the idea, particularly Dewey Lutes, who was administrator of Ravenswood Hospital. Foley also received a great deal of support from Dr. Malcolm T. MacEachern of the American College of Surgeons on a separate professional organization of hospital administrators.

A group of eight or ten Chicago administrators, led by Dewey Lutes, pursued the idea. This resulted in a meeting of interested people at the American Hospital Association annual meeting in 1933 in Milwaukee. At that meeting there was agreement to form the College. There were fifty-four of us in the original group. At a subsequent meeting in January 1934, the so-called "original charter group" was enlarged, and there were 102 charter fellows and seventeen honorary charter fellows, all of whom were prominent in the health field. Dr. MacEachern; Dr. Otho F. Ball, who was editor of Modern Hospital;

Bert Caldwell of the American Hospital Association; and Matthew Foley were among the honorary fellows. I was the youngest of the charter fellows and the only one still active in the field.

With the original membership requirements we had for fellowship, I could not conceive of the College becoming an organization of more than seven or eight hundred people. However, the College continued to grow. There was a credentials committee which approved new members who met the membership requirements. Dr. MacEachern chaired the committee for many years. I was a member of the committee of seven people for seven or eight years.

From the beginning, the College placed emphasis on the education of administrators and on securing professional recognition of hospital administrators. In my early days in the field in the 1920s until post-World War II, I felt that there was not much long-term future for laymen in the field of hospital administration; the medical aspects of hospital operation were such that in the future most hospitals would have doctors of medicine as executives. Up until World War II the majority of nationally known administrators were physicians. This completely changed after World War II with the development of courses in hospital administration at Chicago, Minnesota, later Pittsburgh, Michigan, Yale, and the University of California until now we have over eighty graduate courses in hospital administration leading to a master's degree.

The College has played a very large part in the establishment of these courses and its numbers have played a large part in their development. We have arrived at a time in hospital administration when it is very difficult to become established in the field unless the individual has a master's degree in hospital administration. Some universities now issue doctorates in hospital

administration. From this small group of 119 charter fellows in 1933, the College has grown to an organization of over 10,000. One of the concerns I have is that the individuals who were completing courses in hospital administration fifteen or twenty years ago in most cases could be assured of a top position in hospital administration, but with the number of persons now completing these courses, opportunities are more limited. Many of them now have to start as department heads in hospitals and come up the ranks to the position of assistant administrator before being considered as chief executive officer. I wonder if the field can continue to absorb the great number of persons completing the courses. Many are, of course, moving into related fields. There are quite a few in association work, Blue Cross Plans, in health maintenance and professional review organizations, health systems agencies, and nursing home administration.

The College continues to play a major role in the professional education of health administrators. The last two executives of the College, Richard Stull and Stu Wesbury, have had a background in education.

While there was a period from 1933 through about the middle of the 1940s when question was raised as to whether there was a need for the College separate and apart from the AHA, we have heard little of this concern in the last thirty or thirty-five years; the College is completely accepted by people in hospital administration. They accept the respective roles of the College and the AHA, which are well defined.

WEEKS:

There was an overlap or gray area for a while, wasn't there?

MANNIX:

Yes, there was. I think each of the associations developed groups of

certain loyalists, individuals who felt that the AHA or the College served all their needs. This generally resulted from lack of knowledge on the part of the individual as to the respective roles of the two organizations. Little of this still exists.

WEEKS:

Do you remember Gerry Hartman back in those early days?

MANNIX:

Yes, Gerry Hartman succeeded Dewey Lutes as the executive of the College.

I mentioned earlier the interest of Dick Stull and Stu Wesbury from an educational standpoint. Gerry also had a major interest in education, although his background was in administration. He left the College to become the administrator of the University of Iowa Hospitals and shortly thereafter started a course in hospital administration at Iowa. Its graduates include some top people in the field. I think that Gerry Hartman started the first course that led to a doctorate in health administration.

WEEKS:

Before Jim Hamilton did at Minnesota?

MANNIX:

I believe so.

There was a group of us who were very close to the College during the Hartman administration: Jim Hamilton, O. G. Pratt and myself. We were all close personal friends.

Dean Conley followed Gerry Hartman as executive of the College. He had been with the University of Minnesota Hospitals and did a creditable job as executive.

Of interest in the early history of the College is that a number, a dozen

or more, physician administrators of leading hospitals in the East were very concerned that the College would be an organization of lay administrators. It is hard to know just why this thinking developed except that the eight or ten Chicago administrators who became interested were largely lay people. On the other hand, of the original group of 119 charter fellows of the College, the early supporters of it, forty were doctors of medicine.

There were a few people other than the eastern physicians who questioned the organization of the College. A very close personal friend of mine never became a member of the College, John Hatfield of the Pennsylvania Hospital Association. I never completely understood his feeling toward the College, but he seemed to feel it was an unnecessary organization. John was an extremely competent hospital executive who was later elected president of the American Hospital Association.

#### HEALTH MAINTENANCE ORGANIZATIONS

Competition in the health field has become greater all the time. I believe future competition will not be between Blue Cross and private insurance companies, but between them and health maintenance organizations. In the three West Coast states there is extensive development of health maintenance organizations, which are group practice prepayment plans. The largest of these is the Kaiser program which has been very successful. This idea of health maintenance programs is not new. Prior to the Blue Cross development in 1933, all prepayment plans were of the health maintenance type. Generally they operated in the lumber, mining, and railroad industries. Today on the West Coast we have Kaiser operating in Portland, San

Francisco, Los Angeles, and San Diego, with the Group Health Cooperative of Puget Sound in Seattle, and the Ross-Loos program in Los Angeles. Private insurance companies are now moving into this field. the Ross-Loos program in Los Angeles, which in 1929 preceded Kaiser, has been purchased by the Insurance Company of North America (INA). Prudential Insurance Company is also entering this field. We will probably see the entrance of more private insurance companies into the health maintenance field. At the same time, about forty-five Blue Cross Plans have some type of health maintenance program which are growing rapidly. While health maintenance organizations were largely a West Coast development (probably close to 75 percent of the members in HMOs are in the three West Coast states), they are spreading eastward, and we now have about 220 health maintenance organizations in the country.

From the Blue Cross/Blue Shield standpoint, I think this is a healthy situation. I think Blue Cross and Blue Shield will enter into the HMO development in a very big way. Blue Cross is a group of non-profit corporations which during the last forty-five years has enrolled nearly ninety million people, an average net increase of about 8,000 people every working day. These non-profit Plans will be a major factor in the development of health maintenance organizations.

WEEKS:

Is there any pattern which is appearing in these HMOs for the compensation of physicians? Salary plus profit-sharing, or isn't there a pattern?

MANNIX:

I would say that the pattern is salary plus some incentive payment or bonus arrangement. I am under the impression that up until the last five or ten years it was not easy for HMOs to recruit physicians. This has definitely

changed. Probably some of this change was brought about by the fact that we are seeing a greater and greater ratio of physicians to population which obviously is going to continue during the 1980s. More physicians will be available.

The HMO type of practice, even though it is on a salary and bonus arrangement, is very attractive to a great many physicians, particularly young physicians. First of all, they do not have to incur the capital expense of setting up an office. Next, when they become part of an HMO they acquire a ready-made practice. Also they are pretty much on a forty hour week. They do not have to worry about the business problems of maintaining a private office, employing people, and all the accounting and tax problems. Group practice is becoming more attractive to a greater number of physicians. At the present time Kaiser has about 4,000 physicians.

WEEKS:

Do they pay the malpractice insurance for the physicians?

MANNIX:

They pay for the malpractice insurance also, so that the physician's salary and bonus is pretty much take-home pay. Also, the fringe benefits in these programs are very attractive.

