Interview with Edward Hinman
March 16, 1998
Baltimore, Maryland
Conducted by Edward Berkowitz

Berkowitz: I see that you got your BA from the University of Oklahoma awhile ago. Are you from Oklahoma?

Hinman: I'm from New Orleans originally. I only lived in Oklahoma during the three years I was at the University.

Berkowitz: I see. What brought you there to Oklahoma as opposed to Tulane or LSU or such?

Hinman: My father accepted a position as being the Dean of the School of Public Health at the University of Oklahoma and I went along to be able to go to college and live at home.

Berkowitz: Your dad was an MD as well?

Hinman: That's correct.

Berkowitz: Had he been at Tulane before?

Hinman: That's a long story. His graduate work was done at Cornell. He had his PhD from Cornell. Then he went down to Tulane on a National Research Council Fellowship in tropical medicine and parasitology. When they were starting the LSU Medical School, he was selected to be one of the faculty members there and became a student and faculty member and got his MD from LSU. Then he went with TVA in Alabama, then went to Johns Hopkins for his MPH. (I went to Hopkins for my MPH many years

later.) Then, during the war, he was in Central America with the Coordinator of Inter-American Affairs Office. At the end of the war, he went back to TVA in Alabama and then went from there to the University of Oklahoma as Dean of the School of Public Health. He then went down to Puerto Rico as the Dean of the first graduating class of the School of Medicine at the University of Puerto Rico. Then back to the U.S. with the AID program, then up to Jefferson in Philadelphia where he was chairman of the Department of Preventive Medicine. At mandatory retirement age, he took two jobs as County Health Officer in western New York.

Berkowitz: That's quite a career. I've read *All the King's Men*. I should know about this. The LSU Medical School was in New Orleans, right?

Hinman: It was a Huey Long creation because Tulane wouldn't see things his way, and he couldn't get total control of Charity Hospital, so he built another medical school there. LSU had to share the teaching opportunities.

Berkowitz: Also having read Walker Percy novels, I know that tropical medicine was a big thing in Louisiana. It was a big center for that.

Hinman: Absolutely. Both schools were well known for their tropical medicine and parasitology.

Berkowitz: Did you know you were going to be a doctor when you went to the University of Oklahoma?

Hinman: Yes. Way before then.

Berkowitz: How come? Because your dad was?

Hinman: Everybody I knew was a doctor.

Berkowitz: Other people in your family?

Hinman: My younger brother is also a physician.

Berkowitz: Were you thinking, "I should get out of the region"? I see you stayed kind of in your roots there at Tulane.

Hinman: When I finished medical school, I went into the U.S. Public Health Service.

Berkowitz: That was in 1955 that you finished?

Hinman: That's correct. I interned in the Public Health Service, then served my two years of general duty for Selective Service purposes, stayed in the Public Health Service and took a residency in internal medicine at the Baltimore Public Health Service hospital.

Berkowitz: Wyman Park?

Hinman: Correct. We moved up here in 1958 and, except for 18 months, have been in this general area continuously since '58. I finished my residency and then took a fellowship in nephrology at Johns Hopkins. Spent two years as a fellow in medicine. Then I went back to the Public Health Service hospital in a department

known as the Clinical Investigations Department. I became Chief of that department, then was asked to go back to New Orleans as the Deputy Director and Chief of Professional Services. I was there for 18 months when I was called back to the Baltimore hospital as the Director of the hospital.

That isn't where I first entered what I would call health services research. It goes back even before that.

Just to finish the chronology, I went back as Director of the hospital in '68, was there for three and a half years, then went into headquarters as a Division Director in Regional Medical Program Service. Then I served for a period in the National Center for Health Services Research. Then I was called back to the hospital division and was Assistant Surgeon General and Director of the Division of Hospitals and Clinics throughout the whole United States. I retired from the Public Health Service in '78. That's when I went with GHA and so on.

Berkowitz: Let me just go back a bit. I'm curious about this one institution. In those days when you went to the Public Health Service—in about 1955?—was there still a doctors' draft?

Hinman: Yes. We weren't drafted in those days. You applied to get into the Corps. There were two ways of dealing with the Public Health Service. One was the Public Health Service hospital version of the Berry Plan. The Berry Plan said that you

could sign up and be deferred from the draft for the length of your residency if you would then immediately upon completion of your residency go with that service, the Army, the Navy, the Air Force and fulfill your Selective Service obligation. Dollars didn't change hands. That came with the National Health Service Corps later on. The Public Health Service had a version of that also. But what I did was I applied for my internship on a competitive basis in the Public Health Service, was selected, and then stayed in the Public Health Service and had a twenty-three and a half year career with them.

Berkowitz: I see. And this hospital here, Wyman Park, that was a hospital that was run by the Public Health Service? For Merchant Marine?

Hinman: Correct. That was the principal beneficiary group, but also active duty Department of Defense officers and enlisted personnel, dependents and retirees, federal employees sick or injured on the job, Department of State individuals who were actually Foreign Service officers—there was a list of a hundred different beneficiary categories, but those were the largest.

