HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Anne Ramsay Somers

ANNE RAMSAY SOMERS

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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Lewis E. Weeks
2601 Hawthorn Road
Ann Arbor, Michigan 48104
(313) 662-4298

Anne Ramsay Somers

CHRONOLOGY

1913	Born in Memphis, TN, September 9
1935	Vassar College, B.A.
1937-1943	International Ladies Garment Workers Union Educational Director, various locations
1939-1940	University of North Carolina, graduate study in economics
1949-	Self-employed author, lecturer, consultant
1957-1963	Haverford College, Research Associate
1961-1964	U.S. Public Health Service Investigator under research grant at Children's Hospital, Philadelpha
1964-	Princeton University, Industrial Relations Section, Research Associate
1971-1976	College of Medicine and Dentistry of New Jersey-Rutgers Medical School,* Associate Professor, Department of Community Medicine
1972-1975	College of Medicine and Dentistry of New Jersey-Rutgers Medical School,* Director, Office of Consumer Health Education

*Name of school changed in 1982 to University of Medicine and Dentistry of New Jersey.

CHRONOLOGY (continued)

1976-	College of Medicine and Dentistry of New Jersey-Rutgers Medical School,* Professor, Department of Environmental and Community Medicine
1978-1980	College of Medicine and Dentistry of New Jersey-Rutgers Medical School,* Faculty Seminar on Geriatrics and Gerontology, Director
1981-	College of Medicine and Dentistry of New Jersey-Rutgers Medical School,* Professor, Department of Family Medicine

*Name of school changed in 1982 to University of Medicine and Dentistry of New Jersey.

MEMBERSHIPS & AFFILIATIONS

American Association for the Advancement of Science

Member, 1978-1980

American Board of Medical Specialties

Member, 1975-1979

American Council of Life Insurance and Health Insurance Association of America,

National Advisory Council on Education for Health, Vice-President, 1978-

American Hospital Association

Committee on Health Care for the Disadvantaged, Member, 1969-1971

American Hospital Association

National Advisory Committee on Health, Member, 1971-1974

American Hospital Association

Special Committee on the Regulatory Process, Member, 1976-1977

American Public Health Association

Member

Association of American Medical Colleges

Advisory Committee on Health Services, Member, 1971-1976

Center for Science in the Public Interest

Member

College of Medicine and Dentistry of New Jersey

Consumer Health Education Advisory Committee, Member, 1975-1982

Diabetes Care

Editorial Board, Member

Duke University Medical Center

Board of Visitors, Member, 1972-1978

Duke University Private Sector Conferences

Member 1977-1981

Family and Community Health

Editorial Board, Member, 1978-

Forum on Medicine

Editorial Board, Member, 1978-1980

Group Health Insurance, Inc.

Board of Directors, Member 1968-1971

Group Health Journal

Editorial Board, Member

The Hastings Center: Institute of Society, Ethics, and the Life Science

Member, 1978-1979

Health Facilities Planning Council for New Jersey

Member, 1965-1968

Hospital Research & Educational Trust of New Jersey

Trustee, 1964-1971

Industrial Relations Research Association

Member, 1965-1978

Inquiry

Editorial Board, Member, 1978-1981

MEMBERSHIPS & AFFILIATIONS

(continued)

Institute for Policy Studies

Health Policy Seminar, Member, 1966

Insurance Network for Social, Urban, and Rural Efforts (INSURE)

Vice President and Director, 1980-

Advisory Committee for Lifecycle Preventive Health Services Study

Member, 1980-

National Academy of Science, Institute of Medicine

Member, 1973-

National Academy of Science, Institute of Medicine Board, (originally Advisory Committee) Health Promotion and Disease Prevention, Member, 1976-1982

National Academy of Science, Institute of Medicine, Public Policy for Care of the Dependent Elderly, Steering Committee, 1976-1977

National Advisory Commission on Health Manpower, Consumer Panel,

Member, 1966-1967

National Arthritis Commission, Public Policy Panel

Member, 1975-1976

National Center for Health Education

Board of Directors, Member, 1977-

National Conference on Preventive Medicine, National Institutes of Health and American College of Preventive Medicine, Advisory Committee, Member, 1974-1975

National Fund for Medical Education

Board of Directors, 1977-

National Institutes of Health and the American College of Preventive Medicine, Task Force and Expert Panel on Consumer Health Education, Chairman, 1975-1976

New Jersey Conference on Aging, Task Force on Primary Care and Preventive Health Services, Health Services Committee, Chairman, 1980-1981

New Jersey Department of Community Affairs

Consultant, 1967-1968

New Jersey Department of Health

Consultant, 1966-1967

New Jersey Department of Institutions and Agencies, Hospital Advisory Council, Member, 1966-1971

New Jersey Department of Institutions and Agencies, Medical Assistance Advisory Council, Vice Chairman, 1967-1969

New Jersey Hospital Association

Member

New Jersey Public Health Association

Member

New Jersey Regional Medical Program, Urban Health Task Force

Chairman, 1968-1969

Planned Parenthood-World Population Center for Family Planning Program Development, Member, 1972-1975

President's Conference on Private Health Insurance, Planning Committee, Member, 1967

Princeton University, Woodrow Wilson Round Table on Health Policies in New Jersey, Member, 1968

Private Initiative in PSRO
Management Committee, Member, 1974-1976

Public Affairs Committee
Board of Directors, Member, 1973-

Rutgers Medical School-Hartford Foundation Geriatrics/Gerontology Program Advisory Committee, Member, 1980-

Society of Teachers of Family Medicine
Honorary Member, 1969

University of Texas Health Science Center at Houston
Board of Visitors, Member, 1980-

U.S. Department of Health, Education and Welfare, Advisory Committee on Medicaid Payments to Physicians and Other Practitioners, Member, 1969

U.S. Department of Health Education and Welfare, National Advisory Allied Health Professions Council, Member, 1967-1969

U.S. Department of Health, Education and Welfare, Social Indicators Panel, Member, 1966-1968

MEMBERSHIPS & AFFILIATIONS

(continued)

U.S. Department of Health, Education and Welfare, Social Security Administration, Consultant, 1965-1977

U.S. Department of Health Education and Welfare, Social Security Administration, Health Insurance Benefits Advisory Council (HIBAC), Member, 1972-1975

White House Conference for Aging (1981), Gov. Brendon Byrnes Advisory Committee, Member, 1980-1981

White House Conference on Aging, Technical Committee on Health Services, Consultant, 1980-1981

Who's Who in Health Care

Editorial Board, Member

AWARDS & HONORS

American College of Hospital Administrators

Conley Award for Best Hospital Article of the Year, 1971 and 1981

American College of Hospital Administrators

James Hamilton Book Award, 1973

American College of Hospital Administrators

Honorary Fellow, 1974

American Public Health Association, Section on Public Health Education

Distinguished Career Award, 1978

American Risk & Insurance Association

Elizur Wright Award, 1962 (with H.M. Somers)

Blue Shield Association

Norman A. Welch Memorial Award (with H.M. Somers), 1977

College of Physicians of Philadelphia

Honorary Fellow, 1976

Medical College of Wisconsin

Honorary Doctor of Science, 1976

New Jersey Hospital Association

Annual Achievement Award (with H.M. Somers), 1981

New Jersey Regional Medical Program, Urban Health Task Force

Distinguished Service Award as First Chairman, 1972

Philadelphia Health Management Corporation

First Annual Recognition Award (with H.M. Somers), 1979

Philadelphia Health Management Corporation

First Annual Recognition Award (with H.M. Somers), 1979

Rutgers Medical School Student Family Practice Society

Honorary Membership, 1979

U.S. Army-Baylor University Graduate Program in Health Care, Alumni Association

Honorary Membership (with H.M. Somers)

BOOKS

Geriatric Imperative: An Introduction to Gerontology and Clinical Geriatrics. (co-editor), 1981

Health and Health Care: Policies in Perspective (with Herman M. Somers). Germantown, MD: Aspen Systems Corporation, 1977

Health Care in Transition: Directions for the Future. Chicago: Hospital Research & Educational Trust, 1971.

Hospital Regulation: The Dilemma of Public Policy. Princeton, NJ: Princeton University Industrial Relations Section, 1969

Medicare and the Hospitals: Issues and Prospects. (with Herman M. Somers) Washington, DC: Brookings Institution, 1967

Doctors, Patients, and Health Insurance: The Organization and Financing of Medical Care. (with Herman M. Somers) Washington, DC: Brookings Institution, 1961

Health Plan Administration: A Guide to the Management of Negotiated Hospital, Surgical, and Medical Care Benefits. New York: Foundation on Employee Health, Inc., 1961

Workman's Compensation: Prevention, Insurance, and Rehabilitation of Occupational Disability (with Herman M. Somers). New York: Wiley, 1954

WEEKS:

In looking at your C.V., I noticed that you were born in Memphis and that you were a graduate of Vassar College. I was particularly interested in what I saw as the first job on your C.V. and that was your job as education director of the International Ladies Garment Workers Union. In my slight reading in this subject, I have been impressed with the fact that this union was far in advance of many other unions in social, welfare, education and other such good things. Would you like to talk a little bit about this early part of your career?

SOMERS:

Yes, I'd be very happy to. I was with the ILG off and on for nearly seven years so it was a very important, formative part of my life.

Maybe I should take a couple of minutes to tell you a little bit about how I got from Memphis, TN to Vassar, because that is a long way around. My Memphis background was, as one would expect in those days, a conservative one. My father was in the cotton business and was broke even before the big depression. Then when the depression came along that finished us off completely. I was able to finish college because I had an aunt who helped me. I graduated in '35, right in the middle of--well I guess a little bit

past--the worst of the depression. The New Deal had already started.

Dubinsky, who was head of the ILG, was not well known at that time, but Sidney Hillman, the head of the Amalgamated Clothing Workers, the other big union in the apparel industry, was a close advisor to Franklin Roosevelt.

WEEKS:

The expression "check with Sidney"...

SOMERS:

"Check with Sidney." Yes, I think it was always exaggerated. Nevertheless, he was an important person in Washington for two or three years.

And the labor movement...I forget whether the C.I.O. had actually come into being in 1935. Do you remember?

WEEKS:

In 1935, that was the year they were a committee within the AFL, I think, and they were that way for a couple of years ...

SOMERS:

There was a great deal of excitement about it. Dubinsky and Hillman were both part of the movement away from the AFL and towards the CIO.

WEEKS:

That was over organizing an industrial union, wasn't it?

SOMERS:

Yes, that was the immediate issue, of course. It was also over a general philosophy of government, and of what the union should do, and whether they should try to take in the unskilled or just remain a small craft union, with certain prerogatives and advantages that went with that.

Well, when I got out of college, having majored in history and industrial relations, I was anxious to see what it was all like from the inside. There

was a good deal of radicalism among the student body at Vassar at the time and other campuses too. Before I committed myself to anything, I wanted to really see what it looked like. I had tried. I worked as a waitress during the summer before graduation at the TVA, where the Norris Dam was being built. Then I tried to get a job in a southern textile mill and wasn't able to. Any stranger was almost by definition, a Communist, in those days. I finally got a job that lasted for about six weeks, in a shirt factory in Elizabeth, New Jersey. My first pay was $2.12 a week. The NRA had just been declared unconstitutional, the famous sick chicken/Schechter case. Just anything went, so I got 2.12 in my first week, and the second week $2.80, and the third week, I went up to $12.00. That's where I stayed, and that was a unionized factory! Then I came into New York and got a job in a sweater factory where I made $15.00 a week.

I worked there for about a year, until work gave out. I became very active in the ILGWU, attended meetings, learned a lot, and unlearned a great deal that I had learned at college about industrial relations. I became more conservative, I will say, as a result of that.

Then in the spring of '37, I actually went to work for the ILG and worked for them off and on for nearly seven years. First up at Fall River, Massachusetts, which was a fascinating community, sociologically, to be in. It was still terribly depressed in 1937. The textile industry had almost entirely moved south by then. The older workers, the parents in the family, were mostly unemployed and they were supported largely by their children, mostly very young girls who were working in the garment shops that had run away from New York and from Boston, from the organized centers. They were operating in the old empty lofts of the textile industry.

