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Q: The activity for which you are best known nationally is your service as chairman of the Graduate Medical Education National Advisory Committee (GMENAC). Its report was fashioned almost a decade ago, but it remains the standard work for individuals who assert that the United States faces a surplus of physicians. How do you gauge the impact of the committee’s work now?

A: The most important effect of GMENAC has been to raise the general consciousness that the numbers of practicing physicians make a difference. Most people believe that we have an ample supply of doctors, if not a surplus. I use “surplus” with caution because I do not believe the United States will ever see a surplus such as exists in some Western European countries, where trained physicians have taken jobs as taxicab drivers and have even applied for public assistance.

The increasing physician population has affected American medical care in a number of ways. The number of young people applying to medical schools has dropped dramatically. About ten years ago there were 45,000 applicants to medical school. Now, with 16,500 medical students admitted to allopathic schools every year from about 25,000 applicants, many of whom are reapplicants, I think we are perilously close to a danger point regarding the quality of applicants. A few medical schools have contracted their class sizes, but these reductions are quite small. (The peak enrollment was in 1983, when 18,893 students entered 142 U.S. medical schools, including 127 allopathic and 15 osteopathic schools. In 1987, the number of first-year students had declined to 18,366.)

On the financing side of medical care, the perception that there are a
lot of physicians, and more coming, has had a dramatic effect on the willingness of physicians and traditional insuring organizations to experiment with alternative delivery plans. And a sea change has occurred in physician attitudes toward working for a salary. Originally, among the primary care specialties, internists most often worked on salary. But last year, a survey conducted by the American Academy of Family Practice found that a sizable proportion—20 or 30 percent of newly trained family physicians every year, on top of a large number already in practice—have participated in experimentations with capitated systems, negotiated fee schedules, and preferred provider plans. On the other hand, the impact of GMENAC has been trivial on the nature of practice, on medical specialty distribution, and on working toward universal health insurance.

**Physician Specialty Distribution**

Q: You mention specialty distribution. Recently, as you well know, the number of medical students who have opted to take graduate training in internal medicine has declined rather substantially. Is that a development that concerns you?

A: Yes, very much so. An overriding belief of mine is that the primary care physician should be the heart of the health care delivery system. Americans are shoppers, and not everyone will want to use a primary care physician. A lot of Americans, particularly the educated class, will want to use specialists directly. But the system should work toward the training of enough primary care doctors and placement of them so that every American has access to one. My sharpest current criticism of academic and organized medicine is that too many subspecialists are being trained and not enough attention is being paid by educators to produce doctors that the users need.

Q: Whose responsibility is it to redress these imbalances in the production of primary care and specialty physicians? It seems that no single interest is in charge and that the third parties that essentially finance such training have no voice in specialty distribution.

A: There is a discontinuity between the training preferences of academic centers and the health care needs of Americans that should be addressed. A profession must weigh decisions in its interest against the broader considerations of the public. I believe a profession gets into trouble when it loses its perspective on its responsibility to the public. My own feeling is that the medical profession should reformulate its sense of social purpose and responsibility. In the past twenty-five years it has swerved off course. The profession does need some outside critique, and the federal government is providing it. The government, after all, represents the public. So it is a perfectly natural thing to expect the government to take great
interest in the medical profession.

Q: Are the dynamics within the medical profession such that it is unrealistic to look to it as a change agent in redressing this perceived imbalance between the production of primary care and subspecialty physicians?

A: The profession is interested in the subject but largely ineffective in addressing it because of powerful, competing practical and philosophic forces. On the practical side, the number of individuals trained in all fields is determined by competition within the teaching institutions for residency training positions. These positions are funded largely from hospital revenues, and, as a result, the need for subspecialists in each particular hospital too often determines the distribution of residency slots. That would be appropriate if teaching hospitals were representative of “health care U.S.A.,” but they increasingly are not. They are tertiary care referral centers with a heavy emphasis on high technology. We expect most patients to be two or three standard deviations from the teaching hospital norm in terms of severity of illness and complications.

On the philosophic side, the profession is hampered by an undue allegiance to the concept of a totally free and unfettered marketplace. In recent times, some professional organizations have begun to move away from that, but not totally so. As recently as the 1930s and 1940s, salaried physicians were not admitted into some professional societies. So I think that reliance on the marketplace has led the profession astray and has confused physicians’ attitudes toward our public responsibilities.

