HOSPITAL ADMINISTRATION ORAL HISTOR.Y COLLECTION

Lewis E. Weeks Series

Odin W. Anderson

ODIN W. ANDERSON

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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

Odin W. Anderson
December 7, 1984

Odin W. Anderson

CHRONOLOGY

1914	Minneapolis, born there July 5
1937	University of Wisconsin, B.A., Sociology
1938	University of Wisconsin, M.A., Sociology
1940	University of Michigan, B.A., Library Science
1942-1945	University of Michigan, Research Assistant, Bureau of Health Economics, School of Public Health
1945-1949	University of Michigan, School of Public Health, Instructor
1948	University of Michigan, Ph.D., Sociology
1949-1952	University of Western Ontario, Department of Clinical Preventive Medicine, Associate Professor; Department of Economics and Political Science, Lecturer

1952-1962		Health Information Foundation, New York City, Research Director
	1953-1956	New York University, Adjunct Associate Professor, Sociology
	1956-1962	Columbia University, Adjunct Associate Professor, School of Public Health, and Administrative Medicine
1962-1967		University of Chicago, Center for Health Administration Studies, Research Director
1962-1964		University of Chicago, Graduate School of Business and Department of Sociology, Associate Professor
1964-1980		University of Chicago, Graduate School of Business, and Department of Sociology, Professor
1967-1972		University of Chicago, Center for Health Administration Studies, Associate Director
1972-1980		University of Chicago, Center for Health Administration Studies, Director

1978-1980	University of Chicago, Graduate Program in Health Administration, Director
1980-	University of Chicago, Graduate School of Business Professor Emeritus
1980-	University of Wisconsin, Professor of Sociology

Odin W. Anderson

MEMBERSHIPS AND AFFILIATIONS

Alpha Kappa Delta

American Association of History of Medicine

American College of Hospital Administrators, honorary fellow

American College of Surgeons, Research Committee, past member

American Hospital Association

American Public Health Association, fellow

American Sociological Association, fellow

Association of Teachers of Preventive Medicine

Blue Cross Association, Research Advisory Committee

Committee for the Advancement of Medical Care Research

Delta Omega

Illinois State Board of Education, consultant

Illinois Study Commission on Nursing, consultation

Inquiry, Editorial Board, member

Institute of Medicine of Chicago, member

Medical Care, Editorial Board, member

National Academy of Sciences, Institute of Medicine, fellow

National Tuberculosis Association, consultant

U.S. National Committee on Vital & Health Statistics

U.S. Social Security Administration, Research Committee

Welfare Council of Metropolitan Chicago, Maternal and Child Health, Technical Advisory Committee, chairman

World Health Organization, Fellow in Preventive Medicine, Britain, Norway, Denmark, Sweden, summer 1951

Odin W. Anderson

HONORS and AWARDS

National Association of Blue Shield Plans

Norman A. Welch Memorial Award, 1969

University of Uppsala, Sweden

Faculty of Medicine, Honorary Doctorate, 1977

American Sociology Association

Section on Medical Sociology

Recipient of Distinguished Medical Sociological Award, 1980

American Public Health Association

Conference on Social Research in Health

An Evening with Odin W. Anderson, 1980

American Men and Women of Social Science

Listing

Who's Who in America

Listing

PUBLICATIONS

Enabling Legislation for Non-Profit Hospital and Medical Plans, 1944, Bureau of Public Health Economics, Research Series No. 1, Ann Arbor, Michigan: University of Michigan, School of Public Health, 1944.

Nathan Sinai, Odin W. Anderson, and Melvin L. Dollar, Health Insurance in the United States, New York: Commonwealth Fund, 1946.

Administration of Medical Care: Problems and Issues, Bureau of Public Health Economics, Research Series No. 2, Ann Arbor, Michigan: University of Michigan, School of Public Health, 1948.

Prepayment of Physicians' Services for Recipients of Public Assistance in theState of Washington: Problems and Issues, Bureau of Public Health Economics, Research Series No. 4, Ann Arbor, Michigan: University of Michigan, School of Public Health, 1949.

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Odin W. Anderson and Sol Levine, Blue Cross Experience with Non-Group Enrollment, New York: Health Information Foundation, April, 1956.

"The Effectiveness of Voluntary Health Insurance: Results of a Nationwide Survey," Hospitals, July 1, 1956.

Odin W. Anderson and Jacob J. Feldman, Family Medical Costs and Voluntary Health Insurance: A Nationwide Survey, New York: McGraw-Hill Book Co., Inc., 1956.

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"The Model Health Service - A Search for Utopia." Nordisk Medicin 93:163-168, August, 1978. Jubilee Lecture at Uppsala University's 500th Anniversary celebration.

"The Roots of Contemporary Problems and Issues in Personal Health Services in the United States." Encyclopaedia Britannica. 1980.

"Future Directions for National Health Policy for the United States." Health Policy and Education, May, 1979.

"Trends in the Use of Health Services." Handbook on Medical Sociology, Englewood Cliffs, NJ, 1979, 3rd ed.

ANDERSON:

I was born in Minneapolis in 1914. Then a year and a half or so after I was born my mother was diagnosed with pulmonary tuberculosis so it was not sanitary to me to be mothered by her any longer. She went to a sanitorium with expectations of dying within a year, given the progressiveness of that disease. I was then taken to my father's home farm where he grew up and put in the charge of an aunt who was then 21 years of age. My grandmother was alive and there were ten brothers and sisters still there. In other words, my aunts and uncles. In due course my mother died in early February 1917, and, surprisingly and shockingly, my father died three weeks later of erysipelas.

My father was a very ambitious man according to all reports and all evidence. He went to country school and then he wanted to go to high school which was about five miles away. That was very unusual in those days, particularly for farm boys. So he walked to school, a round trip of nine or ten miles every day, until winter at which time he then lived on a farm on the outskirts of the village of Blair and did chores for his room and board. I say this because my father's model was held up to me from as long as I can remember.

Then he taught country school for three years--you could teach elementary school in those days with a high school certificate--and saved money and went to Minneapolis and entered business college, the Minneapolis Business College. After he graduated from there he got into the railroad business as a freight agent. He was only 30 when he died, as was my mother, and seemed to be on the way up.

After he died I simply continued to live on the farm and I became a ward of the county. I was not adopted. There was no couple there to adopt me, you might say. The banker in town was my financial custodian; my father left me a legacy of $2,000, and that was kept in trust by my extended family. The interest was used to buy me clothes, and I got my board and room.

I look back at that very warm reception I had continually as a part of that family, in it, but not of it, really. So there was a sea of acceptance from that extended family. I was five years younger than the youngest at that time. So I grew up on the farm and worked both in the house and outside since there was a relative shortage of womanpower as the women left for Minneapolis. There was enough manpower for routine work needs. My aunt, who was my foster mother, left for Minneapolis; another aunt left for Minneapolis. By that time I was about 6, I guess.

I naturally then gravitated towards the eldest son, my uncle, who was a natural leader. As I look back, what a tremendous influence he had on me as a model. I recall seeing him frequently bargain with city slicker cattle buyers, as we called them, you know. So, he became the leader of the family with his brother when his father died, my grandfather, in 1916. I came there shortly after my grandfather died.

I bring this up to show you my background. Furthermore, being an orphan I developed, for that reason I think, sort of a partial detachment in looking at people and circumstances. I was what I call marginal.

Then I went to high school. Going on to school was a given. It was expected of me and fortunately I took it very easily. I loved school. I loved country school. I went to school on skis in the winter. I also

remember the impression in walking to school of the variations of seasons. In the city where the seasons are blurred I miss the feeling for the seasons and the birds coming and going and so on.

So I had really a very happy childhood, well received, and I was fulfilling their expectations. I wasn't lazy and I didn't get drunk. I finished country school in seven years. I skipped the second grade which was probably a mistake because I went right into long division and I have had a dislike of mathematics ever since. I am hardly a statistician. I can add, subtract, multiply, and divide but with all the whiz boys around who are such high fallutin mathematicians I can't follow them, and I gather that there are very few who can. Well, anyway, I graduated.

Going on to high school was a given, so I went on to the village and I lived in the village with families. I lived in three places, three different families in the four years. I paid board and room for five and a half days, which was paid for out of my legacy. So at the age of 14 when I started high school I was an autonomous individual. It was my own money. Of course, I was supervised by the community, you know, everybody knows everybody else.