These kids were mostly Portuguese, French Canadian, and so forth. They were bringing home three, four, five, six dollars a week, in pennies, quarters and so forth in their pay envelopes. Most of them, Portuguese particularly and the Italians, their parents would not permit them to open their pay envelopes until they got home. The parents opened them, took out what they could to pay for the rent, and gave the children (they really were children, many only sixteen years old!) lunch money for the week, a quarter or fifty cents or something like that.

When I went to Fall River, most of the factories were non-union. One of the first things we undertook was to try to get a state minimum wage for the garment workers. All the arguments that are being raised against government today were being raised then and they were told the factory would close up and so forth.

What we were asking for was thirty cents an hour. We finally got it in a couple years time and little by little most of the Fall River garment factories were organized. The ILG was very progressive in terms of education and health, etc. The apparel industries, as you undoubtedly know, had mostly a Jewish leadership who had come from the old country, mostly from Russia or Poland. Many were intellectuals. They were very literate and had studied a lot.

They had come here penniless and had gone to work as sewers or stitchers, I guess they were called, and cutters and pressers, in the early sweatshops. This was during World War I and immediately afterwards, some even before that. Let's see, when was the Triangle fire?

WEEKS:

Around 1913, or 1912.

SOMERS:

So this really goes back to the turn of the century, the early 1900s. Many of the leaders were socialists and very idealistic. I don't mean to say that they were not materialistic, because they were. They were very practical people, realizing that you had to get wages before anything else. They found themselves quite at home with Gompers and with the American labor movement. On the other hand, they wanted that plus ("All this and herring, too," as they used to say). They felt that the ILG was a way of life. They put a lot of emphasis on education, workers' education, but not just practical things such as how to run a union meeting or how to bargain with the boss or how to handle a grievance. Those things, yes, but also there was a good deal of emphasis on culture, music, drama, and general reading, and so forth.

I was hired to go to Fall River as the educational director of that New England district. That was my primary assignment--to organize activities for these newly organized young workers. At the same time, I had to do regular organizational work. I used to go every night and knock on doors and try to sign people up. Night, after night, after night, and on picket lines, and all the other things.

As far as health goes, the ILG was the first union in the country to have a health center, which they started in New York. Possibly it was partly as an outgrowth of the Triangle fire, but again because of this "way of life" approach, and because the workers were too poor to have any health insurance. Again, they had come from Europe, where you had a tradition of labor being interested in this sort of thing, much more than in this country.

They started a health center during World War I on Seventh Avenue in New York. It was pretty good for quite a number of years, did a lot of good. I

don't even know if it's still going. It was headed by a remarkable woman, who is still living, named Pauline Newman. Technically now, her title is Educational Director. She was director of the health center at the time. She was not a doctor; she was the lay director. There was a Dr. Price, a very dedicated man, Leo Price, who was the Medical Director of that center. Satellites were started in a number of other communities such as Philadelphia, but none of them ever grew to the dimensions of the New York one.

Little by little, particularly after employer-financed health insurance became more common after World War II, the role of the union health center changed and declined. I think the union decided, more or less rightly, not to pursue it too much. It was very hard to staff. Qualified doctors were able to command such high salaries, at least high in terms of what the union was able to pay.

WEEKS:

I got the impression, too, that there was a terrific turnover of jobs--that you might work for a manufacturer for six months and he would run out of work and then you'd have to get a job somewhere else--in the clothing industry.

SOMERS:

I don't remember that phenomenon. There were two related ones. One is that the industry was highly seasonal. Nobody ever expected to get twelve months work. The women's industry was even more seasonal than the men's. There were always a couple of layoff periods each year. That didn't mean that the people weren't called back, didn't mean that they left and went someplace else, in fact, there was usually no place else to go. If your factory closed down for the June layoff, all the factories in the area were likely to be

closed down too. So it wasn't that.

The other point is that the industry at the time, and even earlier than my day, was marked by a tremendous amount of upward mobility among its employees. The Jews who came over and were the first labor pool for the industry got out of it as fast as they could. That usually meant by the second generation, sometimes the third, but usually the second generation was out because these people were tremendously motivated. They were extremely hard workers, and in addition they had a cultural background. So more than some other immigrant groups, they could absorb the free education, and other advantages which America had to offer. A lot of garment workers, who were cutters or pressers or sewers in the industry...their children became doctors and lawyers, and they moved out fast.

That has not been true, to anything like the same extent, of other immigrant groups who have followed them. When I was there in '35, in New York at least, the majority of employees were still either Jewish or Italian. But already a lot of Puerto Ricans and blacks were coming in. My guess is that today, and it's not a very good situation, you still have the leadership, the very top leadership largely Jewish and Italian, mostly Jewish. There's been a great mass of women workers who are Puerto Rican, Cuban, black, all of the areas of Latin America that are flowing into this country...Chinese. I expect there are a good many Vietnamese there now.

Way back in 1943 when I left, even then, I could see that there was such an increasing dichotomy between the membership and the leadership that it was not going to make for a healthy, democratic union for the future. I think it's to the credit of the leadership, men like Chaikin, who is still the president, that it has remained as benevolent a union as it has. It could

have become quite a racketeering organization because of this gulf between the highly educated and sophisticated leadership and the mass of workers, the rank and file. There was also a tremendous sex bias there.

I was starry-eyed about it when I first went in. No question it was progressive. It was the first union to have a health center, and to do much in the way of worker education. It was also one of the first to have good collective bargaining relations and written contracts, the so-called "Protocol of Peace" that Justice Brandeis came up with. But, by 1943, I had pretty well decided that it was not going to remain a very democratic organization, and that I was sort of tolerated as the "resident shiksa."

There is a famous apocryphal, probably not so apocryphal, story told about Dubinsky and Walter Reuther. Walter had him out to speak to a convention in the early CIO days and Dubinsky was quite taken aback by the unruliness of the auto workers, how much noise and how much chattering there was. Some were reading the newspaper while he was trying to talk. He was annoyed and complained to Walter about it.

Walter said, "Well you know, it's a democratic union."

Dave is supposed to have answered, "Well, the ILG is a democracy too, but they know who's boss!"

I don't think that Dubinsky was inherently any less democratic than Reuther but there's such a difference in leading auto workers and the kind of membership which the ILG became.

WEEKS:

I'm sure there had to be leaders in the ILG, as you suggest. From the type of unskilled people who were coming in, the uneducated people, they needed a leader.

This period you were there was after they had settled the big Communist takeover attempt, wasn't it?

SOMERS:

Yes. Just. It was very important to me to be in this atmosphere at that time because, when I was at Vassar in the 1930s, we were there during most of the depression and some of my friends become quite leftist. I personally became a socialist and I was laughed at a little bit by some who had gone further left.

The ILG, as I said before, had socialist leadership. The whole garment industry had been a specific target for the Communists to take over and it might have happened because they had some terribly long strikes during the depression. You had some radicals in the membership. But both Dubinsky and Hillman--Dubinsky even more than Hillman--made up their minds very early on that the Communists were going to try to wreck the unions and make them instruments of Soviet foreign policy rather than of American unionism. Dubinsky was ruthless in cracking down on them, really ruthless, and very successful. There may have been a few "commies" here and there, but by and large it was open warfare between him and the Communists.

This was quite an eye opener to me.

WEEKS:

After Fall River, you were in other locations with the ILG?

SOMERS:

Yes, I went from Fall River to Long Branch, N.J., the Kay Dunhill plant. There was a long bitter strike there. There I was sent strictly as an organizer, not as an educational person. They didn't have a union; they were just trying to build a union. Then, eventually I got to New York, a much

pleasanter place to live. Those were awfully lonely jobs that I had out in the boondocks.

In New York I became Assistant Educational Director for the entire organization. There was a remarkable Englishman, Mark Starr, who was Educational Director for a good part of this time. He was also a socialist from England, strictly working class, very idealistic, an utterly dedicated person. He had all kind of causes, including Esperanto. Mark is still living. I see him once in a while because I'm on the board of the Public Affairs Committee that puts out those wonderful little pamphlets. They've been doing health education for years and years. They write so that almost any literate person can read.

Mark is on that board also and I see him once every couple of years or so. I became his assistant and stayed there until 1943. The war had started by then and the union was wholeheartedly into the war, being a Jewish union. I can remember sitting in Dubinsky's office on Monday the 8th of December, when Roosevelt announced we were entering the war, right after the Pearl Harbor attack.

So we got involved in a lot of war activities. I set up a canteen, sort of a little U.S.O., and we had what we called the Union Service Corps where we all studied first aid, and ran around getting ready for the bombing. We were practicing civilian rescue work and so forth.

WEEKS:

Didn't the union raise quite a lot of money too? This was mostly after the war wasn't it, for reconstruction?

SOMERS:

That was after the war. But I left the ILG in '43, with very mixed

feelings. I felt that I was tremendously indebted to the union. I had a pretty academic approach to industrial relations when I left college and I think this immersion in the practical world was extremely healthy for me and probably saved me from committing a number of errors. Among other things, it has made me extremely intolerant of social scientists who try to come up with prescriptions for the world, when they know nothing about it.

And I feel almost bitter about many economists, sociologists, and others who (some may have been completely on Kennedy's side or they may now be on Stockman's side) presume to prescribe for the health care industry, and for patients and doctors, when they know absolutely nothing about it.

WEEKS:

Yes, they'd rather build a model.

SOMERS:

It's made me unpopular with some people.

WEEKS:

Isn't it wonderful that you had this experience?

SOMERS:

It really was, yes, I think it was. I paid for it to some extent. Things worked out well, but my family was very unhappy about it. My father was unhappy when I came north to college to begin with. My mother wanted me to come, so that's why I came. But he was unhappy, and then when I went in the labor movement, that was almost equivalent to being a Communist. So that was hard on my family.

WEEKS:

Yes, because he had been on the other side of the fence as a business man.

SOMERS:

They were always wonderfully sweet to me. Of course, by then they were so broke, they couldn't do much else. In fact, I can remember when I was earning $50.00 a week or so from the ILG trying to send home $5 or $10 to my family. But it did lead to a little gulf there for a few years. Unfortunately, my father died in 1944, during the war. My mother went through with him the same thing that I'm going through with Red. He had a stroke. He was much older, he was about 79 when he had his stroke and he lived on to 82 and he never got out of bed. But she took care of him at home with one elderly black man who turned him and kept him clean and so forth.

I never really had a chance to explain things to him and make up with him although he had been so tolerant of me with all of my aberrations. My mother lived to be 87; she was younger than my father, so she lived until 1963. She died just before we moved to Princeton, but she had been to see us at Haverford several times and had come to know Red and the grandchildren, so that was very much better as far as she was concerned. I have always felt so badly about my father.

WEEKS:

I think this happens so often that by the time where we have matured to the point...

SOMERS:

...where you can talk intelligently to your parents, particularly if your parents are a good deal older than you. My father was 50 when I was born. It's fascinating how much history is in two generations. When my father was born, slavery was still in this country. He lived to 82, but when I was a child, I thought of him almost as a grandfather. He was working all the time; he never quit work. Just before his stroke, he was run over walking home from

work and he was 78 then. And after he got over that....

WEEKS:

Wasn't it a wonder that he got along that way?

WEEKS:

I have a notation here that you were doing some postgraduate work at the University of North Carolina along about that time, too.

SOMERS:

Yes, but I spent only four or five months at Chapel Hill, in 1939-40. I was still with the ILG in Fall River and one day I had a letter from a former teacher, who taught labor relations at Vassar, saying there was a modest fellowship available (I think it was $800, which was a lot more in those days than now) and would I be interested in applying for it? I think she felt that I had been out in the practical world long enough and wanted me to go back and get a graduate degree. I thought about it and decided to do so, and to go to North Carolina, Chapel Hill, which had some excellent people on the faculty. It was, at that time, considered a real island, not only of excellence, but of liberalism in the South.