Q: Let me press you further on the role you believe the federal government should play in addressing this imbalance between the numbers of primary care physicians and subspecialists that are being produced. Should the government’s role be so assertive that it actually should establish the number of residency training positions in every instance, as is largely the case in Canada?

A: A policy response to this problem should be tailored for the American system. I think the most effective lever is through Medicare and Medicaid reimbursement. These programs invest significant amounts in graduate medical education but, to date, have registered no opinion on what kind of physicians should be produced with those resources. If Medicare and Medicaid were to exercise some influence here, they would be behaving as almost any customer who pays the bill behaves, and as a public advocate, too. I certainly would not object if Medicare and Medicaid were to be more intrusive in this fashion. I also feel that it is through this payment instrument that the primary care physician should emerge as the central provider in the medical care system. Ultimately, I believe Medicare and Medicaid will do that.

Q: Before we turn to another subject, one more question on a pressing medical care personnel question: the shortage of hospital nurses. How should change be
effected here, through federal and state governments, the medical profession, private foundations, or all of the above?
A: This is certainly a problem, and it is tied to the status of the nursing profession, which is low. It is not uncommon, unfortunately, for large professions in the United States to suffer from low prestige and low levels of remuneration—for example, teaching. The medical profession would have been out front striving to elevate the status of nursing, its role, and its income potential except for one thing: the production of so many physicians in the past two decades. Because nurses, particularly nurse practitioners, compete with physicians, the medical profession has been largely inactive in dealing with the nursing problem. All of those sectors you mentioned must become involved. It’s an urgent situation.

Q: What dimension of the problem might private foundations most usefully address?
A: I believe one of the most important things foundations could do would be to convene, on a continuing basis, colloquia that engage the best people representing the diverse organizations having an interest in the nursing problem. But this investment in the issue must be sustained over perhaps a decade, because anything shorter will be insufficient to address the problem. Any undertaking such as this should be a public-private partnership. There are many innovations possible involving nursing that we cannot even imagine at this point because the hospital is such a complicated place undergoing rapid change. For example, there is probably a lot of work being done in teaching hospitals now by medical students and housestaff that could be done by nurses, which would bolster the prestige of nursing. As the number of residency positions contracts, new roles for nurses will be found.

Tarlov And The Kaiser Family Foundation Agenda

Q: I am interested in your decision to change careers, moving from a distinguished record as the long time chairman of the Department of Medicine at the University of Chicago to The Henry J. Kaiser Family Foundation as its chief executive. More interesting than simply the move from academic medicine to philanthropy, which a number of people have made over the years, is your decision to abandon curative medicine and pursue the potential of health promotion and disease prevention.
A: It may seem like a sharp career turn, I suppose, but I regard it as a natural evolution. For twenty years, I was privileged to work at a university medical center and engage students in their medical training. At the same time, that was the period when cost restraints were first applied and access to care became an increasing problem. I sought to respond to these
new pressures because, as chairman of a department in that environment, I saw that the institution had a responsibility to respond. I sought to make the university an agent of social change, but it was a very difficult role for the institution. When Edgar Kaiser, Jr., chairman of the foundation, and the board offered me an opportunity to become a foundation executive, I became aware of the possibilities of moving into a position where being an effective agent for social change might be enhanced.

While teaching at the medical school, I was interested in such things as support of biomedical research and how best to train people for medicine. There was a confluence of things in the late 1970s and early 1980s. The most central dimension came out of the work in medical manpower, both at Chicago in internal medicine and through GMENAC, where we asked the question, “Does it make a difference if we train too many physicians, not enough physicians, more specialists, or more primary care physicians?” Probing these issues deeply, we concluded that it was inappropriate to measure the quality of medical care by answering process questions alone. The appropriate quality question, from the public’s perspective, is: “How well is the patient doing, not how big is the tumor, or what’s the blood pressure or the oxygen level, but how is the patient functioning in everyday activities and how does health and medical intervention affect the quality of life?”

Q: When you arrived at the foundation in January 1984, how did you decide to proceed with its grant-making priorities? The Kaiser Family Foundation had been investing its monies in the development of medical group practices (health maintenance organizations) and in academic medicine.