I felt I grew up in a very supportive environment. I often feel since we were all Norwegians, Norwegian descent--oh, I forgot, there was one Irishman in the neighborhood--I feel the best way not to have any prejudices is to grow up in a complete ethnic community where you never said, "You damn Norwegian!"

You would say, "Damn you!" No invidious comparison with other ethnic groups.

When I got to the University of Wisconsin, I ran into a big Jewish contingent from New York whom I admired very much. I got to be very friendly

with many of them, and with many other ethnic groups. I arrived at the university with sort of a clean slate, I felt.

Well, in high school I was very active. I was president of the class one year. Then I was manager of the basketball team--helped the coach to manage the basketball team. Basketball and track were our biggest sports. We were active in track. I was very active physically but I was not an athlete. I could run a mile but I couldn't run fast enough. So, since athletics played such a prominent part in prestige in high school, I thought I would get into the act by becoming a manager. I went everywhere with the team.

In fact, we went to the University of Wisconsin to the Wisconsin State championships because we won in our district. We lost on the first round, but anyway we went to the University of Wisconsin. There I got my first exposure in the spring of 1931 to the University of Wisconsin and its environment.

I was the high school reporter for three years, from sophomore year on. I wrote up the athletic events and other events for the local paper. Athletic events particularly for the LaCrosse paper. I would telephone them in. It was a great experience. I began to get the idea of becoming a journalist. I remember getting a letter from somebody who read my writeup of a basketball game. He wrote to me out of the blue and said, "You ought to go into journalism, you have a style."

In the last year I was nominated the most outstanding student in the class overall. The competition wasn't too terrific, the class was some twenty-five students. The nomination was for the outstanding male. Yes, there was a male award and a female award. I think there were about eleven boys in the class. It was the American Legion Award.

Then I prepared to enter the University of Wisconsin. I was very fortunate in having a major university so close by. Somehow the eastern universities or the Ivy League universities never occurred to me, out of my orbit. Furthermore, they were far away and they were very expensive.

So, I went to Wisconsin. The tuition there was $27.50 a semester. I lived in the University YMCA, which was a dormitory for male students, right on the campus next to the student union. I lived there for six years. I had thoughts of joining a fraternity. In fact, I was invited by one, but then figured it was too expensive. I lived on $600 a year for the school year, including clothes, and lived quite well.

I got a job at the university library the second year there, twenty hours a week, working at the front desk which was a very pleasant job. Prior to that I was waiting on tables as a substitute in fraternities, which I hated. I just hate those jobs, they are so menial you know. Not that I treat waiters badly. But I wanted the money and I got a free meal, an enormous meal at one or two fraternities I worked at for the first year.

Then I got this library job which had many incidental, intellectual aspects because I got acquainted with many books. I can read fast. This was a very nice job and it exposed me to the entire campus, you see.

I also was rather active at the University of Wisconsin. I was in the International Club, I was President of the Norse Club, and I was in the Men's Glee Club, very fond of music.

The University of Wisconsin was a great intellectual liberation for me because I was mainly, without knowing it really, an intellectual from the time I started to read. I have read omnivorously. I exhausted the little library

in the country school and then I went every week to the village library. I must have read two, three, or four books a week of one kind or another. So my peers in high school regarded me as an intellectual and might have sneered at me but I was so active in many other things as well as in athletics so I blurred that image.

Coming to Wisconsin--and that area of about three square blocks where I lived, worked at the library, and went to classes--was a tremendous launching pad for me. It was just a liberation. So I majored in journalism. After a year I realized from what I had learned that I couldn't become a Walter Lippmann immediately. I did the first year course in reporting. I did a story every week for one of the local papers. It was a lot of fun but I didn't like to be a cub reporter. Not my temperament.

So I left journalism. There was little lost in that because I had entered the College of Liberal Arts and Sciences and had taken this one introductory journalism course.

So, then what to do? Well, I was pretty good in languages. I took German and became pretty fluent in German after twenty-five hours of courses. Then I ran into a splendid younger professor, Einar Haugen who was then Professor of Norwegian. (Now it's a big department of Scandanavian languages.) Professor Haugen was a philologist really. I took many Norwegian courses.

Of course, I should say that I grew up in two languages. I grew up bilingually, Norwegian for the home front and English for the other culture. That's another aspect of my personality. I feel that being an orphan and also being bicultural I fortified or reinforced my semidetachment in observing. So I fell into the Norwegian courses. I sort of discovered my heritage because

of the area I grew up in. In Norwegian there were no cultural roots to speak of, no intellectual cultural roots. It was still the church language until I was confirmed.

I was almost confirmed in Norwegian. I was the only one left in the confirmation in Norwegian class; everyone else had turned to English. Then the poor minister would have one Norwegian in his class and the others English, so it became too complicated.

So my grandmother said, "All right, take the class in English. You know Norwegian well enough. You can pray in Norwegian, and you can recite the Lord's Prayer in Norwegian. So, all right."

At the University of Wisconsin I must have taken seven or eight courses with Einar Haugen in Norwegian literature and in Germanic languages. I had a good background in Spanish as well at the university. I had French in high school.

At the end of the second year I said to Einar, "I want to be a philologist. I want to be a linguist. I want to be like you, in other words."

He said, "I appreciate your interest in my field, but there are no opportunities."

So, I sort of bummed around the university, you might say, in one field or another. I had a pretty good record even though I was an academic hobo.

Then in the last semester of my junior year I took a course in social psychology. It was a big class taught by a professor who was very eclectic, Kimball Young. That fired my enthusiasm because I began to learn more about myself. I began to realize my bicultural background. So, without thinking

very hard about it, I plunged into sociology. I had to go to summer school to make up courses. I enjoyed the sociology courses and got my B.A. a semester later.

I had my library job so I continued with my graduate work for a master's in sociology which then took only took a year. But, approaching my M.A. in the spring of 1938, I realized there wasn't anything you could do with an M.A. in sociology--and I was running out of money.

Oh, going back a bit: In the summer of 1937 I blew my last $300 and went to Europe and Norway. I had met a Rockefeller scholar from Norway, a sociologist, Arvid Brodersen, whom I still have lunch with when I go to Oslo. He's ten years my senior and a great influence on me. So I went across Europe and up to Norway and stayed in Norway five or six weeks. I hiked in the mountains. It was a fantastic experience because it was like my home village being expanded to a nation. My Norwegian was very fluent, I wasn't even recognized as an American. I had the accent and everything because of my background. That was a tremendous experience to expand my horizon.

As I said, I couldn't use my language skills as a career. There was no future in it. Fifteen or twenty years later there was. There was a lot of regional interest, a lot of language interest later.

So, as I was finishing my last year at Wisconsin with an M.A., I was very despondent, but there in that last year I met my wife. We were members of a dinner co-op, an eating co-op, which was quartered in the Congregational Church Student House. We had luncheon and dinner there. There were about fifty very attractive people, about half and half, male and female. There's nothing like propinquity to find a mate.

So, that last year at Wisconsin. What to do? The head of the library, Gilbert Doan, apparently took an interest in me. He had seen me around the place. He asked me, "Odin, what are you going to do this coming year?"

I said, "I haven't the faintest notion. I have an M.A. in sociology and I worked four years in the library at the front desk."

He said, "Why don't you go to library school? (Sounds very strange these days.) "The field needs male administrators."

I said, "What would you suggest?"

He said, "Well, you know, you can go to Michigan. I went to the Michigan library school. I was on the staff there, too. I know everybody there. They do have a number of jobs in the library, full-time, and you can dovetale the curriculum and the courses which are in the same building. They'll arrange that. I'll put in a good word for you."

I hitchhiked to Ann Arbor from Madison in June 1938 and had an interview. I was admitted to the library school. I had a job interview and was told, "We don't know yet, but possibly. Come back in the fall."

During the summer I stayed on the farm. I had no money, no nothing. So I stayed on the farm. Then I borrowed, just in case, I borrowed $400 from my surrogate father, my uncle, to put me through library school for a year--$400 plus working and so on.

When I got to Ann Arbor, there was a job for me so I earned the magnificent sum of $86 a month which was enough to put me through school. I couldn't afford a car and lived on about $1.25 a day for food and had a room.