Berkowitz: That's very interesting, because that means that the government was actually providing direct care to a very well-defined group.

Hinman: If you go back historically, a fascinating thing

is—you're familiar with the phrase HMO, health maintenance organization—you probably do not know which was the first HMO in the United States. On July 16, 1798, President Adams signed an act to provide for the sick and injured merchant seamen. That act specified a defined group of eligibles, there was cost sharing—the owners and the patients had to cost share—a defined group of providers of service and a defined benefit package. That's an HMO. Until Reagan came along and got that entitlement repealed in '82.

Berkowitz: I know they talk about the origins of the Public Health Service going back to that stuff, but I'd never thought of it as being the first HMO.

Hinman: It really was. Originally the defined group of providers were contract physicians in the various seaports who took care of these merchant seamen.

Berkowitz: Sort of like a PPO.

Hinman: Sort of like that. The commissioned corps didn't start until 1898, something like that, and we wore uniforms. You had to be fairly sophisticated to be able to select out between a naval officer and a Public Health Service officer.

Berkowitz: Right, there was a sort of military aspect to the Public Health Service.

Hinman: That's correct. Most of my career I was in uniform every

day.

Berkowitz: That's interesting. And the head of the Public Health Service was the Surgeon General who was also, at some point, also the Assistant Secretary for Health. That's much later. There was no Assistant Secretary for Health until much later I know. At least the '60s or '70s.

Hinman: I forget who was the first person to be both.

Berkowitz: I wrote a book about Wilbur Cohen, and he was Assistant Secretary of HEW, but there were only two of them in 1961. It was only in the '60s that they increased this.

In the Public Health Service, then, what were your career goals within that service? Did you see yourself as a medical administrator?

Hinman: I started out to be a clinician, teacher and clinical investigator. I got interested in administration early on and then moved—I have not seen patients on a regular basis since 1971. I've been a full-time administrator since then. But it's an interesting type of administration. I told you earlier that there was a thread through all the different things I had done. I saw myself as a change agent. In all the positions I have taken, there was something that needed to be done differently than was happening at that particular moment. It really, I guess, became more obvious when I came back to Baltimore in

January of 1968. At that time John Walsh was head of the Division of Hospitals and Clinics.

Berkowitz: That's a division of the Public Health Service that's in charge of running these various things like the Wyman Park Hospital.

Hinman: At that time there were only nine hospitals left. There had been many, many more earlier in the history. (The history of the Public Health Service is fascinating, but that's not what you're here for today.) He was interested in having us become more involved with community health activities outside the traditional federal beneficiaries and using our expertise and systems to see if we could impact upon delivery of care. Let me give you two concrete examples. We developed an AMHT, an Automated Multi-Phasic Health Testing System for the Baltimore Public Health Service hospital. We redesigned space. The idea was to use a screening technique to gather a base of information upon which you could then build your care delivery for the patients and hopefully intervene early, so that you could prevent the development of full-blown illness. Morris Collen out at Kaiser Permanente and Ernie Sawaw, who's now deceased, were the originators of the Multi-Phasic Health Testing System. Some of the health services research type things go back to the '40s. What we were interested in was could we make this the entry point

into a care system that would then be able to reduce the number of admissions, reduce the number of sick visits the patients would have to have. The second thing we did was develop something that we called a Pre-paid Comprehensive Health Service Center. And this was in 1968. The phrase HMO hadn't been designed, but that's what we were talking about. We began to work with two community hospitals in Baltimore. One was called Doctors Hospital, and the other was Union Memorial Hospital which is still in existence. There was a defined population in what we called the Homestead-Montebello area east of here, which had converted from being a some-white-collar-but-mostly-blue-collar white area into a blue collar/white collar black community. As the people moved out, most of the pharmacists and doctors either retired or moved out. There was an acute shortage of health care. These were almost all working individuals. What we were designing was a system where—we are also one of the first federal hospitals to become a Blue Cross/Blue Shield participating hospital so that we could collect from the people who were insured by Blue Cross/Blue Shield. The idea was that we were going to open up, on a rotating basis, the different hospitals' emergency rooms and see each other's patients. Union Memorial was going to take care of the OB; we were going to take care of a good bit of the pediatrics and the mental health treatment. We

were working toward a common medical records system. The idea was to have a vertically integrated system of delivery of care that would work for the community. Also at the same time, Maryland began to experiment with managed care for medical assistance recipients, and they started talking about it in the very early '70s. It wasn't until the later '70s, '76, '78 that they actually got into it, but we were in negotiations with them at that time also. The objective being to see if we could develop a system of care that was cost effective. It would take care of the patients, it would satisfy them, the providers would feel that it was good care, and we could save money doing it. I would call that health services research.

Berkowitz: Right. These people that were in the Montebello area, they were paying patients, right? They weren't Medicaid?

Hinman: There were some medical assistance patients too, but they were paying patients, many of them.

Berkowitz: How would they get into this? Would their internists refer them in?