A: This question was raised initially in the recruitment process, predominantly with trustees Edgar Kaiser, Jr. and Girard Piel. I indicated that the foundation’s program was excellent but that were I to assume the presidency I would restructure the program of giving. I wished to undertake a two-year study of health, identify new prospects for foundation intervention, and broaden the foundation’s purpose from health care to health, which would give us a wider-angle lens on the world. Last, and I took a chance on this one, I said that the foundation’s programs should be directed at issues or problems that appear unsolvable. After discussion the board of trustees accepted these directions. In the first eighteen months, we studied fifteen or twenty opportunities for foundation attention by commissioning papers, conferring with consultants, holding conferences, and lots of discussion. From that process an interesting compendium of essays, monographs, and conference proceedings was assembled.

Q: How is the foundation investing its grant monies today?

A: Fifty percent of our funds ($7.5 million) is in health promotion/disease prevention activities at the community level. Twenty percent ($3.0 mil-
lion) is invested to encourage the adoption of measures of patient functioning in everyday activities as the principal indicator of quality of care. Ten percent ($1.5 million) is in efforts to increase the number of minorities in the health professions. Another 10 percent is invested in the San Francisco Bay area, strengthening community organizations related to health and providing services to elders and minority groups. Another 3 percent is invested in South Africa, in a new program that emphasizes the development of a primary health care system in that troubled land.

### Health Promotion/Disease Prevention

**Q:** I would like to concentrate on the foundation’s largest target of opportunity—health promotion and disease prevention. Give us an idea of the status of those activities and how the foundation is proceeding.

**A:** During the period when we were studying different opportunities, we concluded that the potential impact on health from health promotion and disease prevention was enormous, compared to the other possibilities we examined. It seemed there was a social movement in its early phases that we could invest in without launching an entirely new enterprise. There already was strong interest in physical fitness, improved nutritional status, and against smoking, substance abuse, and adolescent pregnancy. Private businesses were involved at the worksite, some state governments were active, and the federal government had developed its objectives for 1990. But there wasn’t a coordinated and comprehensive national movement. Rather, a lot of pieces were working out there separately.

Based on the work of John Farquhar (professor of medicine and director of Stanford University’s Center for Research in Disease Prevention), groups in Minnesota, Pennsylvania, and Rhode Island, and other work in Finland and several other countries, we concluded that a community orientation toward behavior, environmental, and structural change could be launched successfully. We had examined the results of those interventions and had satisfied ourselves that community-based health promotion efforts were effective in decreasing smoking rates, modifying diets, and enhancing the public’s knowledge of health and health promotion. Behavior change and the consequent modification of the prevalence of disease had been accomplished by these community-based research efforts. It remained to apply these interventions on a large scale where improved community health rather than research was the paramount objective.

**Q:** How is your program structured to give the foundation the best chance possible to be effective?

**A:** We have adopted a three-pronged approach. The first dimension is
health education, the second is promoting environmental change, and the third is structural change. By environmental change, we mean changing attitudes and habits, customs, commercial practices, advertising, marketing of food, restaurant menus, and the general milieu within a community that favors, say, physical fitness and a more healthy and balanced diet. The structural components are those characteristics of a community that are encoded in their ordinances and laws that have to do with seat belts, drinking and driving, tolerance for sale of cigarettes to minors, and drug trafficking.

The approach is comprehensive and recognizes that individual behaviors have complex origins that do not arise at random but reflect what is going on in the larger society. We are not funding large organizations or well-established institutions with long-established grant-receiving capabilities. Rather, we are going out to communities and establishing, in most instances, new organizations with new purposes and providing them with the resources to establish themselves as a continuing and long-term community organization to improve health.

Q: Why did you and the foundation’s board decide not to direct your funds to large institutions or try to strengthen the scientific basis of activities that undergird health promotion/disease prevention?

A: To return to a point I made earlier, we prefer to invest in problems that appear to be unsolvable, and we adopt a long view consistent with the Kaiser tradition. We view the nation’s support of research to be in relatively good condition when compared with the nation’s support of social innovation. While we consider some of the nation’s health habits as intractable, we feel that the work of Farquhar and others over the previous twenty years demonstrates real potential. The work that had been done under the auspices of the National Institutes of Health in demonstrating the causal relationship between diet, serum cholesterol, and cardiovascular disease was hard enough to base social policy on it. While additional knowledge is always welcome, we felt that there was enough information already accumulated on which to base an intervention. So our program is not research, it’s not demonstration projects, it’s an attempt to make an impact nationwide and to add our programs to those that are being supported by the federal government, state governments, other foundations, and other organizations. We wish to add some national coordination where possible and to attempt to make a real, demonstrable change in behavior and in health in this country.