I did that library course in two years, a one year course, and held my full-time job. Then disaster struck. I was losing my hearing because of

latent middle ear infections, which I had when I was five years old. I never had perfect and normal hearing but I had perfectly good hearing for all practical purposes. In 1941 one ear started to act up and I had it irrigated, this was before antibiotics, irrigated once a week. It was very painful.

During all this there was the problem of working in the library, but they kept me on. There were no (regular) library jobs to speak of either at the time, so I simply stayed on at the university library and went back into graduate work in sociology. I thought if I get a Ph.D. in something that makes it easier, I'm told, to get a directorship in a university library.

So I went back into sociology; I was missing sociology anyway. The library science courses were exceedingly dull, necessary but dull, by their very nature. An exception was the course, I recall, on reference books, that was very good. It has held me in good standing. I am fearless in the library. I handle a big library like a pipe organ. I can go through it rapidly. It helped my library research a great deal, I think.

So, I kept my job at the library and went back into the graduate school. Then in February 1942 there was a call from the School of Public Health from a fellow named Nathan Sinai who wanted to know if there was somebody over there who had a social science background and a library background. I was probably the only person in the United States with that background. So, my name was given, and I wondered what the hell this was all about. So I went over to see him.

There was a building on that central campus, a gray stone building to the right as you stand in front of the library. Do you remember that building? It was called the old Surgery Building. The School of Public Health was under

construction at its present site. So Sinai had an office in the basement, a temporary office, in the old Surgery Building. I'll never forget it. I walked in to see him. He had boxes and boxes of printed materials and books.

He said, "I am intending to establish a section or division on medical care in the School of Public Health. I have accumulated all this stuff from the Committee on the Costs of Medical Care days. (He was on the technical staff of the CCMC, you know.) "I need a person who can assemble a research library for me from this material. I understand you have a library background and can assimilate social science material. Are you interested?"

I said "Sure. I'll probably do better than I am doing at the library."

I thought I'd give it a year and then throw myself on the market. Within a week I was over at his office. My salary increased from $86 a month to $125 a month.

In the meantime I had gotten married. I got married when my wife was able to support herself. She had a part-time job in the law library. She didn't have to support me, I had enough to support myself, but I couldn't support a wife.

I started to work over there for Nathan Sinai. It was quite exciting. In six months I had cleaned up that collection. I ordered the catalogs. I ordered drawers. I ordered cards. My secretary did the typing for the cards and so on. That collection became the basis for the existing library in the Program in Medical Care Organization, you know.

After about six months Sinai said to me, "It looks like you are working yourself out of a job. What should we do now?"

I said, "I have a project in mind."

In that collection was a concentration of the health services medical care literature up to that period. I had read all of it, you know. I had to in order to classify it. So, I had become an expert in medical care, at least bibliographically, in six months.

I said, "There's an interesting project I want to go into: to make a study of enabling legislation governing the nonprofit plans, which had to be passed in order to legitimize the Blue Cross and Blue Shield plans--to take them out of the orbit of commercial insurance regulation, higher reserves and so on."

He said, "Go ahead."

Subsequently I spent many days in the law library reading statutes. That (report) became the first publication from what they called the Bureau of Public Health Economics. That became the first publication, Number 1. I guess it's a minor classic because it's still being referred to.

A lawyer friend of mine, who was working with the group health co-op, pleased me very much. He said, "You know, you must know a little law, you wrote like a lawyer."

I said, "I thought I wrote like a sociologist."

In a year I began to realize I had something by the tail here. Sinai was a dazzling mentor, a dazzling man to work with. He was very good to me and gave me freedom enough to hang myself. I could have hung myself several times in the seven years I was with him, you know, and it would have been my fault.

Then I got into research. The next big project on my own was the one in Washington state. It was a pioneer study on medical care for the aged--it was almost ahead of its time--where we showed--and not much attention was paid to it--the enormous demand by the aged, particularly in nursing homes.

Next I got into the Emergency Medical and Infant Care (EMIC) study, which was a team study. I became the coauthor with Nate on the final document. Incidentally that has been reprinted. It's been reprinted because of the writing Nate and I did on hospital reimbursement back in 1945.

John Thompson of Yale says he uses it as a text book as an example of how to conceptualize reimbursement.

We also worked with physicians' reimbursement. This was with the EMIC program which had to pay hospitals, and had to pay doctors for obstetrical patients and for infants.

I continued part-time working on my course work for my Ph.D. in sociology. I was through my course work by 1945, and then my examinations. Maybe it's pertinent to tell you the tremendous difficulties I had with the Department of Sociology at that time. Aside from whatever capabilities I had, I think the first time around when I took those comprehensive exams, I probably deserved not to pass. Of the five exams, I flunked four, passed one. It seems to be a rather common experience. I went up again. Then, I think I flunked two.

The Department of Sociology didn't really know what to do with me because I was way over in the school...("What the hell are you doing in the School of Public Health anyway?"). I had never been anybody's teaching assistant, or research assistant, or had never marked papers. I had never had a fellowship. I was not integrated into the department. Here again was part of my marginality. I was fighting this group although I had a tower of strength in Arthur Wood, God rest his soul, who kept me going.

Nate said, "They don't know what to do with you. They would like to have you quit. They want you to make the decision to quit. Go back and force them to make a decision about you, otherwise you will live unresolved the rest of your life."

That was a big lesson and I have employed that tactic many times since. When anybody tries to put me into a corner, to make me make the decision when it's actually the other person's decision, I push it right back.

So, I went back for my final round of exams. My wife said when I came back from the exam I was pale. They were tough exams.

The department head called me up and said, "Well, Odin, you came through. You did very well."

I said, "Fine."

My dissertation proposal was "Health Insurance in the United States as a Social Movement." That went through like fire. I had a good committee. Nate was on it. William Haber was on it, because of social insurance. Also I had three sociology professors. The dissertation was commended. I got two articles out of it and it became the core of my book, The Uneasy Equilibrium. That was in 1948.

Let me go back a bit. In 1943, the year after I started with Nate, my other ear flared up and I had to have another operation. It really left me with rather impaired hearing. Fortunately at that time hearing aids had gotten to a very good stage. I got a bone conductor hearing aid which damn near brought me back to a normal level. Ever since the hearing aid has improved so that I hear according to all tests practically at a normal level.

Living with that loss of hearing and fighting with the Department of Sociology, I thought I would go under, but I had a very supportive wife. Then, my hearing was stabilized, no infection, that was cleaned out. I had a marvelous surgeon, an otologist there by the name of Maxwell, head of the Department of Otology. So, with the hearing aid and stabilized hearing and getting through my exams in about 1946, it was then clear sailing. Nate was a good support, too.

I could teach then, you know. I went from one project to another. I must have had about four publications before I finished with Nate in 1949.

The idea was, I guess, that I was to remain at Michigan indefinitely. When I was in the state of Washington that summer working with the welfare department which was the administration agency for the old age medical care program, I was queried as to whether I wanted to join the department.

I came back to talk with Sinai and he said, "Tell me about it."

He said, "Washington is a lovely state, but, you know, after a year of working in that department all you'll have left is the scenery."

I have since advised my students that way. I have said, "Are you going to go there because of the climate or because it's a professional orientation? If you can combine them well and good."

You can't combine them in Chicago. If I had come to Chicago for the climate...I had to decide that Chicago was a good place and ignore the climate.

The Children's Bureau was also a possibility, but I am really an academic oriented person. I feel more at home in an academic setting, studying, being semidetached, and moving in and out of the world. I felt that I had developed

a lot of contacts with health insurance, with hospital administrators, with Blue Cross administrators and so on which I felt left me acquainted with practical problems.

In 1949 the Professor of Preventive Medicine at the University of Western Ontario, who had been one of my students and had taken an M.P.H. at Michigan, went back to head up that department. Doctor Hobbs, Ed Hobbs, got to know me very well as a sociologist. So when he went back to head the department he got in touch with me and said, "I'd like to have a sociologist in my department and you are the only sociologist I know making sense."

I am not sure how many he knew.

He said, "We are going to have health services and epidemiology and demography and so on and so forth."

I went over three or four times during the year and we shaped a job between us. It was a job created for me.

When I told Nate about this, he said, "Glad to have known you. I think you have something now beyond Michigan. Although if you want to stay here, well and good."