The other side of this is that the majority of doctors like to operate on an independent basis, but this is changing. Group practice was frowned upon even on the West Coast thirty years ago. I see no evidence of this today. Group practice prepayment has become so widespread that it seems to be completely accepted by most of the profession on the West Coast.



CONTROL OF COSTS

HEALTH MAINTENANCE ORGANIZATIONS

WEEKS:

I have been wondering about another thing. The Committee for National Health Insurance, the original Reuther group, Kennedy has sort of taken over on the Senate side. The last version of their bill I saw called the Kennedy-Waxman contained a very important point. They say they have a method whereby they can control the costs of the providers, both physicians and hospitals--and others--by setting up certain quotas and certain rates. Do you think the medical profession will every buy a quota or rate system?

MANNIX:

They will not buy it, but it could be forced on them, although I do not think so. There is a real need to control health costs. There is no question about this. It should come in the first instance by the control of use. The public in this country under 65 years of age is using about 800 days of hospital care per 1,000 people per year. The health maintenance organizations are using only about 400 hospital days per 1,000 persons. There is criticism that the people in health maintenance organizations may not be getting the care they need, or that they are a favorable group of relatively well people. I do not think either is true. I think the nature of the health maintenance organization is such that there are built in controls of the use of care.

More and more there is agreement on the part of knowledgeable people in the field that members of HMOs are getting adequate care. My conversations with people in the health field who have been concerned about the development of HMOs in cities where they have had a lot of experience with them agree that

these people are getting good care. In any event, take the San Francisco-Oakland Bay where now approximately a third of all the people are members of HMOs; the HMOs have been successful and acceptable. There are at least two million people in the San Francisco area that are in health maintenance organizations. Well, you might be able to fool a hundred thousand people, but you can't fool two million.

WEEKS:

They aren't leaving the HMOs in droves, are they?

MANNIX:

Some leave the system, of course, but despite a small loss of members, the systems are continually growing. They do have an advantage on the West Coast and in the South that they do not have in the northeast part of the country; there is a tremendous influx of new people into those areas. California has grown from seven million people to twenty-three million in the last forty years, and the increase of sixteen million is more people than there are in forty-eight of our states. These people came without medical connections, without a family physician. They try HMOs and a great majority of them stay in the system. Group prepayment on the West Coast has led to a great increase in group medical practice. Many doctors who were formerly in solo practice are now in group practice. You talk to some of the people in the three West Coast states and you get the impression that there is a group clinic on about every other corner.

Group practice, which was frowned upon fifty years ago in this country, has become completely acceptable. This all started really at the Mayo Clinic, Cleveland Clinic, the Lahey Clinic in Boston, the Ford Hospital group in Detroit, University of Chicago Hospital and Clinics, Ochsner down in New

Orleans, and Lovelace in Albuquerque. These are all well accepted institutions today and serve as patients a great many physicians and their families.

There is one other consideration. We used to kid about the horse and buggy doctor. You just cannot practice medicine in the home anymore. It is very hard to practice medicine in an isolated office building, and particularly in a solo practitioner's office. Medicine has become so complex that is much easier to practice in an organized or informal group. There is no doubt we will have solo practice of medicine with us for a long time to come. I personally have always gone to solo practitioners. I like mine. I have had physicians in all specialties for my family, and they have always been solo practitioners, but this is changing. The big medical centers, Massachusetts General, Johns Hopkins, University of Michigan, Case Western Reserve, or others, have faculties largely in group practice of medicine, with various degrees of formal or informal group practice. It is also possible that the great increase in the number of physicians in this country per 1,000 people which will occur in the next ten years will affect the way medicine is practiced.

HMO organizations have about one physician for each 1,000 members. In this country there are about 1.8 physicians per 1,000 population, or 80 percent more physicians than one being used by HMOs. In 1990, there will be close to two physicians per 1,000 people, or twice as many as are being used in HMOs.

One of the problems HMOs had ten years ago was securing physicians. This is no longer a problem. They are able to get physicians readily and have many applications for staff positions. If all the population were covered by HMOs

in 1990, which is inconceivable, half the physicians would not be needed. This could create all kinds of problems. Obviously that is not going to happen, but there is likely to be a gradual movement toward group practice. A surplus of physicians could result in higher charges for medical service in order for the physician to maintain income. If the cost of medical care continues to increase, particularly if it increases at a rate faster than inflation generally, there will be more public reaction to this and more demand for some government action. There is a difference of opinion today as to what is going to happen: whether physicians are going to charge more to maintain their income or whether the increased ratio of physicians will create competition. Competition based on cost does not apply to the same degree in the practice of medicine as in other activities. When an individual needs medical care, he is not thinking cost. If he has confidence in a particular physician, he will continue to go to that physician.

The combination of the increase in the number of physicians per 1,000 population and the fact that in this country we have over four beds per 1,000 people while HMOs have only about 1.8 beds, and the continued increase in the cost of health care at a rate greater than inflation is going to result in increased public pressure on the health system. Hopefully, in this process there will be the kind of intelligent leadership in the medical profession, the hospital field, and the health field generally that will maintain quality in medical care.

#### HEALTH CARE AS A COMMUNITY SERVICE

Hospitals are viewed by the public as a community service. They are

placed in much the same category as education and religion. We have, at least until recently, favored the non-profit hospital system as we favored non-profit educational and religious institutions.

I had an interesting experience in Detroit. I received a call one day, after having had a number of contacts with executives of the Ford Motor Company, asking that I meet with them that afternoon at the Ford offices in Dearborn. They wished to discuss a prepayment plan for Ford employees. When I arrived, there were two representatives of one of the large eastern life insurance companies present. Normally, I would not go to a meeting where another company was present. I preferred to tell my story; they could tell theirs at separate meetings. But I was there and had no idea this had been arranged. The insurance company representatives were asked to speak first. They made the point that Ford Motor Company was one of the great capitalistic companies of this country and the world, that Henry Ford was one of the great capitalists of the world, and that Ford Motor Company always supported the capitalistic system, that their company was a stock insurance company, and therefore it would be consistent for Ford to deal with a stock insurance company in providing health protection for their employees. This presentation went on for about a half hour and was very effective. It was obvious they had planned it very well.

I finally was called on for my reaction to this. I pointed out that when Henry Ford, Sr. started the Ford Motor Company in 1903, he started a stock company in the state of Michigan. This was as it should be. There was no question that Ford Motor Company was one of the most successful capitalistic companies on earth, that Mr. Ford was one of the world's greatest capitalists, and that nobody had any more respect for the capitalistic system or more

respect for Mr. Ford than I had. I felt that the capitalistic system made this country great, but I should like to point out that when Mr. Ford built a hospital in 1915 (twelve years after starting the motor company), he started a non-profit hospital corporation. He must have recognized some difference between making automobiles and providing hospital care. This meeting lasted over an hour and we were dismissed. There was limited talk about rates and benefits.

I was later called and asked to enroll the Ford Motor Company employees in Blue Cross. The reason for the company's decision is, of course, speculative.

At times people lose recognition of the fact that many view providing hospital care as different than many other activities, and I think most capitalists view hospital care in a special way, including Mr. Ford, Mr. Rockefeller and Mr. Duke, to mention a few, all of whom have made great fortunes and contributed great sums of money to the health field.

WEEKS:

That was a very telling argument.

MANNIX:

However, at the present time, major inroads into the hospital field have been made by investor-owned companies. These chains now have about 1,000 hospitals they either own or manage. They are continuing to grow, mostly in the South and West.

WEEKS:

Are they full service hospitals or are they side-stepping some of the services?

MANNIX:

That varies. I would say that the great majority of them are what we

would call community hospitals.

WEEKS:

With emergency rooms, maternity services, and other "loss leaders?"