Q: Paint a verbal picture, Dr. Tarlov, of the kind of community organization that Kaiser is supporting. Do the people derive from the consumer movement, are they health professionals? I am sure it is a diverse collection of people in every community, but paint a generic picture, if you will.
A: By and large, I would say 75 percent of the organizations that we are supporting did not exist before. We sent about 17,000 pieces of mail to communities in the thirteen western states that we targeted initially as areas in which we wanted to invest. We had 600 responses. In about three-quarters of the instances, different groups in communities came together representing concerned citizens, schools, churches, worksites, media, local government agencies, and the health professions. They came together under the aegis of either a local hospital; the medical society; a physicians’ or nurses’ group; a voluntary organization like heart, lung, or cancer; and some voluntary service organizations like the Lions Club, the Rotary, or Kiwanis. The community organizations we have funded are a diverse coalition of people.

Once the community is awarded a grant, a full-time executive director is hired. In one-quarter of the awards, we have recognized existing organizations. For example, in Colorado, the State Department of Health is the grantee. Similarly, in New Mexico, we funded a largely state-sponsored coalition that already existed through the strong support of Senator (Jeff) Bingaman and the Zuni Indians. In every instance, though, we are funding grass-roots activity. This is even the case in Colorado, where the convening organization is the State Department of Health but the implementing coalition is widely distributed and includes the schools, churches, worksites, and minority organizations in communities statewide. We are trying other statewide efforts in Montana and in other nonwestern states. Behind all of these community activities in the West is the Health Promotion Resource Center, which the foundation established at Stanford University to provide consultation, written and video materials, technical guidance, and encouragement.

Q: Do you plan to move into other geographic areas as time goes by?
A: Yes, very definitely. Our next geographic region is the South, through the Health Promotion Resource Center recently established at Morehouse School of Medicine in Atlanta. In 1989 and thereafter, The Kaiser Family Foundation will extend its grant-making sites in health promotion/disease prevention to the East and Midwest. We will assess closely along the way the potential of statewide programs to reach and tap the grass roots effectively. We know we can help form and deploy statewide coalitions because we have done it. We know that these coalitions can accomplish needs assessments statewide, that they can assemble resource inventories and perform statewide political and social reconnaissances to understand what is going on already and what needs to be done to get communities involved. We do not know yet whether statewide programs can get right down to the community level in health education and social restructuring to bring about behavior change and disease prevalence
modification. But it looks very promising.

Q: The new organizations that you are funding are obviously meant to be change agents. Change often comes painfully, whether you are talking about the local or the state level or professional discipline. It is obviously too early to have a definitive answer to this speculative question, but what sort of obstacles are presenting themselves? What ingredients seem to move these organizations along better in some areas than in others?

A: We have awarded grants to eleven communities at this stage. To summarize, the success of these efforts turns on the effectiveness of the community coalition. Its task is to mobilize community interest and to launch programs and campaigns in health promotion. That requires that coalitions perform needs assessments, do not leave out any population group, and work across diverse cultural, economic, and educational strata. The potential obstacle is not conceptual, not financial, not political, but rather organizational. The limitation is the convening and organizational capacity of the local coalition.

The Role Of Private Foundations

Q: Let’s turn, if we might, to look more broadly at the private foundation community. To set you thinking, I will quote from an essay written by Eli Ginzberg and published recently (Winter 1987) in Health Affairs. Near the end of his paper, which dealt with foundations and the nation’s health care agenda, Ginzberg said: “Earlier in this century, foundation efforts in the health arena were future oriented, transforming medical education, expanding basic and clinical research to improve the education and practice of physicians, ridding the nation of public health hazards. Most foundations today are oriented more to the present than to the future. Part of the explanation lies in the relatively modest means at their disposal to reshape the present very large, very complex, and very costly system. But I believe that additional forces affect foundation policy. Foundations are loath to tangle with government. Government needs strong and continuing critique by informed outsiders who are not seeking to gain specific advantages for any specific interest group. Further, private-sector funders ad providers, accounting for another 30 percent of all expenditures, also need to be subjected to incisive critique. Most foundation trustees and staff, however, do not see their mission as making a big wave.” Not long ago, you were new to the private foundation world. Is Ginzberg’s critique on the mark in your opinion? Are foundations constructive change agents within our society?