I went over to Ontario and had a great experience in the medical school. I think I learned more than the students did about the medical culture. I feel very comfortable with doctors without being, I hope, co-opted; and I feel comfortable with the medical students. So we worked out two or three courses, starting with the first year students, on disease and population. I was sort of a little enclave there. It's a small university. I was there for four

years. I had a five year appointment. The idea was that the Morrow Foundation funded the position and that gradually the university would absorb it, which is what it was beginning to do.

I got to know the Canadian scene very well with all the contacts I made through Canada. My post was unique. It was regarded as unique because of my sociology background. I was the first full-time sociologist in a medical school anywhere. Yale came about six months later, but, Yale being more prominent than Western Ontario, Yale gets the credit, whatever the credit may mean. My Canadian friends always make that correction. When Yale is mentioned in this matter, they say, "Western Ontario!"

We liked London, Ontario. I had two children by then. They were both born in Ann Arbor. The idea was that we probably would return to the States. About that time I had a letter from the Health Information Foundation in New York City. They had just fired their research director. My predecessor was not a research director. He was called a research assistant, or something. He really had no power, and he certainly had no ability. So they thought they would clear the decks and get in a mature person who had a lot of research experience, knew the medical field, knew the health insurance field, and furthermore was not politically typed. The Health Information Foundation had been established by the drug industry and I was sort of suspicious of it. You know, I grew up as a New Dealer, anti-Hoover, anti-big business, and so on. I think it is understandable given the circumstances. So I got a long letter from Kenny Williamson...He was the Executive Secretary. Admiral Blandy was the President. They wrote me a very nice letter which led to my becoming Research Director of HIF.

Here I shall submit to you a short history of HIF and how it led to my association finally with George Bugbee and subsequently to the HIF being transferred to the University of Chicago where it became the Center for Health Administration Studies.

My short history of HIF follows:

Social research is formulated and conducted essentially in a political context; sources of funding must be found which are interested in given research objectives, access to institutions and individuals who are to be studied (hospitals, churches, prisons, physicians, and patients to mention a few) must be politely sought and confidentiality respected, and, as the case may be, the sanctions of appropriate interest groups must be cultivated to give research legitimacy. If the aspiring social researcher lives in a political culture which believes that neutral and objective research is the value to assist in public policy formulation a strategy of social research is feasible within the normal constraints of such a political system. If the social researcher lives in a political culture which believes there cannot be objective social research and such research must be strictly governed by the canons of a particular political ideology, a strategy of social research is hardly possible or necessary--a researcher simply follows the rule book of a particular political creed for choice of research projects, even methods of research, and obviously, proper interpretations.

In the United States it can be argued that all social research in the financing and organization of health services has basically been politically motivated--i.e., toward given types of financing and delivery systems depending on your predilection--but still a wide area of discretion has

existed which facilitates a range in choice of problems for research. This wide area of discretion has been greatly encouraged by multiple sources of funding--both public and private--and by a potential range of types and mixes of health service delivery systems which are politically acceptable.

It was in the foregoing context that a number of presidents of pharmaceutical, chemical, and drug industry decided to establish and fund an agency devoted to research in the general area of health services in 1950. A summary of the stated purposes was:

1. To create in the American people a better understanding of health services and facilities and what they have achieved.

2. To help bring about the best utilization of these facilities and services by all our people, particularly by making services available through the maximum extension of voluntary health insurance.

3. To contribute to still further improvements of our health services and facilities.

These objectives reveal a preference for the development of the private profit and nonprofit sector of the health services with the government entering in at selected and strategic points to supplement and buttress the essentially nongovernmental character of the American health services establishment. The leadership in the industry felt that the health services field would benefit from the creation of a private service of research

findings. The only major source of primary data on the health services at that time was the U.S. Social Security Administration and the U.S. Department of Commerce. The Social Security Administration was suspected of rather "liberal" tendencies in choice and interpretation of data bearing on consumer expenditures and the operation of voluntary health insurance. A private and essentially politically "conservative" sponsor of research as represented by the drug, pharmaceutical, and chemical industries would serve as a countervailing source of research findings, perhaps, both as to selection of projects and interpretation of results bearing on problems of public policy.

The period between 1945, the end of World War II, and 1952, the year in which the Democratic majority was broken after thirty years in power, ending with Truman as the outgoing President, and Eisenhower as the incoming Republican President, was a period of intense controversy over some form of legislation for government health insurance. President Truman was officially in favor of such legislation as one of the legacies for which he wished his administration to be known. A government health insurance bill was constantly in the legislative hopper, known as the Wagner-Murray-Dingell bill--but it never reached the floor of Congress for debate and a vote. The very principle of some form of government health insurance was at issue, not merely one of methods of implementation, as is true today. The political values of voluntarism versus compulsion were debated heatedly, and infrequently on a rational level as to the possible consequences of essentially a private approach to health insurance in contrast to an essentially government approach.

By the publication of seemingly dry and accurate statistics the Division of Research of the Social Security Administration headed for many years by I. S. Falk, a self-admitted and recognized proponent of government health insurance, showed year after year that voluntary health insurance was failing to cover a substantial although decreasing minority of Americans and that the proportion of the private medical dollar paid by insurance was relatively small, although increasing. As is characteristic in situations like this, one side wanted to stress accomplishments, the side wanted to emphasize deficiencies. The implicit, if not explicit goal, was something near 100 percent of enrollment of the American population, and, perhaps, 80 percent of the total private expenditures for personal health services being paid by voluntary health insurance. Again, as is characteristic, in public policy debates on health and welfare matters there was no explicit benchmark of accomplishments which if attained voluntary health insurance would be the main financing vehicle, and if not attained, government would be the main vehicle.

As an industry the pharmaceutical, chemical, and drug industry was experiencing a tremendous expansion in research, sales, and profits flowing from the World War II and postwar developments in antibiotics. These antibiotics accelerated the downward trends in some causes of maternal and infant mortality, influenza, pneumonia, and postoperative infections. This industry was assuming a prominent place in the postwar medical armamentarium and the business community. It was made self-conscious of its profit stance in a health service enterprise essentially nonprofit. It believed, as well it might given its dazzling development and growth, in a substantially private sector for the production and distribution of goods and services, including

health services. The primary vehicle to support, given this view, was the emerging voluntary health insurance. Such insurance was by the latter forties covering close to 50 percent of the population.

During this period the American Medical Association was the spearhead for opposition to government health insurance; the spearhead in support was organized labor. Various organizations arrayed themselves in rank order depending on their relative strength in the coalitions. The American Medical Association launched a vigorous campaign against government health insurance by setting up a separate organization called the Committee for the Extension of Medical Care and engaged a public relations firm, Whitaker and Baxter, to develop the strategy and the propaganda literature. A multimillion dollar fund was collected mainly from physicians, but substantial sums were also solicited from some of the pharmaceutical and chemical firms. The result was a public relations disaster as far as the AMA was concerned. The public relations firm reproduced the famous picture of the doctor sitting in his lonely vigil at the bedside of a sick child with the caption: "Do you want the government in this picture?" Leaflets small enough to be wrapped around prescription bottles were delivered to retail drug stores throughout the country as vehicles for the dissemination of the antigovernment health insurance campaign. It was reported that as a consequence retail pharmacists in Cleveland and Minneapolis were being picketed by members of organized labor, to the consternation of the retail pharmacists. This method of dissemination was subsequently dropped, and the pharmaceutical, chemical, and drug industry reviewed its role and strategy on this question of public policy.

The result was the establishment of the Health Information Foundation with the objectives stated above.*

After the unpleasant experience with the Committee for the Extension of Medical Care, leadership in the pharmaceutical, chemical, and drug industries believed there was a more constructive way to private discussion and debate on health insurance than the polemical approach they had participated in. This was through the power of the fact. There was faith in the basic good sense of the American people that if they were given sound information they would act wisely in their own interests. It is reminiscent of the concept of the informed consumer in laissez-faire economics. There was undoubtedly also faith in the ability of the American health services establishment to survive detailed and intensive scrutiny of its structure, operations, and objectives if such scrutiny were conducted with objectivity, competence, and in a broad perspective.

