

Kerr L. White: Question and Answer

What role has the Rockefeller Foundation and its leadership played in the development of health services management and research in the last twenty-five years? Do you anticipate that its role will change in the years ahead?

Almost 25 years ago the late John Knowles, a physician, assumed the presidency of the Rockefeller Foundation at a time when its funding for medical science and education was at an all-time low. Starting in the 1960s the Foundation began a program in University Development that included support for community medicine initiatives in medical schools in the developing world. I describe this at considerable length in “Healing the Schism: Epidemiology, Medicine, and the Public’s Health”;

On balance I consider the impact of this program on medical education as minimal. It did not get to the heart of the problem which resides in the attitudes, priorities, and practices of the clinical departments, especially Internal Medicine. Knowles and I had had frequent conversations over the years about the Rockefeller Foundation’s 1916 unfortunate (but well-meaning) program to establish and fund Schools of Public Health apart from Schools of Medicine. In 1978 he provided me with an opportunity to initiate and develop the International Clinical Epidemiology Network (INCLLEN).

INCLLEN aims to change priorities and the allocation of human and financial resources to provide more balanced health services, especially in the developing world. This involves the management of facilities and services to meet the needs of the populations served. By training clinical faculty, especially internists, who have the most influence on students and on the allocation of resources it is hoped that gradually change will occur. An exhaustive independent review of INCLLEN in 1992 concluded that it had indeed succeeded in its goals up to that date and should be continued. (This and many other documents on the origins and progress of INCLLEN are in the KKW collection.)

Only INCLLEN’s long-term impact can determine its intrinsic worth. In recent years there has been a major turnover in the ranks of senior officers at the Foundation, including virtually all those in the Division of Health Sciences although INCLLEN continues to be funded. Foundations like other social institutions change over time—and they probably should. The INCLLEN program is still expanding and constitutes the longest lasting program and largest investment the Rockefeller Foundation has made to date (1995). INCLLEN has been incorporated as a distinct entity with an international board of directors and headquarters in Philadelphia and sources of financing apart from the Rockefeller Foundation are emerging gradually.

Earlier in your career, you speculated that the United States would soon have some kind of national health care system. Are you surprised that this has not happened? What is your view of the current debate on national health care policy?

In a 1967 speech to the American Association for the Advancement of Science (AAAS) in New York and at a 1968 meeting of the New York Academy of Medicine I advanced what later became known as the “Airline Model” for the evolution of health services in the United States. I argued that the United States would probably end up with seven or eight vertically integrated national health care systems rather than a single National Health Service (NHS) such as that in Britain. This would come about as a result of increasing consolidation of practices and groups and closer association among physicians, hospitals, and long-term care facilities (e.g. nursing homes) and services (e.g. home health care). Local entities would coalesce into regional, and eventually national systems.

The airline model concept predated Paul Elwood's initiative on Health Maintenance Organizations (HMOs) that he and I discussed at a Sun Valley Forum (see *Medical Cure and Medical Care: Prospects for the Organization and Financing of Personal Health Services*, Andrepoulos, 1972) and later during a two-hour telephone conversation in which we discussed the initiative that later led to the Jackson Hole meetings, the HMO legislation, and evolving concepts of "managed care" and "managed competition." I believe that the four most important elements in health care reform are:

- Vertical integration of balanced staffing and facilities so that there is a seamless service from primary care through consultants to specialists in hospitals, home health care, assisted living, nursing homes, and hospice care all under one management with comprehensive information and transportation systems;
- Reasonable choice (and therefore regulated competition) between systems, clinics, and physicians;
- Universal coverage of the entire population (perhaps excluding illegal immigrants except for emergencies);
- Payment by means of uniform taxes or premiums (i.e. single payer) that are not based on employment but with reductions or remissions for those below a defined minimum income.

Health Care Systems could then bid on capitation payments for enrolling populations based on approval by the CAB equivalent. Savings that accrued could be used to reduce or constrain increases in premiums in future years. The FAA equivalent would publish report cards on the performance of the various systems and their sub-units. Using Federally mandated standards for both coverage (i.e. everybody) and for quality and satisfaction, I would let those States wishing to manage their own health affairs do so. Problems arise, however, when patients move across State lines as, for example, in the New York, New Jersey, Connecticut area and the Kansas, Missouri area. Much of this is like the Clinton plan but I believe it could be made much simpler in concept and execution. Features of the Canadian system, operated by the provinces, but with some Federal input could be adopted.

In summary, I favor a "single payer" system for collecting the taxes or premiums, but regulated competition among systems with respect to providing their services and bidding for capitation payments. I fail to see what the insurance companies provide in the way of value for money. The competition should be between Health Care Systems, not between insurance companies unless they owned System.

From what country do you think the US has the most to learn with regard to health care management?