Hinman: There weren't doctors seeing these patients in the community that much, because the physicians had moved. Union Memorial, for years, was a hospital in which the physicians were out in the burbs, and many of the patients were out in the burbs coming back down because it was an old, traditional hospital that

everybody was just comfortable with. There was an area called MUND, Model Urban Neighborhood Development Corporation. It was funded by Westinghouse and it was from North Avenue to 25th Street and from what's now I 83 to Harford Road. Almost shaped like the state of Tennessee if you laid it out on a map. That was an area that had become predominantly Welfare, medical assistance. It was the area that was bulldozed pretty badly. We were also north of that and formed a community-based corporation known as Greater Homewood Community Corporation, which is still in existence, to bring together the community groups to organize for this health care delivery. We were going to offer this system for people willing to sign up for it beyond the traditional federal beneficiaries and beyond the medical assistance patients.

Berkowitz: That's interesting. Of course, Wyman Park Hospital eventually became a regular hospital.

Hinman: You didn't ask me if we ever got it open and succeeded.

Berkowitz: Did you?

Hinman: No. President Richard Milhouse Something-or-other [Nixon] decided to close the Public Health Service hospitals. So I was forbidden from signing the lease on the building where the first outpatient facility was going to be. We never were able to pull it off. I've still got the plans in my files at home, but

it never happened. We beat the rap because the hospital stayed open for another 10 years and, actually, when I left, we were in good shape in terms of staff and dollars and doing things out in the community and continuing to do different kinds of health services and research. The other things we were doing in health services research in hospitals and clinics ranged everywhere from some of the very early computer applications—does the name Sweeney mean anything to you? He was an early researcher at Tulane during the 18 months I was in New Orleans. There were two of them, Sweeney and Belinfy. One of the things we were looking at was using the computer as a means of planning menus. We had something like an allowance of $1.25 a day to feed the patients in the hospital. You don't buy a whole lot, even in those days, with $1.25, so we developed some fairly sophisticated inventory and menu programs to help plan meals to hold the cost down but still have something that was reasonably attractive for the patients and met nutritional requirements. We also were doing some work on computerizing encounter forms and appointment systems. This was back in the mid-'60s. That was done at the Public Health Service hospital in New Orleans. Out in Seattle, we developed a fairly extensive PHAMIS system [Public Health Automated Medical Information System] that's now a commercial product, still available, that was developed out of our hospital

out there.

Berkowitz: "Your" meaning the Public Health hospital?

Hinman: Right. I'm very possessive about them. My role was to recruit the staff and then make the dollars available to do these things. So I was an enabler; I was not a principal investigator *per se* in these things, although I'm an idea person and contributed a great deal that way. At the Baltimore Public Health Service hospital we were doing work on using computers in the laboratory, in trying to improve the efficiency and accuracy of testing in the laboratory. We were doing other medical record type research there. We had a Health Services Research Department in the hospital.

Berkowitz: Really? How were they funded?

Hinman: Out of our appropriations. We did get some grants from other people, but we took it out of our operating dollars. To me, health services research was the vehicle to help me do a better job running the hospital.

Berkowitz: Did Congress know you were doing this?

Hinman: Actually, yes. Congressman Paul Rogers from Florida was one of our biggest advocates. We saw ourselves as being the arm of the Public Health Service to ask questions about better ways of providing care that would help save money, because costs were beginning to be a real problem. We were a resource—these nine

hospitals and twenty-seven ambulatory facilities—that we felt didn't cost the taxpayers that much and were opportunities to get questions answered. One of the interesting but sad notes: we had always been the place where if there was an unknown infectious disease, a patient with an illness that you didn't know what was going on, you could send them to a Public Health Service hospital. The Public Health Service has taken care of patients with Hansen's Disease [leprosy] for years.

Berkowitz: Right. Another Louisiana thing, right?

Hinman: That's right. We've also been the place where if there was a suspected smallpox case, it was brought—that sort of thing. Which have been the cities with the biggest problem when the AIDS epidemic hit?

Berkowitz: San Francisco, New York?

Hinman: You mean hospitals there.

Berkowitz: Yes.

Hinman: New Orleans, Baltimore, Boston, we had hospitals there too. They were closed, though, at that point. They would have been places where we could have taken care of those patients without the terrible treatment that they received in the general hospitals because of the fear. That's part of our mission.

Berkowitz: Right. But the system wasn't there.

Hinman: Criminal. And it's going to happen again. It's going to

happen again. Something or other is going to turn up and need a place to isolate patients, but the hospitals are gone.

Berkowitz: Yes. Now, let me ask you this. I've never heard about this before. The Public Health Service had this sort of pocket of health services research. How did this National Center for Health Services Research interact with that, or intersect with that? Where was that in the bureaucracy?

Hinman: Unfortunately not successfully. When the powers that be were starting to pull together the National Center for Health Services Research in the mid-'60s, they brought Cesar Caceres's program in. He was doing what led to the automated interpretation of EKGs. There was a series of studies. That was one of the things that was brought in to help start the National Center for Health Services Research. Paul Sanazaro was brought onboard first as a consultant and later as the Director of the National Center, but they went academic.