I always had sort of a conscience about the South, even though I ran away from it and wasn't doing anything about it. So I thought that would get me back in that direction. I did apply. I got the fellowship and took leave from the ILG. I went down there in September, all excited about it, and plunged back into work and was going to do my master's thesis on productivity in the cotton textile industry. I was taking all kind of courses, business cycles, accounting, etc. I was really hungry to get back to this.

However, then it struck. I was there only about six weeks when my eyes began to give me trouble. I had trouble with them several times in my life,

including one year in high school when I had to drop out entirely, but I made that up without much trouble. They didn't bother me through college, although I used them a lot.

But this was too much, apparently. They gave out and I dropped everything but one course, my business cycle course, which I was so excited about and had such a marvelous teacher. I got somebody to read to me and I finished that and I have always been grateful that I finished it that well. Then I had to leave at the end of the semester. I spoke about a couple of aunts, one who lived in Sante Fe, New Mexico, who was another important influence on my life. She was very different from my mother; not an intellectual--she had never been to college--but read a great deal. Unlike my mother who couldn't read at all. (Mother had the same problem with her eyes that I do.)

My aunt read a great deal and was very independent. By then, she was a widow supporting herself through a real estate operation. She was by no means a feminist but just stood up for her own rights and believed that women should take responsibility to do things and earn respect. She did all the right things, but didn't talk about it.

I stayed with her for several months and I never went back to school again after that. I was so distressed by that experience, and the need to give up the prospect of graduate work. Having spent most of the fellowship and to have to tell them I couldn't finish, it was a terribly embarrassing experience for me. I never went back and that is why I have no graduate degree, as you know.

I went back to the ILG and the kind of work I was doing. That's one time when I concentrated largely on the organizational work, didn't take much eye work, and little by little my eyes got better. It was a muscular disorder. I

was nearsighted and had other things, but it was primarily the muscular disorder that no doctor seemed to be able to correct. Anyway, I went back to the union and that was the end of my academic career. But it was an exciting half year and I learned quite a bit of economics during that time.

WEEKS:

How did you happen to go to the Department of Labor?

SOMERS:

Well, I went back to Fall River after the interval at North Carolina and stayed there for another year or so. At this point, I was beginning to get quite restless. It was a very, very lonely place to live. There was no social life at all.

So I moved into New York and that's what we were talking about earlier--about working with Mark Starr during the war. Then, as I mentioned earlier, I was beginning to get restless, even in New York. Because of the feeling that the leadership was a closed shop at the top and there just wasn't much chance to influence anything up there.

I had a friend who was working for the Department of Labor in the Bureau of Labor Standards. She had also worked in the ILG, but was married and living in Washington and enjoying the job there.

She introduced me to her boss, a remarkable woman named Clara Beyer, who was director of--it was then a Division, it became a Bureau--of Labor Standards. Her husband was Otto Beyer, a great authority on industrial relations in the railroad industry.

Clara was interested in child labor and working women and industrial relations and all of those things, but above all, in health and working conditions in American factories. She put me to work in industrial

relations.That was '43 and I stayed there until Red and I were married in 1946. I turned out perhaps seven or eight handbooks on various aspects of industrial relations. I still have them: "The Foreman's Guide to Labor Relations;" "Settling Plant Grievances;" "Living with the National Labor Relations Board;" "Guide to Federal Labor Legislation," and several more.

WEEKS:

That was right at the period when the National Labor Relations Board was really a source of great discussion.

SOMERS:

That's right. That had been started under Roosevelt and was going strong. In addition you had the War Labor Board, headquartered in the Department of Labor building on the fifth floor. I saw a lot of people like John Dunlop and others who were there working with the War Labor Board. It was very exciting at the time in industrial relations.

Employers, by and large, were very open. At that point, I guess most of them were on defense contracts. I spent quite a bit of time at Lockheed in California and had good cooperation from supervision as well as from the union. I did a lot of work with the machinist's union while writing these grievance procedure tracts. It was an interesting and exciting experience.

WEEKS:

May I interject something here, I was wondering if you had any access to Frances Perkins at this time?

SOMERS:

Well, she was the Secretary when I went there.

WEEKS:

What I thought was she had a great understanding of many of the conditions

that you had seen.

SOMERS:

Yes, and Clara Beyer, my boss, was a very good friend of hers, but I was pretty far down the line. I certainly met her and shook hands, but I can't say I ever sat down and spent a half hour talking to her.

WEEKS:

She left in about '45... she left right after Roosevelt died, didn't she?

SOMERS:

Within a year. Truman appointed somebody else.

WEEKS:

I think he asked her to stay, but by this time, she felt she'd been through a lot.

SOMERS:

She had a husband who was an invalid so she had reasons.

WEEKS:

I've always admired her, I thought she did an outstanding job.

SOMERS:

We had a lot of very able women who didn't talk much about being women but just worked very hard and got things done.

WEEKS:

I always draw up a chronology, and in looking at it, it looks like you took some time off to raise a family.

SOMERS:

Yes.

WEEKS:

You said you got married in '46. I have a period around '49 or so where

you list yourself as a self-employed writer.

SOMERS:

I tried to jot down a couple of things the other night in preparation for this. I graduated in '35, which is when my professional life started. From '35 to '46, industrial relations was the big thing. With the union, or for the union, or at the Department of Labor as a labor economist or writing these booklets, industrial relations was the thing. Then I got married in '46 and again my eyes gave out on me, I pushed them too hard at the department. There were two years that I couldn't read anything, couldn't even read a newspaper from '46 to '48. Then in '48 I began to read again and gradually worked up.

From the mid-forties to the mid-fifties I was groping in all sorts of directions. Primarily, I was being a wife and mother; we had two children. We had a number of interesting assignments which kept me quite occupied in spite of not being able to read. When I was married in 1946 my husband, Herman (Red) Somers was working in Washington. He had just been discharged from the service about eight months earlier. Then he had a job doing the official history of the Office of War Mobilization and Reconversion (OWMR) which was also his Ph.D. thesis at Harvard for William Elliott. So we lived on for a year in Arlington. It was interesting because he had lots of high-level friends in the Administration and we did a lot of entertaining for them and so forth.

In the fall of '47, he went to Harvard as a Visiting Lecturer for a year. That was also interesting. Then in the fall of '48, we went to Haverford College. Meanwhile, Sally was born in the fall of '47. That was another new experience for me. Both Red and I had been the youngest of our families so neither of us had been around small children at all. We had a lot to learn in

this area. Peggy, our second child was born in '49.

Gradually, as I was able to read more and as the children got older, I tried to get back into work, but I didn't want to go out to work. So I concentrated on writing. One of the greatest disappointments in my life is that I've never been able to do more in the international field because I've always, ever since college, been very much interested in international matters. I've never felt I had very much contribution to make there. But during that time, I did do some writing in that field.

But the decisive thing that happened in the early 1950s was that we did our book on workmen's compensation. Red had a contract with Prentice-Hall to do a book on social security. My field, of course, was industrial relations; his field had been welfare economics and administration. He was interested in, and knew a lot about, industrial relations but it wasn't his primary field. When he first graduated from the University of Wisconsin, in 1934, he immediately went to work for and became the first director of, the Wisconsin Department of Welfare's Office of Statistics. He always used both economics and political science.

WEEKS:

He came out of that Wisconsin school which was famous...

SOMERS:

Yes, they were very knowledgeable in labor but it was not only that. They were concerned about society as a whole. Red was a classmate of Wilbur Cohen's. Wilbur was maybe a couple of years younger, but they were classmates.

WEEKS:

And of course Altmeyer and Witte...

SOMERS:

All those people were either his teachers or his colleagues and friends. There was a certain spirit those people stood for which I found very compatible too. We sort of merged our interests.' When he was asked to do the book on social security, he assigned me the chapter on workmen's compensation, which we both thought would be a minor chapter in a major book. Well, I got so interested in it that it turned out to be a book by itself and the other book never got written.

WEEKS:

I haven't read it, but what position did you take on state and federal administration on that? Wasn't that the big question as to whether it should be a federal or state program?

SOMERS:

Well, I guess that's the way most outside intellectuals were approaching it but as for me, I always get into the nitty-gritty and the human aspects of things. I can't even remember for sure what position we took on federalization. We probably said that it should be federalized eventually or we may have said that the future depended on what happened so far as national health insurance goes, which of course is relevant. Among other things, we spent a lot of time on rehabilitation and on the medical aspects of workmen's compensation. These were really decisive in our professional lives in two ways.

I guess the most important thing, from your point of view, is the influence of this book on my future thinking. There were three aspects of this study which impinged on, and which got us more deeply into, health questions. We had not been particularly concerned with health care prior to that. One is the prevention aspect, and we did spend some time on the

importance of occupational medicine as well as safety. Second, was the very, very discouraging experience under the workmen's compensation programs in most of the states with the administration of the medical aspects. That is, how to pay for occupational injuries--doctors, hospitals, so forth. We found a lot of fraud and chicanery on all sides: employers denying that a condition was occupationally related, and employees exaggerating--it was very easy to find lawyers to help them exaggerate--the extent of an injury. Low-back injury is, of course, the prime example of a condition which can be carried on for years and years. It is hard to get expert opinion to agree on whether there really is an injury or not and whether it is really related to the occupation or not. So we found that pretty discouraging.

But on the other hand, there was the then new field of physical rehabilitation. This was a very exciting field at the time. The leaders were Dr. Howard Rusk of New York who had started his rehabilitation institute at NYU Medical School, and was also an associate editor of the New York Times. He was very articulate and influential. And there was Mary Switzer who was with the Department of HEW, a close friend of Rusk's, and very interested in building rehabilitation into the American social security system and in getting the Office of Vocational Rehabilitation going.

There are some really miraculous--cure is not the right word--but medical treatments and management which made it possible for very severely disabled amputees and other disabled people to continue to earn a living and to work. This, of course, came to a climax and perhaps somewhat overclimaxed in the last few years when all communities and institutions have been forced to make provisions for people in wheelchairs and so on.

But at that time, the disabled were just shut inside and it was exciting

to do something about it. Those three experiences had quite an effect on us, on me particularly, and made us feel that the health field was very challenging.

The workmen's compensation book was published in 1954. The next year, Red got a Fulbright fellowship and went to London. His host organization, was the London School of Economics and his professional host was Richard Titmuss, who was chairman of the Department of Social Administration. He had been involved with Beveridge in writing the Beveridge Plan and creating the early National Health Service under Bevin, who was then Minister of Labor. Titmuss and a younger colleague, Brian Abel-Smith, had just published another book on the National Health Service. Also an official study had just come out. Titmuss asked us to do a long review article of these two studies for a British journal, which we did. That caused us to study the NHS much more closely than we would have done otherwise, or had any intention of doing when we first went to England.

We learned a good deal about it. We learned how good it was in many respects. On the other hand, one of the things we said in that article, which did not endear us to Titmuss but we believed very much, was that it was also useful to have a small private sector. And they did, even then. About five percent of British health care expenditures were going through the private sector. We said that was a useful "safety valve" for them. We are pluralists. The article was generally well received, I think.

The next year, instead of going back to Haverford, we went to Berkeley, California where Red was invited to teach at the University of California. While there, again we were asked to do an article. This time by the law school, for the California Law Review.

California, at this time--this was now 1956--was agog with discussion and debate over health policy. Justice Warren, before he left to go to the Supreme Court, had advocated a universal state health insurance program. Later, of course, Nelson Rockefeller was to do the same thing, for New York. Kaiser had its headquarters in Oakland, right next to us. We came to know many of the leaders of Kaiser; many have remained close personal friends over the years. Lester Breslow was the Director of Public Health and he had his office at Berkeley. There were a lot of exciting, able people out there at the time.