Late in the 1940s a group of presidents from the major pharmaceutical, chemical, and drug firms organized the Health Information Foundation. It was chartered in the State of Illinois in 1950, as a nonprofit educational and research agency, tax exempt, and not permitted to engage in lobbying or propaganda. A board of directors of 32 members contributing to the Foundation's support was formed. A Citizen's Advisory Committee was also appointed chaired by Herbert Hoover, former Republican President of the United States, 1928-1932, philanthropist, and a continuing symbol of American free enterprise and political conservatism. Nine other members represented indus-

*In due course, the Committee for the Extension of Medical Care was terminated by 1952 with the explanation that it had accomplished its task in that no government health insurance legislation had been enacted and the issue was for the time being dead.

try, science, education, finance, and philanthropy. There was also an Advisory Committee for Research from Blue Cross, Blue Shield, private insurance industry, drug trade and allied industry publications, executives of drug trade and allied associations, and community health facilities research. Louis I. Dublin, Ph.D., retired head of the Statistical Department of Metropolitan Life Insurance Company, past president of the American Public Health Association, and a pioneer in vital statistics research and dissemination was appointed as a part-time research consultant to the staff of the Foundation. Fund raising was handled by a Finance Committee from the Board of Directors of eight members. For the first year of operation, 1950, 131 firms contribured over $626,000. The major support came from the ethical pharmaceutical firms, followed by chemical firms.*

The first President of the Foundation was Admiral William H. P. Blandy, Ret. He was an outstanding naval leader during World War II, in command of the Atlantic fleet, and also the naval commander, after the war, of the Bikini nuclear explosions tests in the South Pacific. His executive secretary was Kenneth Williamson, formerly assistant to the executive director of the American Hospital Association, the national association of the American hospitals. Williamson brought with him a thorough working knowledge of the American health services system. Two technically qualified staff members were engaged, Ed Liebert, for public relations and information, and Walter E. Bock, for research. Liebert was experienced in public relations in voluntary health

*Tamblyn and Brown, Inc., "Survey and Recommendations for the Consideration of the Directors of Health Information Foundation, New York, September, 1953."

agencies. Bock was a young Ph.D. in sociology from Michigan State University. The Department of Sociology in that University had developed an extensive program in community action research stemming in large part from the University's long-term activities in agricultural extension work.

So, here was a retired admiral, a person with past associations with the hospital field, a public relations technician, and a research sociologist comprising the nucleus staff and a fund of money in excess of $600,000, with a fund raising momentum indicating more to come. The Board was to authorize expenditures for specific projects from the general fund. There was great operational advantage in not having to raise money project by project, but rather to develop a general research and information program policy and obtain authorization for expenditures from funds already collected or would be forthcoming.

What to do? The first general problem was to develop a research and information program which would demonstrate that the sponsors of the Foundation were supporting activities in line with the stated objectives. The Foundation, quite naturally, was started under a cloud of suspicion that the sponsors were mainly self-seeking, biased and not really interested in research and information for a broad range of interests. Obviously it was the function and responsibility of the staff of the Foundation to probe the range of topics which it could persuade the Board to support. The Board was composed of the presidents of major industries in their field and did not have the time nor inclination to enter into detailed policy formulation. They were accustomed to delegate and respond to proposals. It was no easy staff assignment given the booby-traps of controversial issues, the speed by which

the sponsors wanted to get results, and the inherent slowness of the research process. Further, the staff had no tenure; they were creatures of the Board.

In a situation like this the art is to find a middle way between excess caution--and emerging with pallid research prospects and results--or, excess boldness resulting in controversies so severe that the sponsors could not sustain them through a research agency. During the first two years the staff probably and understandably erred on the side of caution, but who is to say? On the research side there were a number of relatively small-scale community action studies in three counties in different parts of the country, Middle West, South, and New England, studying how local citizens went about mobilizing for action, change, and improvement of local health conditions. These studies stemmed directly from the community action research of Michigan State University when the research sociologist had been trained. These were conducted by departments of sociology in nearby universities and funded by the Foundation. Another study dealt with the efforts of the Toledo Academy of Medicine, Toledo, Ohio, to establish a round-the-clock telephone answering service, an attempt by the local medical profession to make itself more accessible. Another general overview study was one with Oscar Serbein, a Professor of Insurance, School of Business, Columbia University. He wrote a very detailed source book on the current status of medical care expenditures, public medical care programs, and voluntary health insurance.

As a service to social researchers in the health field the staff established an annual inventory of research in progress and completed in the social aspects of the health field. There was no such medium of exchange at that time and proved to be very popular among researchers.

On the public relations and information side there were several short movies dealing with health education subjects for free dissemination throughout the country. They were very well done by highly qualified media experts and were expensive. Although in theory the public relations and information division of the Foundation was to obtain publicity material from the research division there was necessarily a long lead-lag inherent in the time necessary to produce research results. Perhaps because of this situation the public relations and information budget was larger than that of the research budget. In any event, it would have been difficult for the public relations division to transform research results into mass media type of presentation. Probably exacerbating the problem of a viable research and information policy was that the research sociologist, on whom de facto, the responsibility for jazzy research findings rested was young, inexperienced in research administration, and lacked a thorough knowledge of the health field. The executive secretary, who was experienced in the health field, could not deal directly with the research personnel in the country. It seemed that the Foundation staff had to decide whether or not it was primarily a research agency or a public information agency.

In any case, the result was that after two years of activity and apparent frustration, the research sociologist left abruptly under painful circumstances internally. The Foundation had barely established a base of operation not to mention a coherent program policy. There was now an opportunity to review the entire operating policy. The president of the Foundation and the executive secretary began to look for a person to replace the research sociologist. It appeared that they were now looking for an older

and more experienced person to head the research division, be given a clear operating rank within the organization, and a commensurate salary.

I, Odin W. Anderson, was appointed the new research director. I was then 38 years old, a Ph.D. in sociology fron the University of Michigan, and had behind me 10 years of experience in research and teaching in health services finance and organization and related problems in a school of public health (University of Michigan) and a medical school (University of Western Ontario, London, Ontario). My primary interests were in the application of social science research to public policy problems in the health services. Further, I was not associated with any particular public policy position, a strategic and necessary factor in the choice. My entry to the health field was through a former staff member of the Committee on the Costs of Medical Care, Nathan Sinai, D.P.H.*, Professor of Public Health Administration, School of Public Health, University of Michigan, who hired me as a research assistant in 1942, while a graduate student in sociology at the university. I had also earned a degree in Library Science (University of Michigan, 1940). Sinai, funded in part by the W. K. Kellogg Foundation, was interested in establishing a research library in health services and starting a unit for teaching and research in health services administration in the School of Public Health. I appeared to have the combination of qualifications and interest needed for the position. The link between Sinai's connection with the Committee on the Costs

*Co-author with I. S. Falk and Margaret Klem of the first and now historic national household survey of use of the expenditures for health services: The Incidence of Illness and the Receipt and Cost of Medical Care Among Representative Families; Experiences in Twelve Consecutive Months During 1928-1931. Chicago, University of Chicago Press, 1933. (Publications of the Committee on the Costs of Medical Care: No. 26).

of Medical Care and subsequent research in national household surveys conducted by me at the Health Information Foundation, to be described, is a direct one. It is an interesting example of research continuity. Among the scores of staff members on the CCMC Sinai was the only one who continued his interest into an academic position. Others, notably Falk, Klem, and Louis Reed, became very active in the Social Security Administration and the Public Health Service. C. Rufus Rorem became active in hospital prepayment and had enormous influence on the development of the Blue Cross system. I, in fact, have always regarded myself as a research descendent--and the only primary one--of the CCMC research base. It provided a baseline for further research in health services and consumer problems. I remained with Sinai for seven years until early in 1949, during which time I obtained a Ph.D. in sociology, had several publications from Sinai's new Bureau of Public Health Economics, and participated in teaching. I left Michigan for the University of Western Ontario, London, Ontario.

My experience with Sinai was crucial in shaping my social research strategy. Sinai was a first-class teacher, analyst, and writer and kept his own counsel in the classroom and in writing an analysis. He was regarded as controversial by the powers that be in the medical field, first, for vigorously espousing voluntary health insurance(!), and later for being California's Governor Warren's consultant in his abortive state health insurance bill in 1946. Sinai's effectiveness as an unbiased researcher was crippled after that time. I took note of this and thereafter tested out constantly the role of researcher in controversial areas without compromising research freedom and without being clobbered for doing so. I was mainly

interested in a viable research career rather than an exponent of a particular policy.