Berkowitz: So their mission was to fund places like Johns Hopkins, like Kerr White. They weren't doing clinical work.

Hinman: Not places like us. We were doing the applied side of it. They were awful close to what some people would call bench research. There always was a tension. We took it out of our own appropriations so that they didn't have any control over it, but we were not highly successful in competing for dollars from the

National Center.

Berkowitz: The National Center, was it in the bureaucracy, part of the Public Health Service?

Hinman: Yes. At one time it was part of NIH, and then it was pulled out and put into HSMHA [Health Services Mental Health Administration], and then it was back at NIH for a period of time. Then it was pulled up to being out of the Assistant Secretary for Health's office. It never did real well from a standpoint of having a solid political base and a home that everybody was comfortable with in the Public Health Service, because everybody felt that there was too little control or too much control. Everybody was very dissatisfied and they had problems finding someone that made everybody happy as the director. Sanazaro was the director for quite a period. Then when he left, Bob van Hoek was put in as acting director. He'd been deputy director and was made acting director. He was not an academician. He was a Public Health Service career officer. He never got confirmed. Then they brought in Gerry Rosenthal as the head. He was a PhD economist, way out of touch with the delivery of care. And that was part of the tension. Was your job to fund the economists and the psychologists and the industrial engineers or was your job to try to get things down to a practical level? Some of the programs that they had in the National Center—the

ESPCDS program [Experimental System for Patient Care Delivery Services]. The idea was to try to develop horizontally and vertically integrated systems of care that were rational.

Berkowitz: Sort of like what you'd been doing.

Hinman: Precisely, precisely. Then they had the EMCRO [Experimental Medical Care Review Organizations] program was a fantastic health services research design. But Congress got impatient. Somebody by the name of—the Senator from Arizona—Bennett?

Berkowitz: Not Goldwater. The other Senator from Arizona?

Hinman: Anyway, he wanted to have legislation to oversee Medicare/Medicaid, so they developed the PSRO program. Borrowing all the things that had led to the development of the EMCRO program. The EMCRO program hadn't been evaluated yet, hadn't been in place long enough. So the PSRO program was foisted off on the American public based on good ideas but without any pre-testing. Then there was the Emergency Medical Services program which got bounced around a good bit too, the idea being to try to rationalize our emergency medical care system and not have all the hodgepodge. For instance, if you were in Los Angeles, there were nine different communications systems, nine different sets of jurisdictions, and they all were run as independent fiefdoms, which meant that if you happened to have your auto accident and

be hurt on the wrong side of the street, you could be up the creek. No cooperation. It was a real mess. It was part of the National Center at one time, then pulled out. All this political jockeying going on.

Berkowitz: Yes, I see. That gives me a good feel for it too, I think, that this Center was in many ways the NIH but for these types like Kerr White as opposed to the cancer and the heart specialists.

Hinman: And Charlie Flagle. He got a lot of that money.

Berkowitz: Yes. That's interesting. Now let me ask you one other thing about your career. You had this medical fellowship to do nephrology? That doesn't sound much like what you've been saying. You just left those kidneys hanging there?

Hinman: That's right. When I went down to New Orleans in July of '66, I essentially hung up my stethoscope. It wasn't officially hung up until January of '68 when I went back to Baltimore, because I was still seeing some patients down there in consultation for renal disease.

Berkowitz: I see. So you left Public Health Service. Was that because you had a number of years in or were you disgusted, or both?

Hinman: I had not endeared myself to people, because they kept wanting to close the hospitals and I was extraordinarily

outspoken and active in keeping the hospitals open. So there was no place I could go *up*. At that time, the job I was in had to be *cleared* with the White House but didn't require official approval of the White House. It was time for me to move on. Too many people reacted strongly when my name came up. We'd done a good job. We'd taken care of patients. We were doing it at a cost less than other organizations. We had some good residencies. We had some good health services research going on. Things looked pretty good. Then along came an actor.

Berkowitz: At Wyman Park, I was a patient there, so I know it was an HMO that was the successor to—the Hopkins HMO, the Prudential HMO. They have all those buildings there. Did you live in one of them?

Hinman: Yes.

Berkowitz: So that was a perk, like a military base.

Hinman: Absolutely.

Berkowitz: And nice too.

Hinman: Oh, it was delightful if you didn't mind living in a fish bowl. Originally there had been either four or five duplexes, the officer in charge's quarters, an apartment building and a nurses' home. That was the original construction. The apartment building and the nurses' home went, then the duplexes went and then the officer in charge's quarters went. When we were there,

there were offices in one of the bigger buildings and labs in the other, so from seven o'clock in the morning until seven o'clock in the evening there were people walking right by the house looking in the windows. So you were literally in a fish bowl. Of course, the lovely thing was I could go home for lunch every day by just walking less than a block.

Berkowitz: Yes. That's like living on a military base, I'm sure.