MANNIX:

For the most part they have emergency rooms and maternity service. There are obviously exceptions to this.

One of the big chains is owned by an insurance company which has the financial capacity to expand. The investor-owned chains now control about one-sixth of the general hospitals in this country, although less than one-sixth of the hospital beds.

#### MULTIHOSPITAL SYSTEMS

WEEKS:

What is being done in the community-owned multihospitals?

MANNIX:

There is an advantage to the multihospital system in the investor-owned or non-profit group. There is some evidence that the non-profit chains will show real growth.

The hospital field is becoming so complex, so subject to regulations, that you need a large number of institutions or a substantial number of beds to be able to spread the necessary cost. Many of the large hospitals now have departments to keep track of government regulations. You cannot afford this in a two or three hundred bed hospital. Many of the large hospitals now have departments of risk management concerned with the service rendered to every patient. The small hospital cannot afford this. It would be hard for a

hospital with less than 200 beds to afford a good purchasing agent, for instance. A chain of institutions, whether investor-owned or non-profit, can have a central organization with some really top specialists and spread the cost. They can afford the necessary expertise a small hospital cannot.

I had an interesting experience with one of the very first multihospital systems in this country. I think it may have been the first, although I cannot be certain. I came to University Hospitals in Cleveland in 1930 when we were completing the Lakeside unit, which was a medical and surgical unit; and Hanna House, which was a private medical-surgical unit. Babies and Children's unit, which was a pediatric unit, and the maternity unit had already been built. These four hospitals had been located in different parts of the city. We also had a convalescent children's hospital which was not on the campus. We brought four administrations together, and this created many administrative problems initially because we had four housekeepers, four accountants, four x-ray departments, and so forth. Ultimately we solved these problems. I had previously been with Elyria Memorial Hospital with 175 beds. At Elyria I was carrying on a dozen or more activities while at University Hospitals I had experts in these fields we could not have afforded in that 175-bed hospital in Elyria. At University Hospitals we had at least fifteen executives serving as department heads who were competent to run a small hospital. There is an economy of scale here that is most important. The degree of this today is much greater. At that time government regulations, high technology, malpractice, and modern hospital situations were not problems. We are likely to have more and more multihospitals and shared services as a direct result of the complexity of care.

In this connection, one of the first shared service organizations in the



country was the Cleveland Hospital Council. It started out as a central purchasing agency and moved into many other shared services. This approach offers many of the advantages of a multihospital system and is particularly advantageous for the small institutions. University Hospitals here in Cleveland, the Cleveland Clinic, and other large hospitals also benefit from the shared services of what is now the Greater Cleveland Hospital Association. They probably could afford to operate some of these services themselves if they chose, but a small hospital could not easily afford this.

The greatest pressure on the health system in the balance of this century will probably be from the standpoint of cost of care. The costs are such that it is hard to meet them even on a prepayment basis. As a matter of fact, the costs are such that it is even difficult for the federal government to meet them on a tax basis. There will be many more pressures as a result of increasing costs.

#### TECHNOLOGY

WEEKS:

Will there be more technology?

MANNIX:

Probably. Many people worry about the cost of technology. I do not think this should worry anybody, providing the technology is effective in the diagnosis and treatment of disease. I served for three years on the National Commission on the Cost of Medical Care set up by the American Medical Association on the technology subcommittee. I think it is very hard to demonstrate that technology has increased cost. They talked a few years ago

about the cost of the cobalt bomb, and now about the cost of the CAT scanner. These devices are expensive, but account for only a small part of the total health cost. One of the things you hear over and over again is that every hospital should not have a cobalt bomb. This is true, but every hospital does not have a cobalt bomb; very few hospitals do.

WEEKS:

They can always point to a few bad examples where they are located close together.

MANNIX:

Now they are saying that every hospital should not have a CAT scanner. In the Blue Cross area in Northeast Ohio there are over 60 hospitals and about eight CAT scanners. The cost of a CAT scanner -- which can be well over a million dollars -- when depreciated over a number of years, is a very small part of the cost of operating a hospital. The capital cost of hospital operation, buildings, grounds, all the equipment in it; the depreciation on all that is only about six percent of the operating costs. Cost is now \$250 a day, and the entire capital cost is only about \$15 a day. This is not where the cost is. The cost is in personnel; nurses are not overpaid, but they receive \$18,000 or more per year plus fringe benefits. In fact, the hospital has over three employees for every patient.

WEEKS:

The ratio has gone up a great deal over the years, hasn't it?

MANNIX:

It was under two per patient when I first got into the field; it is now over three. One of the reasons for this is the intensity of care. Fifty years ago, the appendectomy patient came into the hospital and stayed twelve

days; now he stays five. The hospital renders many services in five days that were formerly rendered in twelve.

This is not entirely a fair comparison, but I very often use it. I am very much interested in controlling the cost of health care. The average length of life now is over 73 years. At the turn of the century it was only 47 years; the average life is thus 26 years longer now. We are spending about 10 percent of our Gross National Product for health care. There are many factors that have contributed to the increase in life expectancy. One of the major factors is improved medical care. Most people would gladly pay 10 percent of the Gross National Product to live another 26 years. Most of those additional years of life are useful and productive. I was born in 1902 when life expectancy was under 50 years. I am now 78 years of age and have exceeded the life expectancy at the time of my birth by over 28 years. I have greatly enjoyed these last 28 years.

#### SELF-INSURANCE

WEEKS:

Do you think there will be a move toward self-insurance on the part of employers to cover employees? Or provide health services themselves?

MANNIX:

It is hard for employers to believe that the health care cost of \$250 a day can be justified. Somehow they think it can be done for less. My feeling is that we will see employers experiment with other approaches, but that this will not be very extensive. I do not think employers of even the largest corporations in the country can do this for less money than now.

There have been examples of employees getting into this field. Unions have tried it. Particularly John L. Lewis, who started a group of hospitals in Kentucky and West Virginia to care for coal miners. He was interested in controlling the cost of hospital care. Ultimately they sold these hospitals to a religious group.

Groups of doctors, including some of the best-known clinics in this country, felt they could run hospitals more reasonably than they were being run by others, including some of the religious bodies. None of the big clinic hospitals controlled by physicians are inexpensive, although they are rendering excellent care.

Government felt it could run hospitals. Maybe the classic example is the Veterans Administration. While it is very hard to get comparable data on their costs, the Veterans' hospitals are not inexpensive institutions. Generally speaking, state, city and county hospitals are expensive.

I am sure some employers will move into this field, but I think most of them will be surprised at their experience so that this will not become very widespread.

WEEKS:

Not much is likely to come of it?

MANNIX:

No. We have had it already. I feel sure that in most instances when government agencies, employers, labor unions, physicians, and consumer groups organized hospitals they felt they could render care for much less than it cost in community hospitals. This just has not proved to be true. The only groups that have been able to show some savings to date are the chains. This is true of the non-profit as well as the investor-owned chains. Spreading of

costs makes this possible.

MICHIGAN BLUE CROSS

WEEKS:

Would you like to talk about how you happened to go to Detroit to start the Blue Cross Plan?

MANNIX:

I had worked with the hospital administrators up there. They contacted me sometime in the middle of 1938. They had a committee to study the development of a hospital prepayment plan in Michigan. I met with the committee several times in September and October 1938. I had worked with many other such committees all around the country.

In about November they asked me if I would be interested in becoming the executive of the Michigan Plan. I said no, that my interest was in hospital administration. They made more attractive offers over the following months.

I liked the Michigan people. Some of them were important leaders in the hospital field. I was working principally with the administrators of Harper, Grace and Ford Hospitals in Detroit. At that time Stewart Hamilton was the head of Harper Hospital; his son later became the executive of Hartford (Connecticut) Hospital. Later both father and son served as presidents of the American Hospital Association.