A: Let me begin by commenting on Ginzberg’s essay, which I think will make an important and constructive contribution to foundation activities. Foundations are in a real sense public trusts. If the public did not allow foundations to be tax free, foundation money would be in the U.S.
Treasury. Therefore, private foundations have a responsibility to the public. That responsibility can be effectively sharpened and focused by observers such as Ginzberg and others who summarize and analyze foundation activities. Regardless of whether his critique is an accurate reflection of what foundations do, I can assure you that his paper will be examined carefully by foundation executives and boards of trustees as they exercise insight into what they are doing. Therefore, I applaud that article; it is important for those kinds of reflections to be made.

Personally, I have been focused in the past four years mostly on The Kaiser Family Foundation. So I do not think that I am qualified by knowledge and experience to make a judgment as to whether Ginzberg’s overall assessment is correct. But let me say a few things. I am impressed by some of the programs of other foundations as being innovative, future directed, and in the broad public interest. Whether or not those programs in the aggregate are what should be expected from the total foundation program repertoire, I don’t know. The perspective of The Kaiser Family Foundation has been to seek to identify opportunities for social improvement that would not occur without us. We have sought problems that appear to be unsolvable, and in a real sense that is consonant with our perception of our social responsibility and foundations’ unique capacity to engage in social experimentation and innovation.

Q: That description of a foundation contradicts, in a way, Ginzberg’s assertion that foundations are timid institutions. How would you explain that difference?
A: In the late 1960s, long before I arrived in this community, foundations were criticized and prohibited by law from becoming actively involved in the development of public opinion and public policy. Congress imposed a prohibition on lobbying by foundations. The entire government oversight activities in the 1960s had the net effect of limiting the foundations’ agenda. The federal government once again is probing foundation activities, largely under the auspices of the Internal Revenue Service. As a consequence of these government activities in the late 1960s, foundations moved away from advocacy and from involvement in processes that could be construed as impinging on the legislative deliberation process. I think there may remain a substantial hangover, or reticence from those governmental actions twenty years ago.

But, The Kaiser Family Foundation is not neutral in terms of advocacy. For example, we have taken strong positions on smoking. The foundation does not hold any stock in our portfolio in a tobacco company or alcohol company. We are not neutral in regard to South Africa. We also support advocacy groups working on smoking, alcohol, traffic safety, food and its labeling, and nutrition, to name a few. Our board is not shy on these subjects at all. And we operate within the letter and the spirit of the law.
We scrupulously avoid and insist on no involvement with the legislative process and in lobbying. Lobbying and advocacy are two different activities.

**Grass-Roots Efforts**

Q: Another trend that strikes me as important is the increasing interest of foundations in investing their resources at the community or grass-roots level, rather than strictly at the national level. Do you perceive that as a trend, and, if it is a trend, what do you make of it?

A: I think you are correct; foundations are moving toward community activation. It stems from a perception among foundations that social change can be effectively fashioned, customized if you will, to local circumstances by community groups if those groups are empowered to assume responsibility for it. It’s a discovery. I don’t know where the discovery came from. Perhaps California, with its direct governance by public referendum, has something to do with it. But, in the United States, there is an accelerating trend to empower local organizations and individuals in an effort to seek change. There is sort of a people’s democracy at work here.

Foundations are finding that direct involvement at the community level can be a more effective instrument for social restructuring than work at the institutional level, that is, within universities or research institutions or even centralized government. While The Kaiser Family Foundation is moving more toward community grant making, we become engaged more actively with the communities in the implementation process. Our staff becomes more intimately involved with those communities, offering technical assistance, consultation, and hands-on involvement when we are requested to do so. We are very much a presence in an operational partnership with our grantees, which is different than a passive role in awarding funds. The central objective, however, is community activation and empowerment for social improvement.

Q: This is a fascinating development, so let me draw you out on it a little more. In the middle 1960s, the Johnson administration created a “War on Poverty,” which was implemented largely through a national network of community action agencies empowered to fight poverty. Many state and local governments viewed these community action agencies as very threatening enterprises because the funds came from Washington and the agencies were not accountable to local officials. What is the fundamental difference between that model of community organizing and what you see private foundations doing today?