The Law Review article, like most things we do, turned out to be twice as long as we had originally intended. It turned out to be two articles, not one. While we were working on it, Red happened to come to Washington and went to see an old friend who was then president of Brookings Institution, Bob Caulkins. He told him about the article we were doing for the California Law Review. Caulkins suggested that we turn that into a little book. As everybody knows, in a law review article about 9/10 is in footnotes and references at the bottom of the page. Why not just bring those up into the text and we'd have a book? We felt that would be quite simple and we agreed to do it. We started on it the next year when we went back to Haverford. (Red decided not to stay at California, one reason being that he wanted to be on the East Coast and in closer touch with Washington and Brookings and so forth.)

Instead of taking about a year and being a short book, it turned out to take four years and emerged as Doctors, Patients and Health Insurance (DPHI) which has 576 pages. From that time on, I was addicted to the health field!

The book won a prize from the insurance industry, to our utter amazement--

nothing we'd ever applied for. In fact, we didn't know that that particular award existed. All of a sudden it arrived. It was a major undertaking and left us exhausted, but committed to this field. The breadth, the interest, the complexity of it, I've found irresistible.

WEEKS:

You had finished the book before you did your study at Children's Hospital?

SOMERS:

That's the next chapter. That came immediately afterwards. Of course, it was a direct result of DPHI. We were still living in Haverford at the time and I was still freelancing. What appealed to me about the Children's Hospital job was that I could do it on a free-lance basis. I got a stipend each month, but I could make my own hours and that was important to me. The children were still young.

WEEKS:

What was the topic of your study?

SOMERS:

It was intended to be a study of children's hospital units both in independent children's hospitals and as a part of regular, community hospitals. However, it turned out to be, almost exclusively, focused on Children's Hospital in Philadelphia (CHOP). The principal investigator was Dr. Joseph Stokes, Jr. who was Chairman of the Department of Pediatrics at the University of Pennsylvania and the Physician-in-Chief of Children's Hospital. He ran the place. He was a very active Quaker and on the board at Haverford. He had come to know Red and myself, both through the Board of Haverford and because of DPHI. He asked me to work with him on that study, which I did for three years, interrupted by one year when we went to Geneva. I was in close

contact with him even during that year, 1962-63.

Nothing came of that, as far as publication was concerned. I still have the study here in my office. It was distressing to me because I worked awfully hard on it. I ran into a buzz saw of elitism of every type.

But it was a tremendous learning experience. It was the first time that I had an inside picture of the operation of a major medical center. I was with it long enough and close enough to get some feel for it, not so much the clinical aspects, but for the policy aspects. It was a fascinating institution--the quintessence of the old aristocratic noblesse oblige approach to hospital trusteeship. The board was ninety-nine--maybe one hundred percent--very rich, very influential, very powerful Philadelphia people. Being Philadelphians, I think they have a little more than average--probably the Quaker leavening--a little more than average social conscience. So that it wasn't just straight power brokering by any means. Although there was some of that, but there was enough of the other to make it interesting.

The people who ran the organization were at a point of having to make a decision whether to stay in run-down, downtown South Philadelphia, where they had been for nearly one hundred years. (It was the oldest children's hospital in the country and the area had become a blighted ghetto.) Or whether to move out of town altogether, into the suburbs, or another location in Philadelphia, perhaps closer to the University of Pennsylvania and the Medical School. Or what to do.

They had a lot of money behind them and they had a good endowment. There were some problems. First of all there were two children's hospitals in Philadelphia. St. Christopher's was there in North Philadelphia, too. A good hospital, a very good hospital, but it didn't have the social backing that

Children's Hospital did. Then there were a lot of community hospitals, some of them staffed by graduates of CHOP, who were beginning to develop good units of their own, and would consider themselves really equals with Children's Hospital.

So they were trying to decide what to do, and Joe really didn't know. He was absolutely dedicated to the concept of a separate children's hospital and wanted to do what was best for the city, and best for the community, and best for everybody. He was a good Quaker. On the other hand, you had some among the trustees and the board of managers who just wanted to have a completely separate institution which would be the biggest and the best in the world, certainly in this country. They were not about to consider whether this would hurt St. Christopher's or some community hospital someplace. All they knew was they had the money, and they were determined to do it. I don't mean they had enough money to do it all by themselves. It wouldn't have been any problem then, but they had enough money to get the attention of the state and of the federal government. This was the time the money was being given out.

Then you had a pretty high-powered determined staff. The Chief of Surgery was Dr. Chick Koop the man who has just gone to Washington. At that time, as far as most of us knew, he wasn't a "Moral Majoritarian" by any means. He was very able, and very determined, and rather rigid.....

WEEKS:

A lot of people think a great deal of him.

SOMERS:

Well, he is a magnificent surgeon. He is a great big man, big hands and so forth, but he really could handle those babies, little neonates, with great affection and care and skill. No question about that. But he was a rather

rigid individual even then. You had a high-powered staff. What they wanted was to have society support them and allow them to do their thing with high quality and the way they wanted it done. They were very happy at first with the study because they thought it was going to justify the tremendous expansion and so forth.

Three of us were involved in it. I was brought in first and I brought in Dr. Andy Hunt who had done his residency at Children's Hospital and was chief resident there for a while.

WEEKS:

Was this the Andy Hunt of Michigan fame?

SOMERS:

Yes. He subsequently went there. First, he went to Hunterdon and may have been a couple of places in between. At the time I speak of, he was at Stanford in charge of their ambulatory clinic. While this was going on, he got the call to come to Michigan State and left to go there. He shared many of my reservations about whether this tertiary care hospital ought to spend a hundred million dollars and grow and grow and grow at the expense of the community hospitals.

Then Bob Sigmond came in with us. The three of us were actually the final authors of the report. We came out saying the Children's Hospital probably should move closer to the university and probably should add a few beds, but not many. We put a lot of emphasis on community needs as opposed to professional desires, and certainly as opposed to the board of managers' imperialistic approach. For some of them it was really almost a power play. They might as well have been playing with an oil well, but instead they were playing with their hospital.

Well, Joe resigned. He had put off and put off his resignation and he was well into his seventies and finally did have to resign. So he was out of the picture and I was left on my own. Andy went to Michigan and got completely preoccupied with that. Bob had a lot of other things he was doing and I was left to fend with Chick Koop and Dick Wood who had become president of the hospital.

One of the people whom I had come to know very well, somewhere along the line, was Dr. Ward Darley. He was, as you know, Executive Director of the AAMC when it was out in Evanston. He had been there for a number of years and I got to know him quite well then. He'd been very helpful to me on a number of things. We had published a series of articles together in the New England Journal sometime around that time. He helped me make contacts with Commonwealth. Quigg Newton was then president. We thought he was going to publish it and then he decided not to. I've never known for sure, but I've always suspected that somehow some people from Children's Hospital may have gotten to him on it.

It wasn't the world's greatest study. It was much too long and needed editing and that sort of thing, but it was one of the first serious efforts to persuade an institution, which had the clout to build more beds than the community really needed--to try to persuade it voluntarily to exercise restraints without having to be restrained by external controls. It failed.

It is interesting to think now how they were able to circumvent the planning process completely. Philadelphia had one of the better, stronger planning agencies. It was called the Hospital Survey Agency. This was prior to the big planning law. They were able to keep most hospitals under some control, but not CHOP. Children's would just do end runs around

everybody.They would get to the governor, they would get to the President of the United States, they even got to the Queen of England. They knew everybody and didn't hesitate a second to do this. So they did end runs around the planning agency. What I started out to say, it would be interesting to see how they would fare today under "procompetition." I think they would do just as well. They would somehow manage to persuade people that their product is so good that they should pay three times as much as anyone else. God knows what it's costing now. Five years ago it was several hundred dollars a day. I don't mean just in intensive care. The whole hospital is, in a sense, almost an intensive care unit. They've done operations on Siamese twins. Rich people from South America bring their kids up there. It's a magnificent place, physically. They have an atrium, with practically a forest inside. It is a beautiful place.

WEEKS:

In other words, expense is no object.

SOMERS:

That was another sobering experience. To realize that statistics and logical arguments are of no consequence when you're up against that kind of determined power.

I don't think I'll say anything about Geneva. I did have a couple of very interesting trips over there which Joe Stokes arranged for me. I looked at various pediatric units in European hospitals. I was coming back, of course, to finish up the study here, so I went to the Great Almond Street Hospital in London--one of the first children's hospitals in the world and probably the most famous. And a famous one in Paris, and one in Genoa, and in Geneva, and in Zurich. There are maybe a dozen throughout western Europe and I visited

at least six or seven and wrote up reports. I can't say it was terribly productive; it was just very interesting.

WEEKS:

Good experience for you though.

SOMERS:

One thing you have to say for the doctors I met in the pediatric field is that most of them are really very honest and dedicated. Maybe people don't go into pediatrics if they want primarily to make money. Indeed, Red and I have known an awful lot of doctors over the twenty-five years that we've been working in this field, and have met very, very, few charlatans. They all know how critical we have been on the cost issue, but it has never affected the quality of care we have received. I think we had better than average care, if anything.

My biggest arguments (I didn't really know Chick Koop that well) at the Children's Hospital were less with doctors than with the lay managers. In fact one of the strongest doctors on the staff at the time was Len Bachman, Chief of Anesthesiology. A few years later, I heard from him saying "I want to come up and read your whole report. I need to see it." So he came to Princeton and spent a day and took it back and Xeroxed it. The next thing I knew, he had become Commissioner of Health for the state of Pennsylvania. A very progressive, outgoing person, although he didn't get very far there.

My point is, that whether in Europe or in U.S., whether I agree or disagree with their politics, I have found very little of this so-called venality in the medical profession. That's been, I think, a good experience. However, sometimes, it has handicapped me because I couldn't come out and pound the table and say the medical profession is ripping off the country.

WEEKS:

Well it's hard to generalize, I'm sure there are some but maybe these people wouldn't be the kind of people who would want to meet you anyway. They would avoid you.

SOMERS:

I'm sure that's part of it.

Well, my fiasco with CHOP ended about late 1964 or early '65 and about the same time, I began to get involved (we had moved to Princeton in '63 and our children were in high school by then) in the hospital field, not academic institutions like CHOP, but regular community hospitals, chiefly through two or three people. Lloyd Wescott was the president of Hunterdon Medical Center. A wealthy man, and a gentleman farmer living in Hunterdon County, he didn't have to make a living at all. He was personally, almost solely responsible for the building and for the direction of that institution. He was also at that time chairman of the board of our welfare department--called the Department of Institutions and Agencies at that time, now it's the Department for Human Services. It was run rather uniquely by a board, and he was chairman. He was also active on the Hospital Facilities Planning Council.

Then there was Jack Owen, Mr. Hospital in New Jersey. I still think it's one of the best state hospital associations in the country and, no question in my mind, he is one of the best CEOs of such an organization.

Jack was a graduate of the Program of Hospital Administration at Chicago and then went to AHA for some time, before coming to New Jersey. He's been here ever since as president of New Jersey Hospital Association. A lot of people thought he should be president of the AHA. He's a quiet person, quite a religious person, a very good business man, a real Protestant-ethic kind of

person. He drives a hard bargain. He has done wonders with that organization. They have a huge building over on the other side of Route 1, which they call the Center for Health Affairs. He rents and gives a lot of space to other less affluent organizations like the Assembly of Home Health Agencies. Just an awful lot of good things.

He also set up one of the first state HRETs. That's been in existence since the middle 1960s. Well, I got drawn into this orbit.

As in many of the things I have done, many of the many boards I've been on, I have been the token woman, or the token consumer. Sometimes, it's been frustrating, sometimes it's been boring. Most often I have gotten more than I've given because I've been drawn into situations that are fairly specialized that I knew little or nothing about. I suppose a prime example is my experience as one of two public representatives, for about three years, on the American Board of Medical Specialties. Their conversations were about the most highly specialized intra-professional matters, which often I didn't know anything about and didn't always care a great deal about. It was often an organizational fight between different specialists for different parts of the body. They were very serious about testing procedures and examination procedures and that sort of thing, which again was something I didn't know much about. Credentials have never been my major interest in life and of course that is their major interest. Nonetheless, all these token jobs have been educational and all have contributed to making me a total pragmatist. I see nice people and difficult problems on all sides and it really inhibits you in terms of the simple doctrinal solutions that you need in order to pound tables.