Warren Babcock was the administrator of Grace Hospital. He was the father of Kenneth Babcock, who was later the executive of the Joint Commission on Accreditation of Hospitals. Ira Peters was the administrator of Ford Hospital. Henry Ford, Sr. was chairman of the board of the hospital at that

time.

The committee persuaded me to take the Michigan position. I was interested for two reasons. One, this would be a statewide program. Next, the state medical society was very interested in developing a medical plan. At that time there was only one other medical prepayment plan in operation. California had started one in August 1939, but it was making very little headway. The Michigan State Medical Society was interested, and I was intrigued with the potential for a statewide hospital plan combined with a medical plan.

I started in Michigan on February 1, 1939. In the next few years the program had absolutely spectacular growth. I enrolled Ford Motor Company nationwide, then General Motors nationwide, and later Chrysler.

The plan was started with only a \$10,000 loan, a third of which was contributed by Grace Hospital, a third by Harper, and a third by Ford Hospital. Edsel Ford gave his personal check for the Ford share. He gave the odd penny, by the way. Edsel died three or four years later. His father died a few years after that. Michigan Blue Cross soon became one of the most successful Plans in the country.

When I went to Detroit, I was determined that I would not stay in Blue Cross for more than two years. I thought the idea of a statewide Blue Cross Plan and the possibility of a medical plan was intriguing, and I would like to see them started. I became so involved that I never did go back into active hospital administration.

WEEKS:

One thing I have wondered about, and have never been able to get clear in my mind. I think it was a problem you had in Detroit. That, is, how you

handled these national contracts, when I think you said, there was only one counterpart of Blue Shield and there were some states that were not covered by Blue Cross at that time.

MANNIX:

Frankly, this was very difficult. I suppose I was just young and enthusiastic, and this made it all possible. When we enrolled Ford Motor Company, fortunately most of the Ford employees were in Michigan. The original Ford program was for hospital care and surgical care for the employed person only; the subscription fee was \$1 a month per employee: 60¢ for the hospital care and 40¢ for the hospital surgical care. There was no medical (non-surgical) coverage at all, and no coverage for dependents.

That Ford contract became effective in April 1940. There was only one other medical plan in the country then, and several states were without a hospital plan. There was no hospital plan in Indiana, Arkansas, or several other states. I am guessing a bit, but at that time there were not more than forty states with a Blue Cross Plan.

We served Ford employees on the Michigan payroll from Detroit for a period of time. Ford was not much of a problem because of the great concentration of their employees in Michigan. When we enrolled General Motors employees in November, 1941, just before Pearl Harbor, they had considerable numbers of employees in about forty states with large assembly plants and other large industrial developments in thirty or more states. One of my biggest problems was that there was no Blue Cross or Blue Shield Plan in Indiana at that time.

There is an interesting story in connection with General Motors enrollment. We brought together about twenty executives of the Blue Cross Plans where there was a substantial number of General Motors employees. We

discussed the details of General Motors enrollment with company officials. Later when we returned to my office, one of the Blue Cross executives said, "That was a might fine thing you did, Mr. Mannix. Mighty fine thing for Blue Cross, but I can't take those subscribers."

I laughed and said, "What are you talking about?"

He said, "I can't take those subscribers."

I said, "What in the world are you talking about?"

I am quoting: He said, "I've got 25,000 subscribers in my plan. I don't know what I would do with more subscribers."

There was only one thing that saved me in that case. This was in October, and the program became effective November 1, 1941 in Michigan but not in other states until January 1, 1942. Pearl Harbor occurred in the meantime; General Motors closed their large plant in that state, and did not reopen it until some years later. All the automobile companies stopped manufacturing cars in December 1941.

I went to Detroit with only one assistant and a secretary. We had very spectacular growth, and developing the staff to handle our growth was one of our greatest problems. It became even greater in 1942 with the War Manpower Act. Anytime I employed additional people, I had to get permission from the War Manpower Commission to increase the staff. I had problems with the Manpower Commission even though nearly all our subscribers were engaged in the war effort.

WEEKS:

Did the Blue Cross Commission, or the predecessor of it, set up some kind of mechanism to handle national accounts? National claims, I should say?

MANNIX:



They have done two things to serve national groups. One of the early developments was an arrangement whereby the Plans agreed to cooperate in enrollment on national accounts. The first time that became a real problem was with Ford Motor Company. It became a major problem with General Motors enrollment. Until that time, there were many national organizations which had Blue Cross with local plans at their many locations. There was no coordination of this. They were all enrollment on a local basis. For instance, in the Cleveland Plan, American Steel and Wire, a division of U.S. Steel, was a member of the Cleveland Plan but this was a local arrangement.

When I arrived in Detroit, the UAW-CIO was just gaining real power. General Motors and Chrysler were already organized at that time; Ford was not.

I had originally enrolled some sizeable organizations in Detroit including J. L. Hudson, a large department store; and Parke, Davis, the drug house. Ford Motor Company expressed interest in the very beginning, February 1939. As I said, a third of the original financing came from Edsel Ford, the other two-thirds from Harper and Grace Hospitals. We enrolled Ford in the latter part of 1939. The fact that Ford was unorganized by labor at the time was not, in my opinion, a factor.

It was true that Ford Motor Company and Ford Hospital were very much aware of the problem of financing health care. I learned very early that one of the Ford Hospital's problems was collecting of patient accounts. They were very generous in permitting patients, particularly Ford Motor Company employees, to pay hospital bills over a period of time. As I remember it, they had over \$400,000 in outstanding bills for Ford Motor Company employees, for which small deductions were being made monthly for payment of hospital bills. Probably that close association between the hospital and the motor company

made both groups aware of the problem people have in financing hospital care.

In February 1939, General Motors enrolled with the Metropolitan Life Insurance Company's hospital plan. This made me wonder about the future of Blue Cross Plans because here was the largest corporation in the country enrolling in a private insurance company rather than Blue Cross. However, the General Motors plan only provided \$4 a day toward hospital care and \$20 toward ancillary services. I was convinced that the way to solve the problem of financing hospital care was not a cash indemnity arrangement. What people need at the time of hospitalization is service benefits, complete payment. The Blue Cross Plan was on a service basis. We paid for a semi-private room in full and for ancillary services in full.

I continued to work with General Motors. Two years later, in November 1941, General Motors changed from the original \$4 a day plus \$20 for extras in the insurance company to Blue Cross. This was a great impetus not only to Blue Cross in Michigan, but also to Blue Cross nationally because we enrolled General Motors nationwide.

The contacts I had at that time were joint conference with General Motors executives and officials of the UAW-CIO. Walter Reuther was very active at that time.

The success of the program with Ford and General Motors resulted a year or so later in Chrysler enrolling in Blue Cross.

I'll come back to Blue Shield. The original Ford Motor Company plan was only for the employed person; there was no coverage for dependents. It covered only hospital and surgical care, and did not cover any payment of medical care in hospitalized cases, only surgical care. Because people thought the big expense was hospital and surgical care, they felt they could

finance the cost of medical care without prepayment.

Some year before I came to Michigan, Nathan Sinai had made a study for the Michigan State Medical Society and recommended a program of prepayment of health care. There was a great division of opinion among the medical group on this although I had the impression that the Michigan State Medical Society was one of the most liberal in the country. I think the evidence of this is that they financed the study by Nathan Sinai.

I had a very unusual experience in that connection. All of early contact in Michigan was with representatives of the hospital association that were interested in starting a hospital prepayment plan. The organization I was employed by was then called Michigan Society for Group Hospitalization, later changed to Michigan Hospital Service.