Hinman: I was the last person to live there. I moved out and we put the School for Medical Records in there. That was sad; that was a beautiful home, a lovely home. The kind of thing you dream about.

Berkowitz: Right. No one would have guessed that something like that existed.

So you left the Public Health Service in what year?

Hinman: '78.

Berkowitz: 1978. And then you had this other extraordinary career.

Hinman: I spent five years as the CEO in the Group Health Association.

Berkowitz: Tell me a little bit about that. How were you recruited?

Hinman: For my initial interview I was a little early going down to the building there on Pennsylvania Avenue and 21st. I called

my office to see if there were any phone calls and they said, "Oh, you are to call—" and they mentioned the name of the person who was heading the search. Here I'm in the GHA Building, but I'm making a phone call. He says, "Dr. Hinman, I'm glad I caught you because we're going to have to reschedule that interview." The physicians' strike!

Berkowitz: Ah. I remember that.

Hinman: When I was hired, they were looking for a physician at the time, thinking that might help cool things off with the troubles with the physicians. I was hired right after the strike was settled. I couldn't leave the Public Health Service right away. There was a three-month lag in there. Then I left just six or eight months before the next physicians' strike. I was there between the physicians' strikes. I had a nurses' strike, but I didn't have a physicians' strike.

Berkowitz: Were you a believer?

Hinman: I was a believer in consumer coops. The one in Puget Sound had succeeded. The one in St. Paul had succeeded. The one here, that is in Washington, I think the real problem is that it was still dominated by people who saw it as a social movement, not as a health care delivery system for members.

Berkowitz: Not only that, but they're ethnically homogeneous. They're old Jewish civil servants.

Hinman: Yes. They came out of the Federal Home Loan Bank.

Berkowitz: They're not all from the Federal Home Loan Bank, like Harold Woul.

Hinman: While I was there some of the board members were original members. The way I describe the organization is that the board was elected by the members, from the members, for the members, but not for the organization. The tension—I remember one lady who used to frustrate me no end. She was a true believer, but she couldn't say no. Even though it was not a covered benefit, she wanted us to provide it because the patient needed it. That's a social movement.

Berkowitz: I'm sure I met her.

Hinman: I'm sure you did. A lovely person. Her husband had been one of the senior people in the AFL-CIO.

Berkowitz: Oh, yes. I'm actually related to her, the Rutenbergs, Gertrude.

Hinman: Are they still alive?

Berkowitz: I believe she is. It's one of those things where I'm related by marriage, not by blood. He was a distinguished Assistant Secretary of Labor, I believe. Stanley.

Hinman: Absolutely. And Gertrude, but she led with her heart.

Berkowitz: Her daughter is involved too.

Hinman: She's another story, Ruth. They couldn't focus on trying

to recognize that you had to be business like if you were going to succeed. It could be a not-for-profit, it could be a coop for members, but you've got to run it in a business like fashion. The suspicions—the board was not comfortable with the medical staff; the board was not comfortable with the general staff. The general staff was not comfortable with the medical staff; the medical staff was not comfortable with anybody. And then there were a number of members who thought that the board was out of control, so there was the MAC, the Medical Advisory Committee, who were elected individuals to watch over the board—who were elected individuals.

Berkowitz: Right. Not to mention that you had the Civil Service as a major player and the unions were involved too, the Transit Workers Union.

Hinman: Right.

Berkowitz: So that was a different dynamic altogether. What a combination, huh?

Hinman: Although I survived five years. Wasn't a day less than fifteen!

Berkowitz: Were you doing health services research when you were at Group Health? Or was that just day to day running the place?

Hinman: That was pretty much day to day running the place. I wanted to do some things. We wanted to test out the notion that

for a staff model HMO to succeed you needed what we now call IPA sites for primary care to feed into your system. Because a system where you employ specialists is an avid consumer of primary care patients, because if you do your job in an HMO you don't use many specialty visits. So to support specialists you have to have more and more patients coming in, high enrollment, active enrollment levels. So there was not any real health services research there.

Berkowitz: It's all coming back to me now. There were a lot of people lived in what's called Bannockburn. There's one subdivision that many of them lived in. That's where Harold Wool lived. Near Echo Park, in the city—or just outside the city. And that was another problem. The area was growing was growing quite big on the Virginia side. That was very complicated, right? You had to deal with that. Whereas Washington was becoming really heavily black and depressed. There was time when they were running some kind of a thing in Columbia, one of the sections of Washington or Adams Morgan. It was an experimental thing. That was, I guess, before your time in the '60s.

Hinman: There was a Medicaid Research Demonstration Project done there which was, through Health Services Research, published in the *Medical Care* journal. What they showed was that they could, by having an integrated system, providing primary care up front,

they could reduce the total costs for the Medicaid population. It was so successful that the city got scared of it, didn't pay its bills on time. Ever heard that problem in Washington?

Berkowitz: They don't have that today, though.

Hinman: And the contract was never renewed. It was a superb demonstration of the value of managed care in medical assistance patients.