Getting back to New Jersey, I think we had one of the first of the Health

Facilities Planning Councils. Of course, Michigan had one and Bob Sigmond had one, perhaps the first, but I'm sure we were one of the first half dozen or so. We had good meetings and serious meetings. They met alternately at Blue Cross headquarters and at the New Jersey Hospital Association headquarters here in Princeton. Blue Cross was in Newark.

By Blue Cross' clout, such as it was, we were able to get compliance in a number of instances. There were times when we were defied, but more often than not either we prevailed or people changed their applications. This was all again before the planning law. I think we did have some influence at that point.

Then along came the first of the planning laws, the Regional Medical Program (RMP). We worked closely with them. That did some good in terms of regionalization of certain specialized services--neonatal services, dialysis units, the beginning of getting into open heart-cardiovascular surgery. But RMP not only did nothing as far as cutting costs; if anything by raising standards, it raised costs.

New Jersey RMP did try to address itself to urban problems, although that was not the original intent of the law. We set up an urban health task force that I became chairman of; it survived for about a year. Our effort was to try to establish ambulatory clinics. My own conviction was that they should be primarily sponsored by hospitals. I have generally taken the position that the hospital should be the center of community health services. I felt that's where the resources were, that's where the power was, that's where the talent was, and the action. The hospital, rather than being condemned and isolated, should be encouraged--even forced, if necessary--to take on a broader responsibility for outpatient, as well as inpatient, care and for long-term,

as well as, acute care.

At this point we were trying to persuade a number of hospitals--and did succeed in a couple of cases--to establish some ambulatory clinics for the disadvantaged in their areas. Middlesex Hospital, for example, did set up such a clinic in New Brunswick. It lasted for five or six years and did quite a bit of good. Now, with that hospital being completely transformed under the affiliation agreement with the medical school, I believe they will still have something along that line.

Then came the Comprehensive Health Planning Act, in '66. You began to have the state divided up officially into divisions and regions. In some ways that reinforced and, in some ways, undermined the old Health Facilities Planning Council.

Then, when the 1974 law came along--the Comprehensive Health Planning and Resource Development Act--it took over the whole show and the Health Facilities Planning Council went out of business. The show then was HSAs in the regions and SHCC at the state level. We got a new Commissioner of Health, Dr. Joanne Finley, about that time, who was very much down on the hospitals. I tried to arrange a few meetings--between her and Lloyd Wescott and Jack Owen--but it didn't do any good. I was sort of in the middle and the middle gets trampled on, anyway. They were moving into a whole new era of state control. In 1971, the first state law had been passed which provided both for certificate-of-need and for rate review. Rate review was on the back burner for the first five or six years. Actually it was farmed out to HRET or the Hospital Association. They did better than might have been expected, but it wasn't spectacular.

I don't know whether Dr. Finley already had the concept of DRGs or not;

but she had been in Connecticut before she came here and knew some of the people who had invented the DRG system and brought them in as consultants. New Jersey has been the cradle of the DRG movement and there is obviously something to be said for it.

Once Medicare and Medicaid came in with their completely open-ended reimbursement formulas, no health planning, no state agency could be really effective, because Medicare undermined everything. Red's and my book, Medicare and the Hospitals was published in 1967, the year after the program became effective. (It was passed in '65, became effective in '66, and our book came out in '67.) We said then that the concepts of "reasonable costs" and "reasonable charges" were time bombs that were bound to explode. We criticized the concepts very strongly, fourteen years ago, and we were absolutely correct. You just can't tell people that they can't buy a CAT scanner or they can't build a couple of beds or they can't do this or that, when the federal government comes along and says we'll reimburse you for anything you do, as long as it's audited. So Medicare simply undermined the planning efforts.

Of course Medicare and Medicaid did a great deal of good otherwise. Reimbursement was the "Achilles' heel." It set back the planning effort enormously. Even after the big planning law was passed, it didn't do much good. You have to be sympathetic with David Stockman to some degree in that people in the planning field, as in many other fields, got nice jobs, interesting jobs; and didn't have to take much responsibility. They could advise and study. (That's what I like to do. I don't like to take responsibility either! But I don't get paid for taking responsibility and they were, at least the public thought they were.) Even if they had been

given more responsibility, the reimbursement features of Medicare would have undermined it. It was an impossible situation.

I struggled along in that field for some time. Red was on HIBAC from '68 to '72 and after he went off, I went on. Art Hess was then the director of the Bureau of Health Insurance and I went on for him in '72 and was there through '75. I found it terribly frustrating. Everybody wanted to talk and nobody really wanted to do anything, and this was becoming the atmosphere throughout the planning field and the whole health economics field. The debate over national health insurance had heated up and was beginning to die down. During my years on HIBAC, I took on three lost causes.

One was to try to get them to think about some specific cost controls, particularly for Medicare. But, they didn't want to talk about that. They wanted to talk about national health insurance, but not how to reform Medicare and Medicaid.

Number two, by 1971 and '72 (I had started to work for the medical school), I became very interested in health education and health promotion. I was pretty well convinced that the lack of adequate patient or consumer responsibility was one of the major causes of the rise in health care costs, as well as a great deal of ill health. It's incontrovertible; it's unarguable. What is arguable is what you can do about it and certainly what the state should do about it.

I was able, at the medical school, to persuade the president and a small foundation that he controlled, the Hunterdon Health Fund, to give me the money to start a program in consumer health education. We were the first medical school to have anything like that; I've always been proud of that.

At the same time, I tried to get HIBAC to address that problem. No, no

interest there at all. Later on, there was interest from Ted Cooper because he was a strong believer in prevention. He had come out of the National Heart Institute and really believed in trying to influence diet, exercise, smoking, and so forth, but this was very much a minority view.

The third thing I tried to get HIBAC interested in was long-term care. They gave lip service. They set up a committee on health education just to keep me quiet. Some of my best friends such as Ernie Saward, who was chairman of the council at the time, used to laugh, "There comes Anne Somers with her health education hobby horse again." Long-term care, they had a committee on it, but nobody paid any attention, nobody was really interested.

I had hoped to become chairman of HIBAC and before Charlie Edwards left, he and Ted Cooper, his assistant at the time, asked me if I would do it, I said yes. But before I could be appointed, a Republican on our committee--a nice man from Pennsylvania who was a furniture salesman or something got to Schweiker and Schweiker got to the President, so I lost out.

It was just as well, because I couldn't have done anything. In fact HIBAC became almost sterile and finally was abolished, which it should have been. In the early days, when Medicare was first started, it was very influential. But I got off in 1975 and I think by '78 it had been abolished. It had become an expensive appendage without accomplishing anything.

Well, I became bored with what was passing as health economics in those days. The country was so affluent (or thought it was) and so much money was available to the health field through Medicare and Medicaid, private health insurance, etc. that to talk about cost-effective care, efficiency, increasing productivity, economies, getting consumers to take more responsibility, trying to take care of people in long-term care or home-care instead of more

expensive acute care setting was just shouting into the wind. The money was pouring in. You could say, "This can't go on forever!" as Red and I had said starting back in the 1950s, "This just can't go on forever because at the current rate of increase it's going up so much faster than the GNP that it would eventually absorb the entire national economy." At first people took us seriously, then they didn't.

So I began to feel that our emphasis on cost controls was futile. I got into health promotion and health education and had a lot of fun with that for a number of years. I got the Office of Consumer Health Education going at the medical school, and then I was asked to be chairman of a task force on consumer health education, which was one of eight preparing for the National Conference on Preventive Medicine in 1975, sponsored by the American College of Preventive Medicine and NIH. The NIH's Fogarty International Center was then headed by a couple of doctors who were epidemiologists and had been in public health. One of them, the number two man, was particularly forceful, Dr. Fred McCrumb. He and Kurt Deuschle--the chairman of the Department of Community Medicine at Mt. Sinai Medical School in New York and then president of the American College of Preventive Medicine--apparently got together and decided they were going to revive health promotion and preventive medicine in this country with this big conference.

They set it up, with a division on occupational medicine, a division on health education which I was asked to chair, a division on preventive medicine and personal health services that Lester Breslow chaired, and so forth. That was one of the most pleasant bureaucratic experiences I've ever had, because it was run and financed by NIH. You have never seen such lavishness, nor such care and feeding of outside consultants, as NIH went in for in those days. It

was an absolute joy to work with them.

Well, anyway, they had the conference. My task force report turned out to be very well received. It was published in three different forms. The best job was done by Aspen Corp. That could happen ethically, because, being a government publication, it was in the public domain. Prodist, a small entrepreneur in New York, got the contract for the official publication. They had one with all eight task forces reports in it and then they had separate ones with the different reports. It took a year to produce this report and then there was the conference in the summer of '75. Then the task force was reconstituted as an "expert committee," which went on for another year. The task force report and the continued input from the committee for the following year led to passage in 1976 of PL 94-317. That's the law that established the Office of Health Information and Health Promotion in the Office of the Assistant Secretary. That was a very rewarding and exciting experience.

At the highest level, Ted Cooper's level, and with his complete support, we were going to have an Office of Health Promotion. We felt that all kinds of great things were going to happen. But they didn't. Number one, Fred McCrumb, who was our big support in NIH (He couldn't have been over 45, slim as a pencil, fit as a fiddle, rode horseback every day after work, a handsome young man) just up and died.

Number two, Don Frederickson, who had left NIH and gone over to the Institute of Medicine, apparently got bored over there and came back to NIH. He was brilliant but a hardnosed research person. He had to change somewhat under pressure of Congress in the past few years, and became more interested in dissemination, diffusion, and getting more research findings into application. But basically he is a research man and a real elitist.

Apparently, he decided that the Fogarty Center had no business in health promotion; they should stick to international affairs and that was the end of that.

The third thing that happened was that Carter was elected in '76 just a few months after PL 94-317 was passed. Again we had reason to think this was going to be good. But one of the first things that Califano did, was to fire Ted Cooper. That was the beginning of the end as far as my support of Carter was concerned. Ted was a Democrat to begin with, yet the Republicans had been willing to put him on. But Califano and the White House wouldn't keep him apparently because he had been there under the Republicans.

They finally got in some good people like Julie Richmond and Mike McGinnis. At first they didn't even know that the new law existed and that there was authorization for setting up such an office. I drummed away, and drummed away, and other people who had worked on it did too and finally they discovered it about six or eight months later. But they never set up the advisory committee, which we already had at NIH in '76 and assumed would continue. Earlier we were given an ultimatum--by Frederickson, I guess--that if we wanted to continue to exist we would have to be attached to the Bureau of Health Education down at CDC in Atlanta. I was still chairman and chose to go out of business rather than be moved to Atlanta. I knew the history of why they were in Atlanta. I knew it had been to get them out of the way, with tobacco interests putting a lot of pressure to get them out of Washington. And I wasn't about to play that game. Also, at that time, I thought that with Ted Cooper and some other people in high places I could get enough support to remain on the national scene, but I was wrong. With Cooper gone, and no interest from the Carter people, our "Expert Committee" singly expired.

Throughout the last three years of the Carter Administration Julie Richmond, Mike McGinnis, and Kate Bauer, when she went with them--I had strongly recommended her and was pleased that she did--managed to get out some very good publications. OHIP averaged about a million and a half dollars a year, which was just peanuts, but they kept the concept alive.

Meantime, the Institute of Medicine became interested in health promotion and disease prevention when Dave Hamburg came as president. He was very interested in this. They set up a division of health promotion/disease prevention under a brilliantly able woman, Dr. Elinor Nightingale. They had first an advisory committee and now it's become a Board on Health Promotion/Disease Prevention. Lester Breslow is Chairman, and I am a member.

A number of the same people who had first been with the NIH taskforce and expert committee have now found a temporary home in the IOM which is being funded primarily by HHS. This is a perfect example of why pluralism is so essential.

There is another episode in my health promotion story. Partly as an outgrowth of the NIH conference, partly for other reasons, Lester Breslow and I got together in the summer of 1976 and decided to do an article in which we would try to marry his concepts of periodic preventive health services as part of primary care with my interest in patient education and counseling.