There was a feeling in the state medical society that if there was to be a program for prepayment of health care, it should be under medical society auspices. While that feeling existed among a large number of doctors, nothing was being done about it. This was part of the reason that the Michigan Hospital Association became interested.

The day I arrived in Detroit, I picked up a Detroit Free Press, and the front page, eight column headline said "Michigan Physicians Start Medical Plan." I could not figure out what was going on. I contacted people with the hospital association and was told by them not to worry about that; even though the state medical society had taken this action, nothing was likely to happen.

I went ahead with starting the hospital plan. We only had a hospital plan during the first year I was there. Ford Motor Company insisted upon having coverage not only for hospital care, but also for surgical care. This resulted in a whole series of meetings with the Wayne County Medical Society

as well as with representatives of the state medical society. In March 1940, about a year after I arrived in Detroit, the state medical society finally agreed to start a companion organization, Michigan Medical Service, to cover the surgical care. The Ford Motor Company was the first participant in that joint program. Michigan Medical Service was to become Michigan Blue Shield. The Michigan Hospital Service handled all the enrollment and administrative matters in connection with the surgical plan with the exception of payment of claims. Michigan Medical Service maintained its own organization for claim payment purposes. That dual arrangement continued for many years. Within the last few years these two organizations have merged into a single corporation.

During the early 1940s the UAW-CIO developed an interest in the hospital and medical plan. It was just an interest on the part of the union in some method of protecting their people from the cost of hospital and medical care. During all the early years of the 1940s, the entire cost of the hospital and medical plan was paid by the employee. There was no company contribution. The motor companies simply agreed to deduct the cost of this from the employee paychecks. I can remember at one meeting with General Motors officials, Walter Reuther and several members of his union the matter of company contribution came up. Reuther made the statement that the company should give the men the money and let them pay for the care. He actually was opposed to company contributions at that time.

The company contribution started developing in a relatively small way during World War II because so many employers were in war production on a cost plus basis. They were reimbursed for war work on the basis of cost plus a percentage, so the company profited by paying for the cost of hospital and medical coverage. However, this occurred only to a limited degree in Michigan

during World War II. There is an interesting sidelight in this connection. When I went to Detroit, I took the position that the cost of health care should be paid by the employee rather than the company and made this pretty much a rigid rule. The strong position I took on this resulted in an interest on the part of people in one Michigan area, primarily county employees and school teachers, wanting the county and the school board to pay part of the cost of hospital and medical care. I would not agree to this. The county commissioners went to the state legislature and secured legislation to permit the county to make contributions. This is interesting because many people believe organized labor forced company contributions from the employers. Historically this is not true. I previously quoted Walter Reuther in this connection.

A couple of conditions beginning in World War II changed this. First of all, there was a great labor shortage. Employers could not raise wages, which were frozen, but they could give fringe benefits. Employers became interested in giving very liberal fringe benefits, one of which was health care. There developed another situation which still pertains today. The cost of health care for employees is tax deductible as far as the employer is concerned, and it is tax exempt to the employee.

What really changed the situation on company contributions, however, was the refusal of the steel companies in 1948 to bargain on health benefits with the United Steel Workers union. The steel workers went into court on this case, and ultimately it went to the United States Supreme Court. The Supreme Court decided in the late 1940s that fringe benefits were a bargainable item. After that decision, the spread of company contributions greatly increased. Today it is a rare company of any size that is not paying part of the cost of

health benefits.

The labor situation at that time was acute, however, I cannot say that it had any effect on the development of prepayment for health care. As chief executive of a Blue Cross/Blue Shield Plan, I was extremely careful that I did not favor management or labor. It was not easy to work with both groups. I was able to do this because, after five years in Detroit, I had the friendship I believe, of corporation and unions. In any event, there were a million people enrolled in Blue Cross and Blue Shield. This could not have been done in my opinion, except that we dealt fairly with both management and labor. It was also true, that while there was great interest on the part of the unions in getting health benefits for their people, there also were great numbers of employers interested in this. Some of the large groups that we enrolled early in Michigan, for instance, J. L. Hudson, Burroughs Adding Machine Company, and Parke Davis did not have organized unions at that point. So we were working with both organized employers and unorganized employers.

#### ILLINOIS BLUE CROSS

As I said earlier, when I left hospital administration at University Hospitals in Cleveland to take a position at the Blue Cross Plan in Detroit, I had no intention of staying in the Blue Cross field more than a couple of years. I was intrigued by Michigan because there was an opportunity to develop a program on a statewide basis. I had known of the Nathan Sinai report for the Michigan Medical Society. I believed that prepayment for health care was going to be successful in the long run and would cover all types of health care, not just hospital care but medical care.

After I was in Detroit for five years, I was approached by the trustees of the Chicago Blue Cross Plan as to whether I would be interested in that position. The executive had been there for several years and was moving to another field. I went to Chicago for several reasons. First, it was the center of health activities in the country. It had the American Medical Association and the American Hospital Association, the national Blue Cross headquarters, and the American College of Surgeons. Hospitals magazine was published there; Modern Hospital was published there. There were meetings of health groups in Chicago nearly every day in the year. Illinois was a much more populous state; Chicago was a much more populous city. The Chicago Blue Cross Plan had been started two years before the Michigan Plan but was only about half the size. Next, I thought it was very important in the city that was the center of health activity to have a very strong Blue Cross and Blue Shield Plan. There was no Blue Shield Plan there at all, although at that time the Michigan Blue Shield Plan was five years old. By that time (1944) I had forgotten about my two year limit away from hospital administration, although I never did lose my interest in hospital administration. All through my Blue Cross years I did hospital consulting and still am doing it.

During the twenty-four months I was chief executive of the Chicago Plan, I increased the membership from half a million to a million; enrolled as many people in two years as they had in the previous seven, and had development of the medical plan very much under way.

#### HOSPITAL CONSULTATION

One of my interests has been hospital consultation. I had my first

hospital consulting project back in 1927. I worked with Frank Chapman in consultation on Chicago Memorial Hospital, a hospital on the south side of Chicago, just south of Michael Reese, since merged with the Chicago Northwestern group. I have continued consultation in the hospital field and even now I am consulting with three different hospitals. All during my Blue Cross years I have had direct contact with hospitals. I think this has been helpful to me in my Blue Cross career because I believe it is important for an executive to use their language. This is also true in working with physicians.

I mentioned my concern about the Academy of Medicine when we started the Cleveland Plan wanting the plan limited to hospital care. Some physicians felt that it would lead to socialized medicine in this country. However, in 1979, the Cleveland Academy of Medicine gave me their Distinguished Service Award; the first time it was given to a layman. I served on the American Medical Association's National Commission on the Cost of Medical Care from 1976 through 1977.

My point is that with my close association with hospitals and doctors for sixty years, I have never felt that I was away from the health field.

When I took that position in Detroit in 1939, many of my friends in hospital administration said, "John, we hate to see you leave hospital administration. You shouldn't have done this."

Actually, I probably have had more contact with hospital administrators than most hospital executives because I have been continually in contact with member hospitals. In Michigan and in Chicago I felt I knew more of what was going on in the hospital field as a whole than any one administrator.

It is interesting to me that the only job I have ever applied for in the health field was at Mount Sinai Hospital. Every other position was offered to



me. Nor have I ever solicited consultation.

WEEKS:

That must give you a good feeling.

MANNIX:

Actually, it is only recently that I realized this was true. I have always gone from one position to the other, or from one consultation job to the other.