Berkowitz: Managed care in that up beat sense. It's so pejorative today.

Hinman: You notice I didn't say managed *costs*. I said managed *care*. To me there's a big difference.

Berkowitz: So, OK, you survived five years at Group Health, which I know is quite an achievement. Then from there on to a number of other jobs that you had. You had two years—

Hinman: Running a small consulting group in risk management and quality, consulting with an insurance company, CIMA. Corporate Insurance Management; it's an insurance broker whose offices were in Bethesda, now are down in Old Town, Alexandria.

Berkowitz: Tell me what they do again.

Hinman: It's an insurance broker—it's called a full-line insurance broker—which started a subsidiary to do risk management consulting, and I was the first president.

Berkowitz: Selling the product to other insurance companies? To

corporations?

Hinman: No. To clients. For people who were insured, I would go in and do an analysis of the areas where they had risks that were not being appropriately attended to. The risk could be security, it could be a workers' comp type risk, it could be inadequate backup for key processes. It was involved.

Berkowitz: These were for employers who were self insured?

Hinman: No, these were for people who bought their insurance through CIMA. In other words, if you contracted through CIMA to be your insurance broker and place your fire and your liability

Berkowitz: Say I'm a company.

Hinman: So I as a consultant come in and advise on whether there were other things you should be paying attention to from the standpoint of policies and procedures.

Berkowitz: This sounds like what most insurance salesmen do. They tell you that you don't have enough insurance.

Hinman: Well, you see, my job wasn't to sell more insurance, although, of course, the company had this division to *get* more insurance. My job was to tell you how you could *lower* your insurance premiums. If you did this, this and this, you'd reduce your risk, reduce your exposure.

Berkowitz: I see. Sort of like safety consultants used to be.

Hinman: Correct, only broader.

Berkowitz: It sounds to me like it was a totally different thing than what you had been doing.

Hinman: It was. And I didn't see very much health care, so after two years that was sufficient.

Berkowitz: That's a whole other thing, workers' comp, that's a very complicated business. Is this just one of those things you fell into, that you knew somebody?

Hinman: The person who was the head of the whole shebang was the broker at GHA. So in a suitable period after I left GHA, I went with CIMA.

Berkowitz: I see. Who succeeded you at GHA?

Hinman: Bob Rosenberg. I had brought him down to be the medical director; there was a search, but they selected Bob.

Berkowitz: So you did that risk control services 'til 1986 and then worked for Prudential. That must have been the same thing I was a member of then.

Hinman: Very likely. This was just opened up PruCare Plus in Washington, and I was a contract consultant part-time with Prudential, helping them design the network, train the people to go out and recruit physicians, get the physicians in and do the credentialing, do the utilization review. I did that for what, two and a half years?

Berkowitz: It says three, 1986-1989. I see. This was at a time

when they were very keen to get these HMOs as I recall. They were competing. None of them made any money, as I remember.

Hinman: Well, it was still early enough that there was a tremendous antipathy toward managed care on the part of the physicians. Getting physicians to sign up was a challenge. Now they know they *have* to sign up, but in those days, particularly in Virginia, it was an interesting challenge. Of course, Prudential's a very bureaucratic organization.

Berkowitz: Yes, New Jersey. Did you work up there?

Hinman: No.

Berkowitz: Now they've probably abandoned that.

Hinman: No, I think they're still there.

Berkowitz: I know they bought the Hopkins HMO, because I was a member of the Hopkins HMO.

Hinman: Yes, they did.

Berkowitz: Which exposed the fact that that name was kind of up for grabs. Were you responsible for bringing Wyman Park into that as one of the providers?

Hinman: No, I was not involved in that.

Berkowitz: Because it was. That just was a transition of some sort?

Hinman: When the Public Health Service hospitals were closed, it was an opportunity to become a community-based facility and there

were certain dollars that went with it. *And* remain a USTF, a Uniformed Services Treatment Facility so that DOD beneficiaries could go there just like they could before, just like they could to Walter Reed or any other military base. Then the hospital part was closed and it was all ambulatory, and now I guess it's an ambulatory part of the Hopkins plan.

Berkowitz: So that's what I was seeing. I was seeing those guys with lung problems. They were the DOD guys. And then I was taking my kid there to what used to be a hospital but was now sort of a big outpatient pediatric place and internal medicine place. Where were those doctors coming from?

Hinman: The guy that was head of it for awhile had been someone I had recruited and appointed to run one of the hospitals, Pat Mattingly. Then he left and went up to Harvard Community Health Plan. But the physicians, after it was no longer a federal facility, were then employees of the Hopkins plan.

Berkowitz: And the Prudential plan. Although they seemed to take lots of different plans.

Hinman: Yes, but I don't know. Were they ever really Prudential employees or were they always Hopkins employees?

Berkowitz: All I know is that there were some good ones. The pediatric part had particularly good ones. The internal medicine guys weren't great.

Hinman: We had some good doctors when I left. And they brought some other good ones in.

Berkowitz: I had a thyroid thing. What kind of doctor does that?