I think Canada's "single payer" system has demonstrated cost-effective ways in which the provinces collect taxes or premiums to pay for universal coverage of health services. The Netherlands, Finland, and Canada have most to teach us about the preparation and distribution of primary care physicians. Finland has the most to teach us about health information services. Truly effective health care management globally is in an embryonic state. There are few, if any, large-scale health care enterprises that are based on a full understanding of epidemiological principles (i.e. marketing data) for sizing and balancing facilities and staffing, statistical controls for efficacy, effectiveness, and outcomes, and deep awareness of the biological, social, and psychological vagaries of illness and health care. Britain may be starting to approach the problems of effective and innovative management, especially through the health economists at the University of York. I have avoided believing the received wisdom that "the United States has the best medical care in the world."

What can you say about your experience with the Canadian health care system versus that of the United States? What elements in your background have shaped your view of health care?

My father, a Scot by birth, influenced me substantially in examining public policy issues. He was a journalist writing for numerous international publications (primarily *The Times* of London, *The Economist*, and the *Baltimore Sun*) and had many friends who were politicians or public servants. His best friend was the head of Statistics Canada. That agency's avalanche of statistical documents sparked my interest in health statistics. My formative years in Canada provided an exposure to domestic and international publications and persons that was far from parochial.

Experiences as a graduate student in the Yale Department of Economics, especially under Professor Eliot Dunlap Smith, influenced me more than undergraduate education at McGill in economics. Smith taught a management course in which I learned about the Hawthorne effect, the influence of occupation on health and disease, and principles of organizing and leading human endeavors that could result in enhanced creativity and productivity; Smith was a long way ahead of his times. Experiences in Britain during World War II when the Beveridge Report (also in the K LW Health Care Collection) was introduced and the National Health Service was being designed stimulated my thinking about health care organization and financing. Medical education at McGill and training in its teaching hospitals persuaded me that there must be better ways of providing care than those prevailing at that time! When at Johns Hopkins I appointed as a fellow professor, Robert Kohn, the Deputy Director of the Canadian Royal Commission on Health Services (the Hall Commission; a copy of its report is in the K LW Health Care Collection). Kohn kept all of us at Hopkins in touch with Canadian developments. Later, over the years, I had occasion to visit or consult with most of the Canadian medical schools.

The greatest influence on much of my thinking occurred during a sabbatical year spent largely with Professor J.N. Morris at the London Hospital Medical School and the Medical Research Council's Social Medicine Research Unit. Morris' seminal paper *Uses of Epidemiology* as well his slim volume of the same name gave me the great majority of the ideas I helped to introduce later in the United States.

Which areas of Health Care Research do you think hold the most promise for future research?

I believe the field most in need of vigorous research is primary medical care. Having introduced this term with my colleagues in a 1961 article, *The Ecology of Primary Care*, I have been disappointed by the failure of Departments of Internal Medicine and Family Medicine to undertake research into the hidden parts of the iceberg of illness that can only be studied at the level of primary medical care. The original article was based on one of our first ventures in Health Services Research (or Medical Care Research as we called this emerging field in the 1950s and 1960s) at the University of North Carolina. (Early papers on primary medical care, including a facsimile copy of the famous *Dawson Report* are in the collection.) Primary care clinicians need to collaborate with geneticists, nutritionists, environmentalists, immunologists, pharmacologists, psychologists, and other social scientists to better understand the origins of ill health and the factors that maintain good health.

The biomedical revolution has focused largely on better understanding of disease processes. Exhaustive study of the body's "wiring" is all to the good, but we also need to study the "messages" received and transmitted over the wires. Radio transmission without the music is of limited utility. We should focus now on the earliest manifestations of these phenomena. For example: Why does the patient go into cardiac failure on Tuesday morning at 11:00 a.m.? Why not Thursday evening? Why does the patient's ulcer start bleeding on Sunday afternoon rather than Monday afternoon? Why does the patient wait three days before seeking an appointment—why not two days or two weeks? And how effective is patient-physician communication? One study found that the average time between the patient's first attempt to describe the problem for which help is sought and the physician's first interruption is 18 seconds! It is as if the physician said: "Mister, stop telling me about your problems and just answer the questions!" Another area that was the basis for the "Ecology" paper is the matter of patient referral. Why are patients referred from one physician to another? Is this always done appropriately? Are referrals too

“late” or too frequent? How effective is physician-to-physician communication?

Finally, we really don't know much about the best incentives, on the one hand, for encouraging individuals to look after their own health effectively, use health services appropriately, and, on the other, for encouraging physicians and managers to so deploy and use resources that services are provided in the most compassionate, appropriate, evidence-based, and cost-effective manner. There is much work to be done. Medicine is changing at exponential speed and most of it seems to be for the better.