I was associate professor in charge of the Social Aspects of Medicine, Department of Clinical Preventive Medicine, Faculty of Medicine, University of Western Ontario from 1949 to 1952. In the summer of 1952 I was invited to be interviewed for the position of research director of the Health Information Foundation to replace the research sociologist who had started a research program for the Foundation. I had sketchy familiarity with the work of the Foundation, through contacts with the sociology and health care research community and like many other colleagues had misgivings about the sponsorship and the type of research projects that would likely be supported of major importance to the health field. I then went to the New York office of the Health Information Foundation in an aggressive mood believing it unlikely that I could be made an offer acceptable from a research standpoint in a rather controversial field. Politically in general I regarded myself as a New Deal liberal acquired as an undergraduate at the University of Wisconsin during the thirties. However, I regarded myself as an objective researcher and trained to present findings in a "no axe to grind" manner. Tempermentally I disliked polemics and hope that somehow reason can prevail given valid information. The full day I spent with Admiral Blandy and Kenneth Williamson was most disarming for me. I was impressed with their candor and straightforwardness and their obvious intent to support an objective research agency directed to important problems in health services. They met every reasonable condition necessary to operate an objective research agency; I was to be given primary responsibility for the development of the research program. I left New York

open to an offer and completely undone, as it were, and somewhat rueful about my misconceptions. A very detailed two-page letter from Blandy arrived the next day spelling out clearly all points of discussion and offering full responsibility and top salary. Clearly, the president meant business and he must have sensed as much from his Board.

For me it meant pulling myself and my family out of a comfortable and modest academic and research setting, and moving into a seemingly unstructured and volatile situation with mainly a sense of professionalism to guide me. It will be recalled that at this time social science research in the health services was not yet being fostered by universities (Sinai's modest Bureau of Public Health Economics notwithstanding). Several parallels to Sinai's activities were attempted in several places, but support was lacking. And, schools of public health were chary of controversial subjects. I saw an opportunity in Health Information Foundation to direct the expenditure of several hundred thousand dollars a year to open up needed research in the financing and organization of health services not possible at that time in a university position. I decided to give it a three-year trial to test the Foundation's sponsors and my administrative superiors. Blandy and Williamson were magnificent in their support and counsel. Blandy admitted no knowledge of the technical aspects of the health services or of research--although he was interested in the public policy implications--and he deferred to me and Williamson on these matters. I have felt privileged to know a person of Admiral Blandy's personal stature and integrity.

I took over the research program in October 1952. Several months had elapsed between the departure of the previous research sociologist and my arrival. The research staff on my arrival consisted of a graduate student in sociology, Patrick Murphy, an assistant to the previous incumbent, Frederick Strunk, who was the compiler for annual inventory in social research in health, and a secretary. The offices were in the Graybar Building next to Grand Central Station. The administrative and public relations offices and the research division office were three floors apart. (In about a year a single suite of offices were acquired in the same building facilitating easier staff interchange.)

The first order of business was to review the status of the research projects in progress and make field visits and think through research strategy and tactics. (The Admiral liked my use of military terminology and explained to me carefully that strategy meant an overall plan and tactics meant specific actions in working out the plan.) During the first two years of the Foundation's existence all research was done by grants to individual researchers and research teams in universities. The previous research sociologist had contacted researchers in the field directly to work out arrangements and agreements. I wished to formulate an overall research development largely under my personal direction. Some of the research could be carried out internally by me and my own staff, some could be conducted collaboratively with appropriate research people and agencies, and still some could be by direct grants and contracts. Several criteria for selecting projects were formulated: pertinence to practical problems in the health care field, presence of already adequately established research methodology,

duration, and cost. Steady production under relatively tight time schedules was necessary. HIF was being tested anew by the sponsors.

Before I arrived there had been some discusson between HIF and the National Opinion Research Center, University of Chicago, about the possibility of a national household survey of expenditures for and use of health services, and the extent to which voluntary health insurance was enabling households to pay for the costs of services. I grabbed at this possibility as the first major attempt to give HIF national visibility within eighteen months of my arrival. Serious discussions with the then director of NORC, Clyde Hart, ensued. NORC was trying to achieve some research capability in household survey, but I argued him out of it on the basis of complexity and unmanageable scope within one survey. The current primary problems for public policy were use and expenditures. No household survey of this type had been done since the study by the Committee of the Costs of Medical Care, twenty years earlier and already mentioned. Sampling and social survey methodology had been brought to a high degree of perfection since that time. Because of greatly improved sampling techniques, e.g., it was possible to use a much smaller sample with known limits of confidence and at a smaller cost. The national household survey was formulated as a joint research proposal between the Health Information Foundation and the National Opinion Research Center. I was the overall project director, and the staff of the National Opinion Research Center, particularly Jacob J. Feldman, was the technical staff working with me on research objectives and design. In addition, another special area study was designed to examine the extent to which "prototype" Blue Cross and Blue Shield plans and a private insurance company, Aetna, was paying for hospital

and physician's services and the financial impact on families of uncovered services such as drugs and dental care. The field sites were Birmingham, Alabama (Blue Cross-Blue Shield), and Boston Massachusetts (Blue Cross-Blue Shield and Aetna). The national study would serve as a reference point for the special area studies.

This package of household surveys was prepared for a meeting with the Board of Directors on November 1952, (It will be recalled, I assumed my position in the Foundation on October 1 of that year). The budget for NORC alone was approximately $350,000, the biggest single research budget ever presented to the Board up to that time. There was great enthusiasm among the staffs of HIF and NORC. This research endeavor would bring up-to-date similar research done twenty years previously. One added and crucial element was the possibility of examining in detail the enrollment patterns of the population and the adequacy of the benefit levels of voluntary health insurance. In more general terms this research would be able to show expenditure and use patterns among households. The Social Security Administration and the Department of Commerce could produce only national total data. (The national morbidity surveys of the Public Health Service had not yet been inaugurated and when they started in the early sixties it was some years before the data on health services use were collected, not to mention expenditures.) It is thus seen that the research proposal being presented to the Board for authorization was exceedingly timely.

Concurrently, President Truman had appointed the President's Commission for the Health Needs of the Nation to examine all facets of the status of voluntary health insurance, national expenditures, public medical care

programs, morbidity and mortality, and hear testimony from the full range of interest groups in the country. Truman, as noted, was favoring some form of government health insurance and he gave this Commission the mandate to come up with basic recommendations for the health services and health needs of the nation, promising to abide by whatever recommendations were made. The Commission assembled a first-class technical staff and in only a year's time brought together in five volumes literally the total data as of that time bearing on the health services and expenditures plus an array of opinions and views from interest groups from organized labor to organized medicine. The reports of the Commission were published in early 1953. The issue of government health insurance versus voluntary health insurance was reaching a climax. It turned out that the Commission did not recommend government health insurance (as had been true of similar bodies since 1937) but almost by default let voluntary health insurance become the main financing mechanism for health services for the forseeable future. Democratic administrations were coming to an end. Eisenhower was the Republican presidential candidate in the 1952 November elections. The country seemed to be ready for some relief from the New Deal program of the thirties, World War II, and Truman's Fair Deal programs. It seemed that the social insurance-social welfare developments had reached a crest as viable political issues.

It was in this context the Health Information Foundation and the National Opinion Research Center were presenting their joint research proposal for the massive household surveys. The object of study was the consumers and their problems in relation to the financing mechanisms then prevalent, i.e., voluntary health insurance. It seemed also that once the extreme polemics

over government versus voluntary had subsided and the country settled into a policy consensus that voluntary health insurance would be permitted full play, research into these matters would then be possible. It would appear that research on matters touching public policy is not possible--i.e., will not be funded, access to data sources denied, and sanctions from involved parties withheld--until there is a general consensus regarding such a policy. The parties at interest in health services finance and organization were now ready to accept detailed study on matters of great operational and policy importance to them.

The foregoing details are presented to describe the context in which I formulated my social research strategy. To me there was a dazzling combination of circumstances converging in terms of my training, experience, and interests: a funding agency which could not be accused of being "creeping socialists," a nationally recognized social survey agency, and the political implications of the shift from Truman to Eisenhower. I believed that this research would put the Health Information Foundation on the map, test its sponsors' intentions, cut across all interest groups, and have something for everybody.