Hinman: Endocrinologist.

Berkowitz: Yes, they have a very smart endocrinologist.

So, you worked for Prudential. By now you're an expert in what we call managed care or the management of care. Then you went to this Lincoln National Employee Benefits, which is the same kind of thing?

Hinman: They were the seventh largest insurance company in the United States.

Berkowitz: Really. I should know that.

Hinman: And they were a full-line company. They decided to divest themselves of their health insurance, which they did, lock stock and barrel. The traditional fee for service type, all the managed care products. I was out of a job.

Berkowitz: Why? They just weren't making money on those?

Hinman: They had had a big review by one of these big consulting firms and they had five lines of business and wanted to know what it would take to make them all top-drawer.

Berkowitz: That would be property, casualty, life—they were selling all those products?

Hinman: They were in need of a major new MIS system. That was

the thing that finally tipped the scales. The return on investment that they could expect from the hundred million they were going to have to put in, they didn't think warranted it, so they got out of the business. You see there were other companies getting out of the business too. In the morning paper, New York Life is selling off its health care subsidiary to Aetna. John Hancock got out of the business in the past. A number of companies have gotten out of it because it *is*—it's not a cash cow like it used to be.

Berkowitz: We're up to your present job. This sounds more like to your roots, the one that you're doing now.

Hinman: In many respects.

Berkowitz: This is the Total Health Care, Incorporated.

Hinman: Total Health Care started out as two separate organizations that were neighborhood health centers under the old Lyndon Johnson Great Society program.

Berkowitz: Right. The War on Poverty.

Hinman: That's correct. One of them was known as Constant Care Community Health Center, and the other was known as West Baltimore Community Health Center. Like all the other neighborhood health centers, they were started by a community group in a store front with a hospital sponsor. Like the other organizations, they had their ups and downs. In the mid-'70s

they both became state-qualified HMOs to be able to take and provide managed care to medical assistance recipients that they'd been caring for. There are two principle beneficiaries served by Total Health Care. One is the uninsured. That's the real reason for our existence, a safety net for the uninsured individual. And the other is for those that are considered the under insured and low income, i.e., medical assistance recipients.

Berkowitz: Uninsured? You're guaranteed to get nothing? That's what uninsured means?

Hinman: That's right. What we get is a federal grant, a one-time annual federal grant which, the last time I figured it out, amounts to a couple of hundred dollars per person that we take care of per year, which, of course doesn't cover all the costs. The idea is that if you have your facility in a medically under served area and you're a community-based corporation that is not-for-profit and your board of directors has over 51% users on it, then you can qualify to compete to become the designated community health centers for various census tracks. Maryland has nine community health centers throughout the state. We're the largest.

Berkowitz: Do you serve Baltimore?

Hinman: We serve West Baltimore only.

Berkowitz: There's two of them in Baltimore?

Hinman: No, there are four. There's Peoples, there's Park West, there's Health Care for the Homeless, there's Baltimore Medical Systems and us—there are *five*. There's also Chase-Braxton, but they're not technically a federally qualified community health center.

Berkowitz: So you serve the uninsured. No co-pay, no deductible for the uninsured?

Hinman: Everybody gets means tested and is expected to make some contribution. The contribution can be 0% or it can be 100% of our fee schedule. Everybody is supposed to pay *something*. There are a number of people who don't; we get to write it off.

Berkowitz: You get unlimited hospital days for this?

Hinman: The uninsured do not get any hospital days for that. All this is is ambulatory care.

Berkowitz: So when they go in the hospital they have to apply for Medicaid to pay for them?

Hinman: No. The uninsured go under charitable care. Any hospital that's received federal funds under the Hill-Burton program has to give back charitable care. And it's through that part of their budget that they pay for the inpatient care. We do the outpatient care that can be provided in our physical facility. They have to go into the hospital as uncompensated care.

Berkowitz: Do the hospitals take them?

Hinman: Yes.

Berkowitz: Really?

Hinman: Oh, yes. In Maryland, the way the fees are set includes their uncompensated care as well as an allowance for depreciation for replacement of equipment. That's why hospitals in Maryland haven't been closing.

Berkowitz: I see. So if you're a patient over here, you go to Hopkins; if you're a patient here you go to some other place.

Hinman: We're speaking only of the uninsured patients now. That's correct. Under our medical assistance patients we have had a full risk HMO contract up until now. That means we're responsible for the inpatient care.

Berkowitz: There's this movement now to provide managed care to Medicaid, right? We say medical assistance in Maryland, but people say Medicaid.

Hinman: Yes, but it's changed this year. It's been turned topsy turvy.

Berkowitz: So you're no longer doing that?

Hinman: It's not quite that simple. We are part of an MSO [Medical Services Organization]. We're an equity partner in a group known as Care Partners, which was created by four owners—Free State Health Plan, University of Maryland Medical System, an entity known as PCC which is Mercy plus a series of

community health centers, and Total Health Care. We're a 20% owner of the corporation. We contract with Free State Health Plan to provide medical assistance, managed care, MCO services in our service area, West Baltimore. Because of that, we're getting out of being an HMO, probably next month. Once all the old HMO patients are gone into the MCO, we will no longer be an HMO.