A: There is not a lot of difference, except that those Great Society programs were federal, and some of them did not require broad commu-
nity activism. Now there is a greater willingness for foundation programs to grow up under local community and state auspices rather than what some perceive as the heavy hand of a centralized government. But I believe that the Great Society programs of the Johnson administration were well conceived. Joe Califano (who is a member of the board of The Kaiser Family Foundation) was the president's domestic adviser, and Wilbur Cohen, who later became secretary of health, education, and welfare, was heavily involved. The neighborhood health center movement was a successful program. Head Start, too, was a successful initiative in early learning development for disadvantaged children.

These programs fell out of favor for many reasons. The public perception of the value of these programs was confused with another sea-change social program at the time, having to do with civil rights. The civil rights movement, which occurred at the same time as the Great Society programs and the War on Poverty, pushed the American public to the limit of its capacity to assimilate change. The motivation for these various initiatives became confused. Programs being developed by private foundations at the local level find a greater receptivity now than they might have in the 1960s. There is greater acceptance now that poverty amidst plenty should not be tolerated, and that health is intimately related to education, income level, jobs, and access to transportation.

Foundation Partnerships

Q: When a foundation attacks these substantial social problems of the urban and rural poor, what is the role of collaboration between such organizations themselves and the several levels of government? Is collaboration between these private- and public-sector interests being exploited to the fullest?

A: We can always do better, but I attach a high priority to multifoundation partnerships in fostering social change. While there may be some potential disadvantages—for instance, that multifoundation partnerships could dampen the creative individuality of each participating foundation—this potential problem can be managed. We should get on with addressing the targeted social ills with the compound force of multiple foundations collaborating together and with governments.

Many multifoundation partnerships evolve as each organization brings its individuality to bear on a different aspect of the problem. For example, in Kaiser's health promotion program there are nine partners, but each one adds a different dimension. The Stuart Foundation, headquartered in San Francisco and in Los Angeles, has a primary interest in education, primarily health education. So their resources are targeted on school-based programs. The Carnegie Corporation of New York has an
interest in child development, thus bringing its knowledge of that sphere to our health promotion efforts. The San Francisco Foundation is interested in Bay area projects; the Ruth Mott Fund in poverty; The Pew Charitable Trusts in substance abuse; The J.M. Foundation in prevention of alcoholism; The Robert Wood Johnson Foundation in prevention of adolescent pregnancy; and The Colorado Trust in the mountain states. These diverse interests working together reflect a key principle: that these problems are deeply rooted, and that most health problems are not only health problems, but are problems in education, child development, poverty, parenting, and economic development.

In summary, the health promotion program, in which we are collaborating with eight other foundations, could not be done effectively by one foundation alone or by the funds of nine foundations acting independently. There is more to it than money. There is the expertise, the perspective, that gives us the courage to go into a community with a broad program, beyond our foundation’s individual knowledge base.

Quality Of Medical Care

Q: Let me turn to another subject with which you are closely identified as a national leader: the pursuit of improved quality of medical care. During the 1980s, a subject that comes up invariably in any discussion on this issue is the notion that it is no longer acceptable simply to measure the quality of care rendered in a particular instance by looking at the processes involved in the delivery of that care. More and more, individual researchers and organizations are looking at the consequence of delivered care–the outcome of care. You have been involved in that area for a number of years, long before you joined Kaiser. How did you become involved in perceiving the importance of measuring the outcomes of medical care, and what is the status of those efforts today?

A: You are referring to the Medical Outcome Study, which we started in 1983 while I was still at the University of Chicago. Funding was provided by The Robert Wood Johnson Foundation, The Pew Charitable Trusts, and The Henry J. Kaiser Family Foundation. Its origins grew out of GMENAC. All through that long exercise, as we interviewed literally dozens and maybe hundreds of people, we were trying to determine how many physicians of a particular specialty the United States would need in the future. Also, we sought to determine whether one specialty was more effective in dealing with a certain condition than was another. The question would always arise, “Does it really make a difference?” And we would respond, a difference in what? The outcome to the patient? Is obtaining a blood count on a patient with anemia an outcome?