JOHN MARSHALL INSURANCE COMPANY

I mentioned that in 1939, right after I went to Michigan, and probably before, I felt that there were too many separate Blue Cross corporations; that there needed to be much more coordination among them. I had encountered great difficulty in working with national employers. This started with my enrollment of Ford in Detroit which wanted coverage for employees throughout the country. I saw this to a much greater degree when I enrolled General Motors, with employees in probably 40 of the 48 states. In view of all the circumstances, I think we did a very good job in working with national employers. There was, however, much difficulty because hardly any two Blue Cross Plans in the country had the same set of benefits. Most of them were very cautious about extending benefits. All the Plans, for instance, started by providing twenty-one days of care a year. When I enrolled Ford Motor Company, I changed this to seventy days of care per year. There was concern about the early development of a medical plan by people who questioned the financial soundness of prepayment for hospital care with greater concern about the financial soundness of prepayment for medical care.

With the difficulties I had in serving national employers in the motor industry in Detroit and later with the meat packing industry in Chicago and many other national employers, I realized that the great mass of Americans are employed by national employers.

I had advocated an American Blue Cross in 1939 without any support from my colleagues in the field. The executive of the Blue Cross Plan at Huntington, West Virginia, was very interested in solving some of the problems of nationwide enrollment and serving national employers. He asked me if I would be willing to consider starting an insurance company that could be licensed in all forty-eight states that could solve some of these problems.

One of the things I insisted on and had a written agreement on, was that at least 99 percent of the income would be used for hospital and medical care, or for necessary overhead, limiting corporate dividends to one percent of gross income. People were willing to finance this and agreeable to the one percent limitation on any dividends. Although I had been connected with non-profit organizations, I felt we could afford one percent of the gross income for stockholders if it solved many of the other national problems.

Among other things, I was interested in extending benefits to at least 120 days. It was difficult to get many Blue Cross Plans to provide more than 70 days, although there was a national demand for this on the part of the large employers. Next, this did not cost very much. The greatest cost of hospital care is the first fourteen days of the patient's stay.

A combination of conditions resulted in my starting the John Marshall Insurance Company in July 1946. I was very concerned with the possible effects of inflation. I talked with at least two bankers in whose financial knowledge I had great faith. I was assured by everyone that after World War

II we were going to have a major deflationary period. One of these discussions took place in late 1945 or early 1946, and everybody thought that with the stop of munitions manufacturing there was going to be a deflationary period. We had exactly the opposite; we had very severe inflation after the war. In the 1946 to 1948 period, right after I started John Marshall, there was a very substantial increase in hospital costs. I originally had only a half million dollars in capital, which seemed like a great deal and would have been much more than enough based on hospital cost prior to that time. The costs from roughly 1930 to 1945 had stayed near \$6 a day, even during World War II. Of course, we had a freeze on salaries and wages during the war. Anyway, I had real financial problems. Finally, we had an opportunity to sell the company to Bankers Life & Casualty, which was owned by John MacArthur.

Just about the time I sold John Marshall Insurance Company to Bankers Life & Casualty, the executive of the Cleveland Blue Cross Plan retired. I was contacted by the trustees of the Cleveland Plan as to whether I would be willing to come back. I think the conversations were started before I actually sold John Marshall.

I came back to Cleveland in August 1948, to be the executive of the Cleveland Plan for the next seventeen years. I retired early in 1965. I have never been so busy since.

CLEVELAND BLUE CROSS - 1965-1980

When I retired as chief executive officer of Blue Cross in Cleveland in 1965, I wanted to establish a research department at Blue Cross. I wanted to do research for a maximum of seven years, until I was 70, with the

understanding that this would be on a year-to-year basis. From my retirement until 1972, I organized and conducted a research department. I did two things that are still operating and still provide a tremendous amount of data on use and cost of health care.

One of these projects was an analysis of hospital discharges by diagnosis in what is called the QUEST program, which started largely as an analysis of the diagnosis of disease and surgical operations. Finally, we incorporated into it an analysis of ancillary care--laboratory services, x-ray, and other diagnostic and therapeutic services.

This was intended for use by the individual hospital medical staff for analyzing quality of care. The nature of the program was such that many other uses for it developed. All hospitals were reporting on all patient discharges, and after a few years this gave us a detailed analysis of the practices of all physicians. These data were collected on a very confidential basis. It is processed by Blue Cross but for the use of hospital medical staff. It became very apparent in a short time that we had a more complete list of physicians than the county medical society.

WEEKS:

This was in your service area that you were doing this?

MANNIX:

We did it for the Blue Cross of Northeast Ohio area, which operates in thirteen counties. This resulted in another very important factor. We were able to relate diagnosis to a measured population. Through Blue Cross records we had a very good analysis of people who came into the Cleveland area for care. We were able to do something that other programs were unable to do. They had extensive data but could not relate it to a measured population. The

regional medical programs made a very extensive study and used the data for studies on heart, cancer, and stroke.

It also became apparent that the demographic data was very useful in planning hospital facilities and services. The faculty of the Case Western Reserve medical school has used the data in a number of special studies. The first of these was a very extensive five year study on rheumatic fever. We were able to give the medical school research staff a demographic list of all cases of rheumatic fever in all hospitals. To do this we had to get the written approval for use of the data by the researchers. In that case we also received approval of the Academy of Medicine. We were very careful about the confidentiality, particularly where the data referred to an individual patient or physician. Patients were identified only by a hospital admitting number and could not be individually identified. The doctors were all identified by a code number.

Another research project we developed was a financial analysis. There had been an analysis of the cost of hospital care in eighteen hospitals in the Cleveland area which went back nearly fifty years, but Blue Cross has over sixty member hospitals. We developed a computerized program of financial data. First of all, we divided all the hospitals in the area into five categories, putting similar hospitals in similar categories, and then made a line item analysis of their costs on a patient day basis with a lot of supplemental analysis. This could not have been done on a manual basis and have it timely; there are over 90,000 computer computations in those quarterly financial and statistical reports. It is the most complete analysis of hospital costs anywhere in the country. The only program that comes close is the Health Administration Services of the American Hospital Association. The

fact that we have a group of over sixty hospitals in thirteen nearby counties makes it possible to identify differences that would be difficult on a national basis. The combining of medical and financial data makes extensive research possible. The demographic data became the bible of the planning agency, the Health Systems Agency.

In 1965, when I retired, I had been in top administrative positions for over forty years. I must admit that while I found it intriguing and exciting most of the time, I just wanted to do something different. I felt I want to devote more time to consultation which has always interested me very much. I am fortunate to have my combination of background in hospital administration plus financing of care. There are very few people who have this combination of experience. I am now 78 years of age and still active and enjoying it.

#### AMERICAN BLUE CROSS

Because of the experience with Ford, and later General Motors and Chrysler, and the difficulty of serving national employers with Blue Cross and Blue Shield, I became interested in a single national organization that would take care of this. I first proposed a national organization with the chartering of local units in 1939. The head of one of the larger plans in the country nearly read me out of the movement as a result of this. The plan executives were concerned about their local autonomy.

In 1944, I proposed an American Blue Cross with a national charter similar to the charters of the American Red Cross and the American Legion with chapters throughout the country. There was national publicity on this. I have a folder of newspaper clippings from practically every large city in the

country as a result of an address I made on this at the American Hospital Association, with stories in both Newsweek and Time.

The Blue Cross organization has, of course, made arrangements for national enrollment of employees of national organizations and provision of uniform benefits across the country. Arrangements have been made for national administration of benefits so that benefits for a member of the New York City Plan hospitalized in Los Angeles are handled by the Los Angeles Plan. There is an interplan bank that operates like a regular bank clearing house where there is settlement of claims that one plan pays for another plan at the end of the year. There is a great deal of coordination and cooperation including a nationwide wire system between all the plans. The wire system also feeds into the Social Security Administration in Baltimore for the handling of Medicare claims. There are still 120 separate Blue Cross and Blue Shield Plans at the local level; this requires a great deal of cooperation.