Back to the Board meeting: The members had received copies of the research proposals beforehand and had apparently read them carefully. Admiral Blandy presented the proposal and recommended authorization. (Hart of NORC was also present.) After a brief discussion Jack Searle of Searle and Company, then chairman of the board, recommended adoption. The research proposal was duly adopted. That was all! I staggered out of the Board meeting overwhelmed by the responsibility. Hart promised preliminary data on the national survey in less than fifteen months.

During the designing of the studies, meetings were held with representatives of Blue Cross and Blue Shield plans, private insurance companies, hospitals, and medical and dental professions for advice as to content. Letters sanctioning the studies were obtained from the American Medical Association, the American Dental Association, the American Hospital Association, the Blue Cross Commission (now the Blue Cross Association), and the National Association of Blue Shield Plans. These letters were made part of the packet that 250 or so interviewers for NORC carried with them to assure household informants (approximately 3,000) of the legitimacy of the research project.

The studies for special areas had not been predesignated, but after funds were authorized I examined the range of possibilities among Blue Cross-Blue Shield plans and groups covered by private insurance companies. I selected Blue Cross-Blue Shield in Alabama, Blue Cross-Blue Shield in Massachusetts, and Aetna Life Insurance Co. in Massachusetts. Full cooperation was promptly obtained from all of them, indicating great interest on the part of voluntary health insurance agencies. Their cooperation was in no part small; their respective central offices needed to produce the records of membership in order to draw samples of households enrolled in the particular plans.

During 1953, while the brunt of the work on the household surveys was being carried out by NORC with me in a counselling capacity as to content, I began to explore other possibilities for research, attempting to build on the base being established. My strategy was that given the sponsor's desire to produce information to "improve" the American health services implying thereby a belief in an incremental approach to change, (as was also personally

subscribed to by me as well) the operating strategy was then to promote research which would examine and evaluate the performance of the prevailing system, i.e., voluntary and autonomous hospitals, private medical practice, and voluntary health insurance. And voluntary health insurance was at that time paying almost exclusively for inpatient hospital care and physicians' services in the hospital. The covering of physicians' services outside of the hospital was controversial and feared because of presumed difficulties of controlling volume of services. The controversial answer to physician's home and office calls was the then pioneering efforts of medical group practice plus prepayment as represented by Health Insurance Plan of Greater New york (established in 1946), Kaiser-Permanente on the West Coast (established during World War II), Group Health Association in Washington, D.C. (1937), and Puget Sound Health Cooperative in Seattle Washington (1940s). For those who did not actually witness the bitter controversies occasioned by these group practice plans in the main body of the medical profession, it is difficult to transmit the rancor surrounding them. Even in 1952, there were many who felt that the benefit package of voluntary health insurance--hospital services and in-hospital physicians' services--was inadequate even from an insurance standpoint. Proponents of this benefit package argued that out-of-hospital expenditures were of minor financial consequence to families and did not need to be insured. Nevertheless, there was continuous criticism of the prevailing benefit package and the state medical society sponsored Blue Shield Plans bore the brunt of this criticism. The medical profession was almost paralyzed, however, regarding expanding benefits to home and office calls for fear of uncontrollable volume and in turn costs. In the latter thirties there had

been a disastrous experience with home and office calls in Michigan sponsored by the Michigan Medical Society. Group practice prepayment was the completely unacceptable answer to the problem of providing home and office calls. It was a dilemma.

After the social surveys described in the foregoing were launched late in 1952, I began to work on the possibility of studying the operation of medical prepayment plans which included physicians' services wherever they may be provided--home, office, hospital--and retained the fee-for-service method of payment. In other words the prevailing structure of private medical practice remained intact. The physicians contracted with a prepayment agency--their own--to provide services at given fees for each service. Such plans had been in existence since the latter thirties in the State of Washington and in Windsor, Ontario, as well as in other parts of Canada. In the State of Washington there were (and still are) twenty-two or so countywide medical prepayment plans (in a state federation) sponsored by county medical societies offering physicians services wherever they may be provided and using the fee-for-service method of payment. I had studied these plans in 1945. Further, the Windsor Medical Service, across the river from Detroit, had operated, from all known evidence, a successful city-wide prepayment plan for all physicians' services on a fee-for-service method of payment basis. In both Washington and Windsor the costs had not gone sky-high, but had stabilized at some tolerable level. Large employed groups were enrolled. In the State of Washington the Boeing employees were covered; in Windsor the auto workers.

Curiously, the main stream of the organized medical profession had never looked seriously at the Washington or Windsor experience as an acceptable compromise to group practice prepayment. The existence of these plans was of course, known, but somehow their experience was not felt to be applicable to other areas in the country: "The doctors in Washington and Windsor are different!"

I then visualized an opportunity to deepen my research attack (quite an appropriate word under the circumstances) by making intensive studies of the experiences of comprehensive medical prepayment plans in the State of Washington and Windsor. I was well known by appropriate gatekeepers to the medical plans in both areas. Sinai, my former mentor, had in the early years of the Windsor plan, studied it extensively for the very same reason that I was now proposing a thorough analysis. By 1953, Sinai's research unit had become well-established and a leader in university-based health services research in the country. I approached Sinai as to his interest in taking on studies of both Washington and Windsor under a grant from HIF. The suggestion was readily accepted.

In view of the past controversial nature of Sinai's career, previously described, I, with the backing of my administrative superiors, Blandy and Williamson, took a calculated risk in working with Sinai. I hoped that by this time--and in another political climate--Sinai's past would be overlooked. Also, I could not honorably by-pass my former and respected mentor by finding somebody else to do the study in Windsor. (Washington was not involved in the same way.) Sinai and his staff had continuing relationships with the Windsor Medical Service experience. Sinai conferred

with the Windsor Medical Service as to their cooperating in an intensive study. The Windsor group readily assented. I went to the State of Washington and conferred with authorities in the Medical Bureau (as they were called). Cooperation was readily assured there. Past relationships helped. The research sites would be the King County (Seattle) plans, and Okanogan, an outlying plan east of the Cascade Mountains.

Sinai and his staff worked out a research proposal with me. The proposal was presented to the Board of HIF in the November meeting of 1953. Blandy was enthusiastic about the proposal, and felt sure he could handle the Board. This time the Board demurred; there was already a great deal going on, as was true: "Can we wait until the current and massive research efforts have borne fruit?" Blandy and I said that we must keep up the research momentum by overlapping research projects so as to establish a flow of research results. The project itself did not seem to be at issue, nor Sinai and the research agency. After some discussion the Board decided to defer action until another Board meeting early in 1954.

On the way back to the office, Admiral Blandy was furious. He felt he had lost a naval battle. He said to me: "Odin, I promised you I would back you up on this project, and the next time around we will beat them!" The next time around the board did authorize the project after a brief discussion. I like to believe that the Board recognized the cutting edge quality of this research project at that time. Aside from approving of my research proposals, I learned to respect the sagacity and intuition of the Board of Directors during my ten years with the Foundation; clear cut and quick decisions were obtained. In a small agency like the Foundation there were no layers of

committees and red-tape. Action was possible, and action with no undue pauses was necessary to maintain a momentum. I was working at the Health Information Foundation not for it. I was working for a concept and the Board accepted it.

I was quite self-conscious as to my reputation among my many "liberal" friends and colleagues for taking on the research development of HIF, given its sponsors.* If I could get results I would enhance my past reputation as a researcher, if I could not, I would quit. The nationwide survey was the first test; the Windsor and Washington studies was the second test. In the latter, my dealing with my former mentor, Sinai, would alert the "liberal" health care community as to my stance regarding research sources. In addition, as the national household survey got under way, I asked for and obtained two consultants (in addition to Louis Dublin), both of whom were very knowledgeable in the health field, one regarded as a moderate, C. Rufus Rorem, formerly of the Blue Cross Commission, and concurrently director of the Philadelphia Hospital Council, and an "extreme liberal," Franz Goldmann, associate professor of medical care, School of Public Health, Harvard Univer-

*As a case in point, shortly after becoming research director I attended the annual meeting of the American Public Health Association in Cleveland. I was a charter member of the rapidly growing Section of Medical Care. Every year the Group Health Association, the federation of group health plans, held a meeting (announced in the program) to discuss problems pertinent to their plans. I attended this meeting in which I knew many friends and colleagues. The then chairman of the Association, Dr. Fred Mott, walked over to me and said I should leave, because given my new appointment and association I was not welcome in that meeting. Somewhat stunned I left. A couple of weeks later Dr. Morris Brand, the new chairman of the Association, and prominent in group health activities called me up and asked what had gone on between me and Mott at the Cleveland meeting. I described the encounter. Dr. Brand was indignant and personally invited me to attend the next meeting under his chairmanship. No other incidents of this nature among "liberal" colleagues took place.

sity. Rorem had many voluntary health insurance connections and was active in the formation of group practice prepayment plans. Both of these consultants, as was Dublin, were helpful in legitimizing me in the broad interest group spectrum in the health field.