GMENAC was marvelously broad and unrestrained in its willingness
to explore the purpose of medicine. And so questions arose—what is an appropriate outcome, what is quality of life, is health related to it, and what are the measurable outcomes of care that we should adopt as indicators of the effectiveness of medical services? At the same time, several other important developments were evolving. First, a dozen or so investigators around the country, mostly from the behavioral sciences, were beginning to measure function of patients in everyday activities. In this process, they sought to relate function to a number of social variables: physical function, mental function, social function, role fulfillment, general satisfaction, and levels of happiness.

John Ware of The RAND Corporation was very much a leader in these pursuits. About the same time, Jack Wennberg of Dartmouth Medical School was examining variations in medical practice patterns. It seemed to us that the outcomes of care, as measured by morbidity, mortality, and costs based on Wennberg’s work, did not bear a close relationship to the intensity of the medical intervention. As a result of the work of Ware and Wennberg, and a dozen other people who were examining functioning, we thought it would be possible to measure long term patient function related to medical care. So we launched, with the support of three foundations, a major effort to assess the outcomes of medical services against many variables—patient variables, physician variables, systems of care variables (prepaid versus fee-for-service, for instance) and medical specialty variables. For example, given a diagnosis of diabetes, and controlling for severity of illness, do family physicians, general internists, and endocrinologists deliver a different type of care? And does that result in a difference in outcome to the patient as measured not only by the standard measures of cost and mortality and morbidity, but also by how a patient functions in everyday activities? Functioning is certainly a part of one’s quality of life. There are obviously other dimensions to quality measurement than medical outcomes, but this represents a start in applying a broader measure of quality. It’s an exciting study. We have already collected a year and a half of data. Data collection will be completed in late 1988.

Once I assumed the presidency of Kaiser, and became a grantor as well as a grantee in relation to the Medical Outcome Study, John Ware took over my role as principal investigator. The five investigators involved are Ware, Edward Perrin (chairman of the Department of Health Services, University of Washington’s School of Public Health and Community Medicine), Michael Zubkoff (chairman of the Department of Community and Family Medicine, Dartmouth Medical School), Sheldon Greenfield (of the Department of Medicine, UCLA School of Medicine), and myself. There are about 526 physicians in various cities and roughly
22,000 patients under study. The patients are largely those with hypertension, cardiovascular disease, diabetes, clinical depression, obstructive lung disease, and arthritis. We are about to report on differences in severity of illnesses in practices of different specialists, and differences in outcome related to prepayment versus fee-for-service. The first manuscript to emerge from the study is now ready. We anticipate there will be a couple of dozen papers over the next four years.  

Q: Recognizing that many results are not yet in and that data collection has not been concluded, could you speculate on the results of the study? For example, will the study send a message to the medical profession that physicians must take a closer look at how they allocate resources, and must do a lot more soul searching about the clinical practice of medicine than has occurred before?  

A: Yes, I believe that that will be the case. I think that several things will be affected by the Medical Outcome Study. One, I think that there will be an attempt in the 1990s to routinely collect data on patient function as a principal measure of the quality of care. Some of the large health care corporations are starting to attempt to make inroads into that domain. Another impact will be further thrust toward empirical rationalizing of the intensity of medical intervention as greater knowledge emerges on the relative effects of various interventions on patient functioning.  

Q: One of the great debates that is raging, albeit quietly, in the medical profession and among third parties is whether or not the United States faces a future of a stricter rationing of health care resources as new technologies burgeon, patient demand rises, and competing claims are made on available dollars. Before we arrive at that painful day when stricter rationing becomes a necessity, though, some analysts assert that if the medical profession placed a greater emphasis on sorting out efficacious care from that deemed inappropriate or unnecessary, rationing would not be necessary. How does the medical outcomes study relate to that equation?  

A: I prefer not to use the word rationing, but I do think that in the next decade we will see a variety of attempts to constrain the growth of medical care spending. Until now, despite many attempts, the expansion of medical costs has not been contained. I anticipate that the results of the Medical Outcome Study and many other studies having a focus on outcomes will become more effective restraining influences on the use of diagnostic testing and some therapeutic interventions than the regulations that have been relied on in the past. But I think that the greatest impact of the Medical Outcome Study will be to open the feasibility of routinely collecting outcome data as a useful instrument for assessing various interventions and quality of care. I think that this represents a promising horizon for the future as we attempt to allocate our scarce medical resources in a more responsible fashion.