Berkowitz: OK. What does that mean for a patient?

Hinman: The only difference they will notice is that in this MSO we only use two hospitals, Mercy and University Hospital, whereas in our old system we used a couple of others too. That's really the principle thing they'll notice. Well, and that their cards now say Blue Cross/Blue Shield, Free State, Total Health Care instead of just Total Health Care.

Berkowitz: In Maryland, in Baltimore, are there people that don't really have health care then? If you cover the uninsured and there's medical assistance and there's regular people, it sounds like there's very few holes in the safety net then. Yet people talk about these thirty-five million uninsured. Are they really insured?

Hinman: They're really not insured. Because, whereas we receive some funds to be here to be able to provide care to them, that doesn't take care of some of their pharmaceutical needs, it doesn't take care of a number of their other needs. So they have

to compete. If they show up at our doorstep, we'll take care of them, but they have to know to come to our doorstep. We do some advertising. But the uninsured person has to get out and hustle to get their care.

Berkowitz: Right. And if you're a 35 year old male you may not fit anywhere, and then you go to ER when you get hurt.

Hinman: If they can come to us, we'll take care of them.

Berkowitz: But you'd have to be sick, I would imagine, for that to happen.

Hinman: On the back of our ID badge is our mission: "Total Health Care is a not-for-profit, community-based, managed care organization dedicated to improving the health and quality of life for *all*, regardless of ability to pay." But you have to come to us. Well, somebody could bring you, but the point is that a person who's homeless, they can't even apply for Medicaid without a permanent address, which is an interesting irony. Most of the uninsured are not the real poor; most of the real poor, unless they're homeless, qualify for medical assistance. The ones that are uninsured are the self-employed, the service workers, that's where many of the aliens get trapped because the job they work for—they're on a thirty-hour a week basis—you can get by without having to provide any benefits. They don't make enough money. If you're making $15,000 a year there's no way you

can pay $7,000 a year for your health insurance for a family. So many of them, the bulk of the uninsured are either students—an awful lot of students go uninsured—or service workers, other employed individuals but at marginal income levels. The deuced thing that we've done over the years is that a medical assistance patient, you get them a job and they start going out and making a little money and getting proud of themselves and want to take their place in society, they lose their medical assistance. If they've got a sick kid they can't afford that. It's a weird system we've got. It's inconceivable to me that as a nation in the almost-21st century that considers itself to have a strong Judeo-Christian background can have 15% of the population uninsured. *It doesn't make sense.* It's costing us more in the long run. It's an absurdity.

Berkowitz: So if one of these marginal people gets AIDS or something and shows up in an ER, then, presumably, they get care, this uncompensated care. So you have to get very sick, which, of course, defeats any preventive medicine set up.

Hinman: That's right. There's 700 organizations somewhat similar to us—most of them are smaller—around the United States being this safety net. There are migrant health centers, there's health care for the homeless programs as well as the type of thing we are. We have four primary care sites around the city.

We have a substance abuse site. And we have this headquarters building.

Berkowitz: Where are you primary care sites?

Hinman: One of them's at Mondawmin Mall, one of them's at 1500 Division Street which is just off Pennsylvania Avenue in old West Baltimore, another is at 1500 West Saratoga Street, and then one on the east side of town not far from the intersection of Harford Road, North Avenue and Broadway.

Berkowitz: I see. Now are you doing health services research in this setting or are you just providing care?

Hinman: There are things I'd like to do, but we've been so busy we don't have opportunity to really do any research.

Berkowitz: So your career then, you did your health services research really in the Public Health Service, and then you got into administration and managed care.

Hinman: We're getting ready to do something that would be a legitimate health services research, assuming we get it all pulled off, and that is an organization known as IHI, the Institute for Health Care Improvement, was formed by Don Berwick. Don Berwick, who was one of the early people in total quality management at the Harvard Community Health Plan formed this not-for-profit corporation, IHI, which is using some health services research approaches to diffusion of innovation, and we're getting

ready to start a major project with a number of community health centers to try to improve encounter, the actual episode of the patient arriving and the patient departing and all that happens in between. There are things that are known that are not being applied. The problem of diffusion of innovation is that if you let it go naturally it takes awhile. We're going to try to jump start it. If we ever write it up, that will be legitimate health services research.

Berkowitz: Do you have docs that are interested in publishing? Do the docs that work for you see themselves as helping?

Hinman: Our physicians are mostly community physician oriented. Many of them have come from impoverished backgrounds themselves. Some of them come from the National Health Service Corps scholarship program where they have payback time. They receive money going through medical school. Most of ours are not academically oriented that are here. There are some plans that have more of an academic base of residents rotating through, and there are a number of the physicians who are more academically oriented. Ours are more service oriented.

Berkowitz: Thank you. You've been very helpful.

Hinman: I enjoyed it.