Until 1972 the Blue Cross Association worked very intimately with the American Hospital Association. There was a change in this relationship, the so-called "partnership" of the organizations, that resulted in the Blue Cross Association taking over the approval program that was formerly administered by the American Hospital Association. This resulted in a change in the Blue Cross symbol that until then had the seal of the American Hospital Association superimposed on it. Now it has a man superimposed on a blue cross. The Blue Cross Association had headquarters in the American Hospital Association buildings for many years. Now they are in separate leased buildings several blocks away.

Another development has been a merger of the national Blue Cross and Blue Shield organizations, which has operated separately.

There has been a marked tendency for the plans to be operated on a statewide basis, rather than a local basis. Most plans originally were local. There also has been a tendency to merge Blue Cross and Blue Shield operations at the state level. Perhaps twenty-five states now have a single corporation; one Blue Cross and Blue Shield Plan with a single board of trustees and one executive. The movement for the last forty years has been for greater consolidation. The problem of getting cooperation of separate, very successful corporations where there is a great deal of local pride involved is not easy. The movement is in the right direction; there is no question about that.

Generally speaking, although the 120 corporations all have their own autonomy, the servicing of national employers works relatively smoothly. I think Blue Cross and Blue Shield does an excellent job taking care of the employees of the automobile, steel, and communications industries and others. It does not mean there are not problems.

MONITORING BLUE CROSS AND BLUE SHIELD

WEEKS:

One thing I have wondered about is the ability of Blue Cross and Blue Shield to monitor the individual plans, and if they found them wanting, to do something about it. Is there a mechanism for this?

MANNIX:

There is a mechanism for reviewing the performance of the individual plans. In most instances the plans themselves request this. There have been only a few instances where a particular plan has had major management problems.



One of the interesting things about Blue Cross and Blue Shield, which have a major financial risk and are operated on a very narrow margin, is that there has never been a failure in Blue Cross and Blue Shield. That speaks for itself. There have been financial problems in several plans, but they have always been handled, and the situation has always been corrected. This is particularly interesting in view of the fact that public opinion fifty years ago was that the idea was not financially sound.

In my early days in the field I talked about a prepayment plan for hospital care. I was continually told -- and I mean continually -- that if people could go to hospitals without direct cost, there would be no way to build enough hospital beds to take care of them. This has not proved to be true. My background at the time was in hospital administration, and my experience was that people did not want to go to the hospital and did not want to stay in the hospital longer than absolutely necessary. The exceptions are rare.

Prior to starting the Blue Cross Plan in Cleveland, I developed a brochure on the prepayment idea, explaining the actuarial basis for this. I estimated, as the result of a great many studies I made, that people enrolled on a group basis could expect to receive about 850 days of hospital care per 1,000 per year -- less than one day per year per person. The Cleveland Blue Cross Plan last year, and this is typical of plans throughout the country, actually paid for 828 days of care for a person 65 years of age and younger. One of the common impressions is that group hospitalization cost has increased because of use of care. This is not true. The real problem of increased cost is the cost of a day of care, which has gone from \$6 to about \$250.

When I got into the field in the early 1920s, most of the nursing care was

rendered by supervisory nurses, head nurses, nursing aides, and student nurses. There were very few paid general duty nurses. There were many special nurses who were paid individually by the patient.

During the 1930s in Cleveland, and this was a pretty accurate index of what was happening nationally, the salary for general duty nurses was \$45 a month and maintenance. Nurses now receive about \$18,000 a year or more.

Contrary to the opinion of many who think that people with hospital protection go to the hospital and stay too long, the average length of stay for every common condition has been greatly reduced in recent years. In my early days in the field, appendectomies, hemorrhoidectomies, and herniotomies stayed about twelve days; they now stay about five. Maternity cases stayed twelve or more days; they now stay three or four. Cholecystectomy patients stayed about sixteen days; now they stayed around seven. This has had another effect. The care that is rendered now is a very intense type of care that results in shorter length of stay but has increased the cost per day very substantially.

#### BLUE CROSS SYMBOL

In 1938, it was decided to approve Blue Cross Plans which met certain standards established in 1933 by the American Hospital Association. They were to place emphasis on the public welfare, operate on a non-profit basis, enlist professional and public interest, have economic and financial soundness, free choice of hospital and doctor, and limit benefits to hospital service.

In establishing the approval program it was agreed that there should be a symbol for use of the approved hospital plans.

E. A. van Steenwyck, the executive director of the plan in Minnesota, was using a plain blue cross on his letterhead without using the term "blue cross." It was decided to adopt the blue cross as a symbol for the approved plans with the insignia of the American Hospital Association superimposed on it. This symbol was continued until recent years. The symbol was changed within the last ten years when the Blue Cross Association accepted responsibility for the approval program. The present Blue Cross symbol has the figure of a man superimposed on it. The American Hospital Association insignia no longer appears.

It is rather interesting that although a blue cross was used in 1938 with the American Hospital Association insignia, the words "Blue Cross" did not come into use until 1942 or 1943. I double-checked the literature and cannot find the words "Blue Cross" prior to 1942. Now most plans in the country are known as Blue Cross Plans, and many of them have changed their corporate name to a name with the words "Blue Cross" in it.

When the first medical plans were established in California in 1939 and Michigan in 1940, they decided they should have a symbol. I believe the medical plan in Buffalo was the first one to adopt this Blue Shield emblem.

#### BLUE CROSS MEMBERSHIP

Let's discuss Blue Cross enrollment compared to other organizations. While Blue Cross Plans started in the 1933 to 1934 period, private insurance companies did not enter the field until about 1936, although they previously had indemnity coverage for loss of time for the workers, so-called sickness and accident insurance. Private companies are now growing at a slightly

higher rate than Blue Cross and Blue Shield. Blue Cross/Blue Shield is a coordinated movement even though there are about 120 corporations involved. They compete with over 600 companies that are in the field of hospital and medical care insurance. Blue Cross and Blue Shield nationwide have nearly as many members today as all the insurance companies combined; there is not one private insurance company that even comes close to the Blue Cross/Blue Shield membership.

AREA HOSPITAL PLANNING

WEEKS:

I am looking at my notes here. At some time you were a member of an American Hospital Association committee on areawide planning?

MANNIX:

My interest in facility planning is a result of something that occurred a couple years before I entered the field. Back in 1919, the Cleveland Hospital Council, now the Greater Cleveland Hospital Association and the first local organization of hospitals in the country, decided to do a study on hospital facilities in the Cleveland area. They retained Haven Emerson, of the Columbia School of Public Health, as the consultant. This resulted in a study of the inpatient and outpatient facilities in the Cleveland hospitals and publishing of a 1000-page book on health facilities in Cleveland. I believe this was the first community-wide survey of hospitals in the country. I have copies of later similar publications from a number of other cities, but Cleveland was a pioneer in this. The recommendations of that study had marked effect on the later development of hospitals in the Cleveland area.

The next major development on hospital planning in Cleveland came about 1941 when George Bugbee, who was administrator of Cleveland City Hospital, which later became Metropolitan General Hospital, became interested in facility planning. For all practical purposes, there had been no hospitals built during the 1930s. No one had money to build facilities during the depression years. At that time, Harold Burton was mayor of Cleveland, and George Bugbee's boss. Concern on the part of both Bugbee and Burton regarding hospital facilities resulted in the establishment of a Joint Hospital Committee. This was a committee of thirty people, ten appointed by the mayor, ten by the hospital association, and ten by the Council of Social Agencies (Cleveland Welfare Association). During the World War II years this committee developed a plan for facilities of approximately 1,000 beds to be built after the war. Later those recommendations were closely followed.