We merged our interests and produced an article which, after a couple of rejections, was published in the spring of 1977 in the New England Journal. It was called "The Lifetime Health Monitoring Program, A Practical Approach to Preventive Medicine", generally known as the LHMP. It caught on like wildfire. It was very well received. We began to get (I got most of them because the very day it was published Lester left for a six-months trip to

Europe and has been in and out ever since) a lot of requests from patients, doctors, group practice clinics, HMOs, everybody asking for our protocols and to help them design their own.

There have been many sequeli. The IOM held a conference at the request of Julie Richmond and produced some variations of their own which were supposed to be included in the Administration's national health insurance bill, which of course never came off. The most ambitious sequel is a project, which is just getting underway now, called the Lifetime Preventive Health Services Study. Ours was LHMP, this is LPHSS, but it is basically the same approach.

This is a three-year million dollar study funded, thus far, primarily by the commercial insurance industry, headquartered at Metropolitan Life Insurance Company in New York, and run by a doctor named Don Logsdon, who used to be medical director of HIP in New York. It aims to provide a national clinical trial of the LHMP type of protocols.

The last thing I want to mention under this heading and just spend a couple of minutes on, because it's not really in existence yet, but I did say earlier that the Institute of Medicine has now set up a Board on Health Promotion/Disease Prevention. We had our first meeting earlier this month, July 1981. One of the proposals which is being strongly made to the board and will be made, I believe, through the board to the council of the IOM, will be for a permanent office of preventive services in primary care. There are so many people who want to do something like the LHMP--age-related, with varying periodicity, to get away from the ritualistic annual physical--and who want to know what is the latest state of the art. Do you use mammography for women under 50 or not until after 50? And how often do you do it? How do you do counseling? Who should do the counseling? Should it be the doctor himself?

Should it be a nurse? Should it be a health educator? How much does it cost? Can it be included in health insurance? There are an awful lot of questions to be covered.

One of the reasons that the insurance industry is funding our study is because the leadership of the industry is convinced, just as Walter McNerney is, that health promotion and prevention have to be pursued. But how you build it into your contracts to sell to management and labor is another story.

So we are suggesting the establishment of a permanent office, not in government but in IOM which is, as I said, quasi-government, to be the monitor. To provide information and a sort of "Good Housekeeping Seal of Approval" to third-party carriers, doctors, patients, anybody, as to what seems to be a cost-effective, health-effective schedule of preventive services that can be provided by the doctor in his own office, or through a hospital, or through a group practice clinic today. I'll be very, very happy if that works out. It could be one of the best practical results of this decade of floundering around with health promotion and disease prevention.

Lester Breslow is one of the real heroes in this area. It was primarily his idea, although a lot of people have been involved. The Kaiser people were involved in the early days, making it financially feasible by doing it on a mass basis. Automating it, they brought down the cost enormously. The Health Hazard Appraisal is a very different approach, but they also deserve credit. That approach has been sort of "bastardized." I have a great deal of affection and respect for Jack Hall, Lou Robbins, the people who started the Health Hazard Appraisal. But, it has been taken out of primary care and has become sort of a gimmick which can be done on television or by computer. I don't think much of that, but it does attract attention.

One other area--before I leave health promotion--where I think I made some contribution was in the idea that, not just disease, but trauma and violence should be taken seriously as health threats, particularly for the young. Particularly for adolescents, between the ages of 15 and 24. Their major causes of death are related to violence and trauma. For blacks, homicide is the major cause of death in that age group. For whites, it's accidents, primarily automobile accidents. Accidents, homicide, and suicide are the major causes of death for all young people between the ages of 15 and 24.

The medical profession has paid very little attention to this. In our report on health promotion, we had to take cognizance of this. One of the aspects that we became very much concerned with in our committee (I was one of those who was most concerned) was the impact of television violence on children, both as victims and as perpetrators. This led to the only really big fight we had in our group and that was a real donnybrook. Because we had one representative of the television industry whom I personally invited to be on the task force. He was outraged and accused me of undermining the First Amendment and all sorts of things. However, I won out by a vote of nine to two.

Nothing that we recommended has been implemented; but the issue won't go away, because it is a real issue and constantly reappears. The question of violence is being looked at right now by the advisory committee on education for health of the insurance industry, of which I am vice-chairman. That's the group that started the LPHSS study.

WEEKS:

Don't you think there is a great difficulty in any educational effort in getting the population to accept what you are trying to teach...such as not

smoking?

SOMERS:

All things considered, when you consider the amount of money that is still being spent on ads in this country, promoting smoking, as compared to the amount that is spent on trying to educate people not to smoke, I think it's remarkable what has been achieved in the decline in adult smoking--what has taken place just in these past ten or fifteen years, and the number of lives that have been saved. You can't prove the cause and effect, it's not a simple thing, but there has been a very striking decline in cardiovascular deaths in this country starting around 1963-64. There had been a steady increase from the turn of the century up until then and all of a sudden it began to decline. That's the time that the first Surgeon General's report on smoking came out. It's about the time the Heart Association, Paul White, and others began to exhort us all to take more exercise. The American Heart Association and the Heart, Lung and Blood Institute began to do something about diet. Then a little after that came the big push on hypertension. That has been an unappreciated, but highly successful, health education effort, one of the most successful efforts that any country has ever had.

WEEKS:

I'm so concerned with the young people today who are smoking and the young girls who are smoking particularly. We don't seem to be able to reach that part of the population. You don't see many doctors smoking. I've never watched the program, for example, the Dukes of Hazard, but I've seen some ads for the program which come on before something else I'm watching, when I see how they wreck cars and do all these things that must possibly appeal to those young people, 15 or 16 years old, it frightens me.

SOMERS:

Well, it does me too, which is one reason I got so passionately involved in the fight on violence in television entertainment. I share your concern completely.

All I meant, in reply to your question, is that it's not fair to say that we have tried very hard to educate people and they have rejected it. I don't think we've tried very hard. There are just so many vested interests that are opposed to our trying. It is not just the tobacco people, you have a writer and a wonderful person like Russell Baker of the New York Times editorial page. He thinks that the idea of trying to persuade people to change their habits smacks of McCarthyism. "Leave people alone; you shouldn't interfere with their habits." Even many liberals, on First Amendment reasons or other reasons, are dead set against a serious health education program.

WEEKS;

I'm sure that you would argue or that others would argue on the other side of the coin that these people, if you want to look at it from a purely monetary sense, are causing society an expense, because they have this unquestioned freedom.

SOMERS:

No question about it! At one time or another, in spite of all the complexities, I've liked to think that I had answers, at least temporary answers, to a lot of problems. They satisfied me at least. But one question, that I can't come to grips with--even in my own mind--is what to do about people who absolutely refuse to stop smoking or to stop overeating, in the face of some specific threat that they know will affect them personally, and then get ill and then cost society a great deal. I've just been through this

with a former maid who worked for me. A nice person. She worked for me for seventeen years and I was devoted to her. As loyal as she could be. For all those seventeen years I tried to get her to stop smoking; I never could. Also, she drank, not on the job, but she drank off the job. Finally she died this spring, so many problems, just unbelievable. She had cirrhosis, finally tuberculosis, and of course, that threatened all kinds of other people. She probably had lung cancer, also. She had no insurance, she had worked as a domestic all her life. She had worked, though, so she wasn't on Medicaid, she was too young to be on Medicare, was only about 56 when she died. Her death cost the hospital about forty-five thousand dollars. The hospital picked it up. There is something there that is wrong, and yet I cannot myself come to grips with that. I think everything along the line should be done in terms of varying health insurance premiums for nonsmokers, giving nonsmokers a break. Once we determine, through the LPHSS clinical trial or otherwise, the right periodicity for preventive health services (certainly people don't need to go every year) people who follow that should get some break in terms of premiums.

We cannot in this society, however, just say to a person who appears at the hospital, "Well, you smoke, don't you? It's your own fault! Therefore we are going to let you die." You just can't do that in our society. First of all, you cannot differentiate, you cannot really be sure how much of a given cancer is due to smoking and how much is due to the pollution of the air, particularly in many dangerous jobs. I think in her case, it was clearly behavioral, rather than environmental, but in many cases you can't break that down that precisely. I don't know how you handle that and yet I know there's got to be some incentive. The procompetition people, I think, have nothing to add to that quandary. They'll just complicate it by making everything a

matter of dollars and cents, and dollars and cents don't mean much to people when it comes to their health.

In the long run, as long as we are a society that believes that people shouldn't be allowed to die on the streets, what do you do with people who deliberately commit suicide?

WEEKS:

There is no simple answer to this one, is there?

SOMERS:

All right, that's the story of my life as far as health promotion goes.

The last chapter started, I guess, with my growing old and becoming more aware of problems of aging. Everywhere I look now, almost every family I know, has somebody seriously ill in it. I went to the hospital night before last, I had two friends, one who had just had a cancer operation and one who was scheduled to have one yesterday. They were in rooms next to each other. There are so many.

Professionally I began to get interested in geriatrics about 1975 when Red and I were working on our book for the Robert Wood Johnson Foundation, Health and Health Care: Policies in Perspective, sort of retrospective. We tried to make it as comprehensive as possible. It started out because we had been asked repeatedly to update Doctors, Patients, and Health Insurance, our 1961 books; but somehow we never had the courage or the intestinal fortitude to tackle that. There was always the memory of what a formidable job that was when we were twenty years younger! We did, however, agree to do a retrospective, going back over our own works, and to try to pull it together into a volume which could, we hoped, provide sort of an updated DPHI.

One of the obvious gaps in DPHI was the almost total absence of any

attention to long-term care. That reflected the general lack of interest in it in the country as a whole. I was really surprised to see in the 1960 Kennedy Committee report that any serious attention was paid to nursing home care, home care, and extended care. For the most part, it was viewed primarily as a cheaper alternative to acute care. There was a real "iron curtain" between acute care and "custodial care" as it was called then, or whatever comes afterward. The stroke patient for whom nothing else can be done; or the senile patient. They were just confined to a sort of limbo.

So when we were working on this last book in 1975, we decided that it should at least have a chapter on long-term care. Looking for an excuse to go to England anyway--which we both love--we decided to go over and see what they were doing. They didn't use the term "long-term care" over there at all; didn't even know what we were talking about. But they were talking a lot about "geriatric care." So I ended up doing an article on geriatric care in the U.K. We also went to Holland and spent some time there looking at it. To do justice to it, I found that it was too long and I couldn't handle both countries, so I dropped Holland. An article came out in the spring of '76 in the Annals of Internal Medicine called "Geriatric Care in the U.K: An American Perspective." The timing on that was again very fortunate.

About a week after it came out, the Institute of Medicine, in conjunction with a couple of Royal Colleges in England, held a conference on geriatric care in Washington. My article was distributed there. Out of that conference, the Institute then set up a working committee on health care for the dependent elderly. Those of us who had been working on the IOM conference became involved in this committee: Bob Ball for example, the former Commissioner for Social Security who was then a resident scholar at the IOM;

and a wonderful man, an internist from Rochester, named Frank Williams, T. Franklin Williams. I met him when we were both interested in health education because he was very much involved in diabetes. Diabetes is one area where patient education is terribly important. He recognized it. Now he's the medical director of the large Monroe County Hospital in Rochester and has become one of the country's leading geriatricians. He was chairman of that committee. We turned out a small study, which was not read by many people, but which still stands up.

About the same time, I got together with one of my colleagues at the medical school. You may wonder what I was doing at the medical school all this time since they were paying my salary. They have been very generous in letting me spend a lot of time on outside things--with the Institute of Medicine, HIBAC, and so forth--but I'm always pleased when I can do something internally which shows more immediate results as far as the school is concerned.