The interest of Bugbee and Burton during this period affected the national situation because Burton went on to become a United State Senator. While in the Senate, Burton and Senator Hill became interested in the whole problem of hospital facilities. It should be remembered, we had a period of about fifteen years during the 1930s and World War II years when there was a large increase in population with little building of hospitals in the country. There was a tremendous shortage of hospital beds nationwide in 1945. The interest of Senator Burton and Senator Hill resulted in the Hill-Burton Act and the federal financing of hospital facilities.

I had been away from Cleveland from 1939 to 1948. When I returned in 1948, I served as a member of the Joint Hospital Committee. Even though nearly all the building had been planned during the war years, the construction did not take place until the 1950s.

The Hill-Burton Act resulted in nationwide planning of community facilities. A large part of this happened on an individual hospital basis, generally differing from Cleveland where planning was communitywide.

About 1960, there was concern in the country that we might be arriving at a point where we would have excess facilities in the metropolitan areas with a lack of necessary facilities in the rural areas. This resulted in the establishment of a national committee made up of members appointed by the American Hospital Association and the U.S. Public Health Service. George Bugbee was chairman of that committee, and I was a member. The committee issued a report on areawide planning for health facilities which became the basis of the Comprehensive Planning Act and later the basis of Health Systems Agency planning.

It is interesting that this first study of community hospital facilities was made in Cleveland in 1919 and that Clevelanders George Bugbee and Senator Harold Burton played such a large part in the federal action in this connection.

MONSIGNOR MAURICE F. GRIFFIN

WEEKS:

Will you tell me something about Monsignor Griffin, whose name is often mentioned in accounts of this period?

MANNIX:

Monsignor Griffin was a priest in Youngstown, Ohio, in a parish which included St. Elizabeth's Hospital. There were just two hospitals in Youngstown, Youngstown City Hospital and St. Elizabeth's. Back in World War

I, Monsignor Griffin was pastor of a church and also the Catholic chaplain for St. Elizabeth's Hospital. He became interested in the entire hospital field and very active in the Ohio Hospital Association. For many years he was a trustee of the Ohio Hospital Association and at one point, he was president. He later became a trustee of the American Hospital Association and served the AHA for more than twenty-five years. He served in that capacity longer than any one person before or since. He was also at one time president of the Catholic Hospital Association.

I became acquainted with him in my very early days in the hospital field and got to know him quite well when I became secretary of the Ohio Hospital Association in 1927. I continued to work closely with him during our years of interest in the American Hospital Association. He did, in my opinion, a great deal to bring the Catholic Hospital Association and the American Hospital Association close together. I felt that relationship was excellent over the years.

He and Bert Caldwell worked very closely together. Besides being professional friends, they were close personal friends. They were about the same age, and extremely well-traveled individuals; both had been around the world several times. During Bert Caldwell's capacity as executive secretary of the American Hospital Association, he and Monsignor were very close. During most of that period Griffin was a trustee of the American Hospital Association. Sometime in the early 1930s Monsignor Griffin was transferred from Youngstown to Cleveland and was pastor of a Catholic parish for many years until his death in the late 1940s.

Perhaps one of the most interesting things about Monsignor Griffin and his hospital connections was that, though very active in the Ohio Hospital

Association, the American Hospital Association, and the Catholic Hospital Association, he never held a hospital position. I believe many of the people in the field thought he had some direct connection with a hospital as a trustee or in some administrative capacity; that was never true. His was a general interest in hospital care.

OLIVER G. PRATT

WEEKS:

You mentioned one of the men who did not join the ACHA first year was O. G. Pratt.

MANNIX:

I think he may have been influenced by James A. Hamilton. I got to know Jim Hamilton prior to 1934 when we both became members of the American Hospital Association Committee on Membership Structure. As I remember it, I recommended three people to represent state hospital associations: Jim Hamilton, John Hatfield, and Graham Davis, who was at the Duke Endowment. The first time I met Hamilton, I was very much impressed with him.

As a result of my friendship with Jim Hamilton, I became close to three other people from New England: O.G. Pratt, Scott Witcher and Bill Wood. The three of them were very close friends of Hamilton. People would kid me about how I got associated with these four New Englanders. Ultimately, with the death of Scott Witcher and Bill Wood, Fred McNamara joined the group. He was at one time from New England. The group became Hamilton, O.G. Pratt, McNamara, and Mannix.

O. G. Pratt, in my opinion, was one of the most lovable people in the



entire hospital field; lovable in the finest sense of that word. O.G. was truly the salt of the earth. He was very considerate of everyone's feelings. He would go out of his way to help other people in an endless variety of ways. I do not think I ever heard O. G. Pratt make an unkind comment about anyone.

When I first got to know him he was the executive of a hospital in Salem, Massachusetts. He previously had been the head of the city parks in Salem. I remember visiting a park in which they had reconstructed an old Salem village and had incorporated a history of witchcraft in the Salem area. He apparently became so well-liked that he was chosen to administer the hospital without any previous hospital administration experience.

He went on to become the executive of Rhode Island General Hospital at Providence. He was an extremely competent person and served as a preceptor for a number of graduates of the University of Minnesota course, including the current president of Rhode Island Hospital, Lloyd Hughes. Rhode Island General Hospital dominated the hospital situation in Rhode Island and had a very large portion of all the hospital beds in the state. O. G. Pratt at one time was recommended for the presidency of the American Hospital Association. As far as the nominating committee was concerned, he was it. He begged off at the last minute, feeling that he just could not take that time away from his position in Providence. I felt that it was too bad; that he should have had that honor.

He had a lovely family. One son, with whom I visited several times, is an expert in oriental languages and has traveled with a number of American presidents when orientals were present. I have been with him when we have had a Chinese or Japanese present, generally visitors in the health field. He

would speak Chinese or Japanese language. It was absolutely amazing. I think the most surprised were the orientals to hear a Caucasian talk their language. O.G. was one of the outstanding hospital administrators of the century, in my opinion.

KENNETH WILLIAMSON

You were asking about Kenny Williamson. I first got to know him when he was the executive of the Western Hospital Association, probably in the early 1940s. The Western Hospital Association was not a big organization at that time. He did an outstanding job, particularly in government relations in California. It was because of this that he was chosen for the position at the Washington office of the American Hospital Association where he was an excellent government relations person. The American Hospital Association has the problem of there being a great difference of opinion in the hospital field itself as to the direction hospitals ought to go regarding government relationships. Kenny Williamson, in my opinion, leaned toward more government activity. I am sure he was reading the pulse of the majority of members of the AHA in doing this. I sometimes found myself in disagreement. In the financing of care, hospital operation, and even planning, I tend to favor doing this on a voluntary basis, through voluntary agencies. Kenny seemed to feel that more and more government intervention was unavoidable, and on the basis of that assumption, it was very important to work closely with government. He was very active in the Washington office during the period when we were getting more and more federal legislation affecting the health field. Until the Hill-Burton legislation in 1946, we had very little federal

legislation affecting the health field in this country. There has been a lot of it in the last thirty-five years.

There is no question that Kenny did a very competent job. What he did was accepted by the field. He was politically astute enough to judge the feeling of the majority of people in the field. He and George Bugbee were very close friends. They were both competent people who had also worked closely in both the American Hospital Association and the Health Information Foundation. George has always been a staunch supporter of Kenny Williamson. Kenny has thousands of friends in the hospital field.

The American Hospital Association had become much more involved in regulatory matters in recent years. I suppose this was inevitable. This began with the financing of facilities, then planning, then some of the early legislation covering the care of the indigent, then the Medicare and Medicaid Acts, later PSRO and HMO legislation. Today I think we have arrived at the point where one of the major concerns of people in hospital administration is regulation. Government help was welcomed in the 1940s and even some later years, but it has created many problems for hospitals.

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