In 1977, I think, Woody Warburton, who was then in the Department of Family Medicine, and I decided we would try to start an elective in geriatric medicine for medical school students. We found that the best time was the fall of their second year--that is "best" not in any abstract sense but in terms of their own curriculum. So we did. That's been going ever since. We'll be going into our sixth or seventh year, this fall. Dr. Warburton has since left for Duke and we have a young geriatrician on the staff who is now in charge of the program. However, I'm still involved. I'll be giving the first lecture, which I was working on yesterday, called "Who are the elderly?" The socio-economic, demographic aspects.

I had tried to get the medical school to commit itself to a much broader,

more ambitious geriatric program, the kind that some schools are beginning to go into now, and that Bob Butler at the Institute on Aging is trying to encourage. I wasn't able to do that. But in addition to starting this elective, I also started a faculty research seminar in geriatrics and gerontology.

The first year we brought in outsiders to give papers. We were fortunately able to get Bob Butler up once and then I got Bob Ball and Richard Besdine from Harvard and Les Lebow and Frank Williams and some other well-known names in the field. This went on over a period of two years. We started out entirely with outsiders but ended up entirely with our own people. We stirred up enough interest in the faculty to have them submitting papers. At the end of two years, we culled out the best and produced a book, The Geriatric Imperative: An Instruction to Gerontology and Clinical Geriatrics which came out in April 1981. It has my name on it but all I wrote was one chapter. But it served a useful purpose in terms of stirring up interest in the faculty.

So there was two things that I did at the school in the field of geriatrics. Meantime, other things have come along. I've been asked to speak a lot on geriatrics. The 1981 White House Conference on Aging, which will be held next winter, has been, as far as I'm concerned, an off again/on again affair. I chaired the subcommittee on prevention, subcommittee of the health committee, for the Governor's Conference in this state. We met last fall four or five times and put together a report which then was merged with others in the health committee and was presented to the Governor's Conference last spring. I did the task force report and most of the consolidated report. But again, I don't play politics, I don't know how. It's not that I look down on

it, I respect it but I just don't seem to get into it.

WEEKS:

You are not a political animal.

SOMERS:

I think politically, but I don't act that way. Perhaps I am interested in too many things. I don't know what it is. But anyhow, having done that for the state level, I also got involved at the national level. John Beck, whom I've known for many years, (He had been president of the ABMS when I was there, and he was with Rand.) and is now director of a large program in geriatrics at UCLA, was chairman of the Technical Committee on Health Services. John asked me to be a consultant, also with two or three others. We had several meetings in different places including New Orleans. Two of us--Dr. Robert Kane, a doctor at Rand, who has been interested in geriatrics for some time, and I--did most of the final report. I assumed, that we would be delegates to the conference, although we were just consultants to the committee.

But then came the change in Administration and everything changed. We were told: "No, we would not be delegates!" By the time I learned that--it was not until April 1--it was too late to become a state delegate. That's why I say as far as I am concerned, the White House Conference is an off again, on again thing.

The Institute of Medicine is also getting more interested in geriatrics. They've made a good beginning. They have set up a little task force which will be meeting next month, to see what they should be doing in this field.

These then are the three areas I've been interested in in the health field--health economics, health promotion or health education, and

geriatrics. They are all fields that we can't escape. There are serious problems and issues, whether we want to face up to them or not. It's simply a question of whether catastrophe comes before we are prepared or not.

WEEKS:

There's something I've been wondering for some time and I meant to ask you, is there a good profile of the sixty-five and over population? Do we know what they're really like?

SOMERS:

There are a lot of them.

WEEKS:

The reason I say this is because so often the political picture is one extreme or the other, you know. You get the impression that persons 65 and over are poor, or 65 and over are this and that.

SOMERS:

It depends on whether, when you are looking at a glass of water, you say it's half empty or half full. There are a lot of old people who are poor, but there are even more old people who are not poor. At the moment. Now, by the time Reagan gets through with us, we may be. But right now, the majority of old people are not indigent. The average income for older people is obviously far less than it is for the working population, but it is far better than it was a few years ago. Social Security has helped a great deal.

WEEKS:

Well, even in my own case, I sometimes think I'm getting too much Social Security, for what I've paid in. My idea in the beginning of Social Security, as a young man enrolling, was that some day I was going to get something like an endowment that would be paid in the form of a pension but it would be like

I were buying an endowment insurance policy. But I feel that now I'm getting paid a lot more than I would if there had been an endowment policy. Of course, I don't know, but it just seems to me that I'm getting too much money.

I personally could afford to get along on less, I could afford to get along on what that endowment might pay. On the other hand I know there are many persons who are in need and maybe it would be better if they'd could take some from me and give it to the people who really need it.

SOMERS:

Well, they are doing that also. That's the difference between social insurance and private insurance--your benefits are not related exclusively to your contributions. It's a combination of what you paid in, over how long a period, and how much you were earning, plus this levelling or "bending" effect, plus, of course, indexing.

It's indexed in two ways, as you know, both to prices and to changes in productivity and wage levels. Maybe that's a little extreme. Maybe it should be one or the other and not both. However, to me the most urgent Social Security pension reform is to adopt a policy, which would have to be instituted slowly and gradually over a period of time, but would eventually, within about fifteen years perhaps, lead to raising the retirement age from 65 to 68.

You cannot do that overnight. It isn't fair to people who have made plans on the basis of the existing commitment.

WEEKS:

Someone has suggested adding a month or two each year, something of that sort.

SOMERS:

That's right, that's what Victor Fuchs suggested, that's one way of doing it. I suggested, although I think maybe Victor's way is better, adding a year every five years. That's in more abrupt jumps. It would be a little bit easier administratively but I think that with computers today the other would be perfectly feasible. But in any case, if you started say in 1985, it would take to about 2000 to make that three-year change.

I mentioned earlier that I was going to have an article published in the Journal of Health Politics, Policy and Law. It was an assigned subject, and, I had to work hard on it because I didn't know much about it at the time. Frank Williams was having a big bash on geriatrics up at Rochester and he asked me to talk on the question of mandatory retirement. Of course that's tied up very closely with the adequacy of pensions. I came out of that study feeling very strongly that people should be given every incentive to stay at work as long as possible not only for economic but for health reasons.

I think there should be a broad range of ages at which people can retire, maybe starting even earlier than 62. Perhaps it should be 60 and maybe go up to 80, with graduated reductions, depending on how early you opt out. With rewards for staying at work longer. But there is no reason for the norm not to be raised over time.

WEEKS:

Isn't the mean under 65 now?

SOMERS:

Well, it depends on what words you are using. More people retire under 65 than over. It's about 60%, I think. And the life expectancy of a woman today at 65 is nearly 19 years. Most old people are women. To expect to be supported for that length of time--twenty years for a person who retires at 64

and then lives out a normal life expectancy--to expect to be supported adequately is really asking a lot of younger people who have to pay the tax.

WEEKS:

I've been wondering if what I call "great expectations," everybody is copying Dickens, I guess, if most of us aren't expecting too much. I look at my friends who are retired and wonder if they aren't getting too much medical service. I mean aren't they going to the doctor too often, if this isn't something you fall into because it's there? I don't know. Maybe I'm being cynical, but it just seems to me that we are expecting too much today.

SOMERS:

Yes, I think almost everybody is sort of cynical and selfish today. We've been rich for so long. Some people have played Cassandra--Red and I for example--warning the health field that you can't go on, year after year, with these unrestrained cost rises. But it did go on. Now, of course, it's beginning to come to an end. But, unfortunately, people seem to have to learn from personal, hard experience rather just being intellectually convinced.

WEEKS:

What do you see for Medicare? Do you have any ideas of what could be done or what might be done or what might happen if we don't do something?

SOMERS:

There are a lot of things that might happen. The Gephardt-Stockman bill calls for practically dismantling Medicare. I gather that Stockman really wants to do that. Give people vouchers and let them go out and bargain for their own best health care. To me this is just about as practical as.....

WEEKS:

Well, it isn't reasonable at all, because as patients we are not capable

of judging, or bargaining, because we don't know our condition, we don't know our options, we don't know anything.

SOMERS:

That's part of it and the other part is what we were discussing earlier--my dilemma with the people who refuse to stop smoking and so forth. If people do make a bad bargain and buy a policy that has no long-term benefits, or one which promises to be good but isn't, society is still committed to take care of them. Bad as Medicaid is, or charity care, it still costs the hospital quite a lot of money today. You are not going to let people die in the streets. People who buy a bad car, a bad camera, or any bad product--that's just too bad. They may write a letter, they may get mad, but society doesn't have to pick up the bill for them. But with health care, it is different. There is a spoken or unspoken commitment. Actually it's statutory now, but obviously that doesn't stop Stockman because he has made clear that he doesn't think there is such a thing as legal entitlement. But I really don't think that we are going to let people die just because they bought the wrong package of health care.

WEEKS:

I think the very indication of the response to Reagan's tax cut bill, the response by telephone and telegram and so forth, should tell them that they are going to get the same kind of response against any great change in Medicaid, Medicare, Social Security. I think the public is going to respond just as vociferously as they have in this case where they think that they are going to get a reduction in taxes. But don't you think that what we were talking about a few minutes ago, if there was a gradual change, if it's gradual enough, that possibly the public would accept it?

SOMERS:

In the White House Conference Committee Report, I managed to persuade most members to go along with the idea of an older retirement age. I sold it primarily--partly--on the health aspect but also, on the fact that this would give us money that we could then bargain with to get long-term care or more preventive care. Now there isn't any reliable source. We're spending a heck of a lot of money for long-term care, particularly on nursing home care under Medicaid, we're spending a lot more money than people realize--twelve or thirteen billion dollars a year.

WEEKS:

Are all the states giving it as a benefit?

SOMERS:

All but Arizona, I think. But probably very limited in some states.

WEEKS:

I know that at one time Florida was not giving nursing home care.

SOMERS:

They had to give some. It was spelled out in the original law, but it didn't say how much. You could give one day, I suppose, and meet the legal requirement. We have what is considered one of the more restrictive Medicaid laws in New Jersey. It's not for the "medically indigent;" it is only for those on categorial welfare programs. Still, we spend, I am told, more than half of our Medicaid dollars for nursing homes in this state.

It's a very different population, you know. It's not your usual welfare mother. It's middle-class people who have "spent down," to use the terminology, who have exhausted their private resources, and since we don't have child responsibility they are able, in one way or another, to get onto

Medicaid. That's even more true in New York, which is less restrictive than we are in New Jersey.

WEEKS:

I think we "spend down" to $1,500 in Michigan.

There's no question it's a special problem that has been moving in on us in the past generation and we've got to do something about it.

SOMERS:

Of course one of the reasons the problem has grown so fast is because the acute care has been so successful and we have kept people alive. Red, ten years ago, would not be alive. He was in a coma for five weeks but he came out of it. A lot of people are alive today who simply wouldn't have been ten or fifteen years ago. The life expectancy at 65 has increased substantially in the past decade, but so many of the people who have been salvaged still have considerable residual disability.

WEEKS:

I've noticed in some of the figures I've read that the older brackets among the over 65 are increasing.

SOMERS:

That's right. And that's where the big nursing home population is.

Now there's another factor, the shrinking, the thinning out, of the typical family plays a big role here. In the old days, most people (not everybody--there were always poor people and we always tend to romanticize the old days to some extent) lived in bigger houses. One of the only reasons I can keep Red here is because we have a big house. And the only reason I have a big house is because we get a subsidy from Princeton University in terms of low mortgage rates. But most people don't have that. People live in

apartments or--you walked past these new condominiums that are just being built up here on the corner. Very nice job, very attractive. But they cost $200,000 for some not much bigger than this room!

People can't afford to take in their aged. There is no place to put them. Now matter how much they want to, there's often no place to put a parent with a stroke.

WEEKS:

And with working wives now, this makes a difference. So many things that have changed.

SOMERS:

Children move. We have two children, one of them lives in California, the other's in Boston.

WEEKS:

Many families are far apart, most families are.

SOMERS:

So that's another part of the problem.

My latest research project, the one that I'm hoping to get word on in the next week or so, is a grant from a small foundation to spend a couple of years looking at this question of financing long-term care. If I had my druthers, I would throw it into Medicare. Take it out of Medicaid, put it into Medicare. Transfer these enormous funds that are passing through Medicaid now for nursing home care to Medicare.

WEEKS:

Would you end the open-ended reimbursement?

SOMERS:

Oh, yes, absolutely. That's the time bomb that we talked about. But you

don't hear a word about that out of Washington today, not a word. The idea that there should be fee schedules for fee-for-service medical care. Oh, you try everything else--you set up HMOs, you have a revolution, but you can't use that word, fee schedule or even negotiated rates. Or, that there should simply be some agreement on prospective rates. I don't like the term "prospective rate." Who invented that? It just means that the provider agrees in advance, like you do for almost everything else, on a fixed price and does not demand a totally "blank check." One of the mysteries of life that I will carry to my grave, I guess, is why nobody thinks about that.

WEEKS:

I talked to Ig Falk about the Committee for National Health Insurance and their plan of alloting money regionally and when the money runs out, cut down the doctor's fees. He is convinced that they can 1) sell the medical profession this and 2) that it will work if they do sell them. I'm trying to get him to write an article on it, I would like to see what they think. But Kennedy apparently is convinced that this could be done, it's in his bill, I think. I haven't seen the last bill. Do you think that there's going to be a time when physicians in general will accept the fee schedule?

SOMERS

I suspect so, but I think we're going to have to go all the way around Robin Hood's barn half a dozen times before we get to that. But it's what is done in practically every other country, including Canada right next door. But it's too obvious, I guess. I suppose we have to do everything else first. It is just so natural.

We were moving that way before Medicare, under Workmen's Compensation, Maternal and Child Health programs, and so forth. You had begun to have

negotiated fee schedules. You had a really useful development--relative value schedules--that started in California before Medicare, and was spreading until the URC movement came along and undermined it. Then the anti-trust people attacked it. But in order to have an equitable fee schedule, you have to have relative weights for different procedures. This is something that the profession itself should work out internally, the weights. Then you would negotiate with the payer, whether it's Prudential or Metropolitan or Blue Cross or HCFA. You negotiate the value of x, the basic unit.

There have been too many social scientists around getting contracts, getting grants to try to think up something original. Of course the medical profession and the hospitals, all they were interested in--most of them--was retaining the status quo. So they sort of encouraged much of this nonsense. Now they are having, particularly the doctors I think, terrific second thoughts about some of these procompetition ideas. They had thought, if you get rid of regulation, you would just stay with the status quo. But that is not what Stockman has in mind. He wants to make the HMO and Blue Cross, if it wants to, or Metropolitan if it wants to, into the new regulators. They should fight and compete with each other and to hell with the patients and to hell with the doctors.

WEEKS:

But as I think you mentioned earlier, there isn't competition in every region or every area. There can't be.

SOMERS:

You can't have competition on who can do the cheapest neonatal care. You can't!

WEEKS:

Because competition means that the patient has to chose the service and as we said before the patient is not capable of doing that. The patient goes to the physician and follows his physician's advice. It may be good or bad but the patient doesn't know the difference.

SOMERS:

And once the patient is in the hospital, he or she has virtually no say about what is done. What procedures, how long he is going to stay, what drugs he takes, even what operation. Both of my friends that I spoke of, when they went under the knife, they had told their doctors, "Doctor, just do whatever is necessary." Now suppose that doctor thinks, "How much is he going to pay me or how much is that HMO going to pay me? Should I do my $500 operation or should I do my $300 operation?" Health care is not like that.

WEEKS:

I had an interesting conversation with Dr. George Crile about this fee-for-service. He doesn't believe in it, of course.

SOMERS:

Doesn't believe in fee-for-service?

WEEKS:

Right, for surgery particularly. We have an article coming up in the next issue of Inquiry by him on this topic.

What do you think will happen in the future as far as proprietary, or for-profit hospitals are concerned?

SOMERS:

I think they will probably increase, either through ownership or, even more likely, through management contracts. There have been some real lemons and some real ripoffs in some of these for-profit chains, but some of them are

quite good. I have a lot of respect for the Hospital Corporation of America, for example. I am very impressed by the fact that so many community hospitals, Catholic hospitals and others, have called these people in to manage the shop for them. Nobody has forced them to do that. That hasn't been the result of competition; it's just survival to get good management.

It's clear that they have something to give, whether the market is free or regulated, that the non-profit sector seems to desparately need, at least portions of it. So I think that they are not only here to stay for the forseeable future, but will probably grow. If we move towards a really competitive environment, I think they would grow much faster.

If you haven't seen it, there's a very interesting article in the current issue of the New England Journal by John Iglehart called "Drawing the Lines for the Debate on Competition." I have not been following this too much, but I found this extremely interesting. He spends a good deal of it quoting a speech that Stockman gave at the HOPE conference last year. I think it was Stockman who said, "I think most hospitals will become for-profit on their own." In other words, he thinks that a gradual transformation of hospital ownership or management will occur in the future.

The for-profits have obviously contributed something, as I said, in terms of management. Sheer size permits them to do so. I visited HCA in Nashville in the spring. For example, they run a nursing school in the Philippines where they take graduates of Philippine nursing schools and put them through some postgraduate training before they bring them over here in their own hospitals. You have to be a big corporation to be able to do that. That sort of thing is imaginative and good. But to put the entire health care industry in this country on a "bottom line" basis will not work.

WEEKS:

Have you looked into nursing education at all?

SOMERS:

Not really. I have a lot of friends who are doing so. You know about the big study that Art Hess is heading up?

WEEKS:

No, I don't.

SOMERS:

It's being done by IOM for HEW, I'm not sure which branch, HRA, I guess. Art Hess is heading it up, although he is in the hospital at the moment, like everybody else I know.

WEEKS:

It's going to be a question that is going to be difficult to answer, I think, because of the desire to upgrade them.

SOMERS:

One other thing I ought to comment on is the academic health center and its relation to community hospitals. I think the academic health centers, in a sense, have dug their own, at least partial, grave--and my CHOP story is a prime example. There are two problems--one that they perhaps couldn't help, and one that I think they could have helped.

They love the concept of regionalization, as long as you concentrate on the "hub," because we all like to think that the world revolves around us. However, what they refused to accept was that, if you want to be the tertiary center and get all of the tertiary referrals, you then have to accept restraint as far as doing the secondary or primary functions. CHOP would not do that. Chick Koop said we've got to have the hernias and we've got to have

the tonsillectomies in order to be able to stay in business. That's not fair. If you want Podunk Hospital to send the babies with the open hearts and the shunts to you, you have to let them do the primary procedures. Otherwise you don't have regionalization. But instead, they wanted everything.

Secondly, they trained their own undertakers. They turned out too many tertiary care doctors. Everybody wants to be tertiary today, the institution wants to be tertiary, and the doctors want to be tertiary.

The academic centers have turned out so many first class surgeons and anesthesiologists and other people who now want to have a tertiary center of their own. So the old regionalization concept had broken down even before Stockman started a battle against it. You can't have regionalization and procompetition. It's absolutely antithetical. One is planning and one is free-for-all.

WEEKS:

Strangely enough, we had a regionalization plan in Michigan back in the middle '50s in the upper part of the Lower Peninsula, around Traverse City and those towns. Traverse City has a very good medical center, but it wanted to be the tertiary hospital and wanted them to send the patients out of Mancelona and Kalkaska and all these other little towns. Those hospitals were to supply Traverse City. But it developed jealousy, the very thing you said. Traverse City was doing everything. They would take patients for minor things from Kalkaska and yet expected Kalkaska to send them the serious cases. So it doesn't work unless there is a good working arrangement.

SOMERS:

Restraint is the name of the game under regionalization or under voluntary planning of any sort. Prior to Medicare and prior to this tremendous infusion

of money and blank check reimbursement, the old hospital leadership--Ed Crosby, and Russ Nelson and Mark Berke and that generation--was prepared to sell this concept of restraint, I think, to all parties. The community hospitals had to give up something to the academic health centers and the academic health centers had to give up something to the others.

Today, it's dog eat dog, everybody for himself. There's no real moral or ethical counterweight to Stockman's philosophy, that I can see. It's not just in the health field, it's that the Democratic Party is generally in programmatic, as well as political, disarray. They've had it good for so long. It happens to everybody.

My mother used to say, in the South, it only takes three generations, from shirt sleeves to shirt sleeves. Well, that got thrown off because we built in social security, social safety nets, and so forth. We had a big country and such a rich country and we had such cheap oil and we exploited other people. We coasted; we lived on our moral capital for at least fifteen years, I would say. Those of us who pointed this out were called Cassandras. What is happening now is perhaps not entirely unhealthy. The tragedy is that the people who will suffer most are the people who always have suffered. And the people who will somehow get away without cost will be the people who were doing well anyway. But as far as society goes, something like this probably had to happen.

WEEKS:

Well, I'm afraid so. It seems to me, I know it's a dirty word, that the means test might be the answer, if we could find another word and another way of approaching it. What I'm trying to say is, if I don't need it, why should I get it? Rather than if I need it, please give it to me.

SOMERS:

The substitute, the alternative is not the "means test" but the "functional test." It shouldn't be just on the basis of income or assets but it should be in terms of physical, mental, and social as well as financial need.

One of the many things I didn't mention to you is that we have a project going at the medical school now. We have a grant from the Hartford Foundation. We are trying to develop a program for health promotion for the well, relatively young elderly, those 65 to 69. We are doing functional assessment on these people and trying to help them decide, even when they are healthy, what they should be doing. Counseling to go along with it.

There is a good deal of literature, there's a good deal of experimentation started down at Duke in their gerontology center, with functional assessment. It's expensive, it's a lot more expensive than just asking a person what their income is and what their assets are. But it is a lot fairer to society and I think probably would be less expensive in the long run.

WEEKS:

Yes, if a certain income is adequate for one person it might not be for the other, even though it's the average.

SOMERS:

You're right, I have above-average income, but when you are spending $1,100 a week for nurses, you certainly don't feel rich. From a social point of view, it is hard to justify having Red at home as opposed to putting him in a nursing home. But there's no question that he would not be alive today if he'd been in a nursing home. Once you are aphasic and incontinent, you're almost certainly going to get bed sores and infection and probably die. Maybe

it takes six months, maybe it takes a year. The reason he is here today and getting a little better is because he is getting 24-hour-a-day attendance. Still, I know the nation couldn't afford to maintain twenty-five million elderly people at this price.

WEEKS:

That's right, but you can't put aside all these wonderful years you've had together and say we want to settle this logically. You've got to settle this with your heart, to a certain degree. Even if it took every cent that you have, you probably would want him as close to you as you could.

SOMERS:

Of course, that's what I want. But, it still has to be paid for in one way or another. And right now, the nation has no systematic way of handling such problems.

WEEKS:

But not every case is this extreme.

SOMERS:

There are many. Do you remember the article that I had in Inquiry, last year? It started out with a number of letters. What irony that was! Every one of those letters was from a woman whose husband had had a stroke. One of them--her husband was aphasic and hadn't spoken for five years and she was still taking care of him at home, alone, a man who hadn't spoken for five years. And she said, "I can't go on, what should I do?" So, I'm not alone on this. We've got to find some solution, even if it means cutting down on the acute care.

You can't say this for other people, but believe me, when this happened with Red, he had not made a living will. I've not only made one, but I've

sent it around to every member of my family, doctors, lawyers, everybody. I want them all to know, "Don't save me, don't keep me alive!"

WEEKS:

But if this situation were reversed and you were the one downstairs...

SOMERS:

Oh, he might have done it. But as a practical matter, let's say that I outlive him, which is not at all certain now, but if I did and then something like that happened to me. Who would then take of me?

WEEKS:

I understand. But what I was thinking was that it's very difficult for us now when we are comparatively healthy to know what we would say when we were paralyzed.

SOMERS:

I know. That's one of the things that people who oppose the living wills always say. When it comes right down to it, people do want to fight for life.

WEEKS:

Yes, the instinct is there.

SOMERS:

That's good in a sense.

Well, I didn't cover many of those last points of yours.

Interview in Princeton, NJ

July 30, 1981

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