While the staff of HIF was pushing ahead in 1953 with the research projects the Board and administration were also pondering seriously the fund raising capability of the industry for a research and information agency which in the industry's view would attract financial support. In the spring of 1953, HIF engaged a consulting firm, Tamblyn and Brown, Inc., to appraise the fund raising capability of the industry, and the operation of the research and information program. The consulting firm noted that from 1950 to 1953 there were contributions from 165 firms totalling almost $2,300,000.* The report the consulting firm submitted noted that support had been received from only a limited number of firms within the industry and both the number of firms contributing and that total amount contributed had declined. Still, the average amount of money per firm contributed had increased from roughly $5,000 to $7,000. The range was very wide; some top contributors going $40,000 and over. The main sources were twenty-four pharmaceutical companies and eight chemical companies. Thirty-five individuals in the industry were queried plus questionnaires to 846 other individuals in the health services and insurance industries. (The latter groups, however, yielded an exceedingly low response vote--six percent and thus impressions are necessarily very sketchy.)

Among the contributing firms the consulting agency reported that great interest was expressed in the ongoing national household survey on use and ex-

*Tamblyn and Brown, Inc., op. cit.

penditures of health services. One contributor noted that "unless HIF comes forward soon with some striking facts and figures resulting from its research projects, supporters will lose interest and contributions will drop." The consulting firm was given the impression, with which the agency concurred, that "a single fact or finding of elemental importance, if dramatically presented, has much greater impact than a wealth of detail about the ways and means of ascertaining this fact." One is reminded in this connection of the bacteria and virus specific research on antibiotic drugs. The consulting firm recommended that the contributions be increased by $350,000 a year to $750,000 and that a full-time fund raiser be hired as a regular staff member of the Foundation. (The fund raiser was hired and subsequent annual contributions stabilized roughly at $500,000 a year given by a hard core of steady contributors.)

The national household survey proved to be the appropriate research project to produce "striking facts and figures." By early 1954 NORC was scheduled to produce a mass of preliminary data which proved to have a great deal of publicity value. I worked closely with the NORC staff in determining the kind of base tables and analyses to produce. The public relations and information staff member of HIF, Liebert, was eagerly looking forward to having some tangible and pertinent data from the research department for broadside publicity purposes.

As is characteristic of academically oriented researchers, I was nervous about premature publicity of preliminary data which may have to be revised after getting fully checked out in final form. Too many interest groups were involved to risk the possibility of substantial revisions. Time, however, was

of the essence, and preparations were being made for an extensive press release and a news conference in New York, late in January 1954. Seemingly reams of tabular material were being air-mailed to me periodically for a few weeks prior to the press release which I worked over and selected for a preliminary report. After I completed the first draft I took the overnight train to Chicago to confer with the NORC staff as to statistical validity and appropriate interpretation. (The timing was so close that I did not want to risk flying in January weather. The railroads were still dependable.) A day was spent with NORC and I took the train the next night back to New York. On arriving in New York the next morning the publicity director practically grabbed the report from my hand and rushed to the printer. The Board and the administrative office appointed a committee of three men from the industry--mainly research oriented staff members--to review the preliminary report with me after it came from the printer. The day prior to the meeting with this ad hoc review committee at which Blandy and Williamson were to be present, Blandy died suddenly at his home from a stroke. His presence and support were depended on, and the meeting was held as scheduled anyway. The committee was very laudatory of the preliminary report as being factual, straight-forward, and unbiased and it was readily approved as originally prepared by me. Blandy's death added to the tension under which I was working, but the momentum created by the social survey kept the activities moving as scheduled.

The public relations and information director prepared a press release and set up a press conference in New York with the major wire services and New York newspapers on a Friday for Sunday newspaper stories. The press was

handed the preliminary report, I gave a short resume, and asked for questions. There were a few, but one in particular was pertinent. Earl Ubell, science writer for the New York Herald Tribune, asked about the household sampling method. I said "It was an area probability sample and..." "OK that is enough," said Ubell, thereby indicating approval of the general research methodology. I had always insisted on sound research methodology so that controversial research results would not be attacked on that vulnerable point, and I also had access to top research consultants. The press appeared to be more than casually interested. On Saturday the New York Times' writer covering this story telephoned me at my home in Larchmont because the percentage components of the medical dollar added up to 101 percent. Would he give the exact decimal points so that the medical dollar would add up exactly to 100 percent? I said these were best and rounded estimates anyway and it was acceptable to publish data that way in such circumstances. The correspondent said that his editor was a stickler for detail and was insisting on at least two decimal points. I produced this spurious specificity and on Sunday the New York Times duly produced a table with the desired decimal points.

Every major Sunday newspaper in the country carried the results of the household survey in a prominent manner. As was to be expected "horror" aspects of the research findings were highlighted, such as, 15 percent of American families or 7.5 million of these are in debt because of medical care costs; and voluntary health insurance is paying for only 15 percent of private expenditures for health insurance. Under these lead items there were rather detailed presentations of the main findings such as expenditures per family

and individual by type of service, distribution of magnitudes of expenditures, and enrollment in voluntary health insurance.

Sparked by the administrative staff of HIF, and particularly Williamson, the supporters of the Foundation apparently got what they wanted to put the agency on the map. The excellence and scope of the newspaper coverage exceeded all expectations. Reactions from the health field were immediate and favorable. The nature of my general correspondence and telephone calls changed abruptly. It appeared that the members of the Board of Directors were startled by the massive publicity, but when it turned out that the response to the survey was favorable, they settled back with the feeling that they had demonstrated their public service objectives. The single fact of 15 percent of total health expenditures being paid for by voluntary health insurance (hospitals, 50 percent; surgery, 38 percent) was striking, because a year earlier the Social Security Administration had estimated a similar percentage from national aggregate data. At that time the publication of this figure caused a furor and the AMA doubted its authenticity. When HIF corroborated that figure, plus the datum that among <u>insured</u> families voluntary health insurance was paying for 19 percent of total expenditures among those families, there was no public reaction from the AMA or the insurance industry. There was some dismay in the insurance industry that the figures were actually that low but HIF had established benchmarks of rough indicators of achievement. It was obvious that the percentages should be higher.

Another figure that caused some concern in the AMA was the publication of the percentages of the medical dollar going to hospitals, physicians, pharmacists, dentists, and other components. The annual data produced by the

U.S. Department of Commerce since 1929 had revealed that the percentage of the medical dollar attributed to hospitals in relation to physicians had been increasing until the early 1950s until which time it exceeded the physician proportion. Frank Dickinson, the AMA economist at the time, had made much of this fact attempting to throw major blame on the hospitals for the rising costs of health services. When the HIF-NORC survey findings were released, this survey showed that the physician proportion was still higher than that of the hospital. (Subsequent surveys conducted by HIF-NORC also showed a higher hospital proporton as the result of a long-term trend, the exact year of the crossover being problematical.)

The HIF-NORC results were lower for hospitals (and higher for physicians) than the Department of Commerce data because of the differences in data gathering. HIF-NORC through its particular methodology was better able to separate expenditures for hospitals and physicians. (The Department of Commerce staff agreed.) Nevertheless, Dickinson was upset that HIF-NORC had dared to use estimating methods different from those of the Department of Commerce. I was startled one morning to open the latest issue of the AMA journal and find my name in a banner headline over a critique by Dickinson entitled, "Anderson vs. the Department of Commerce." Curiously enough nothing more came of this.

Bugbee queried the Executive Director of the AMA about this. He said, according to Bugbee, "You should have seen the first draft of the criticism."

Dickinson and I were very well known to each other and on friendly collegial terms for several years prior to this churlish critique.

(Williamson, former Executive Secretary to Admiral Blandy, reported to me that when Dickinson learned I had been appointed Research Director of HIF, he remarked, "Anderson is a good man, but watch him, he is too honest."

With Blandy's untimely death the Foundation had no president, and the sponsors began to search for another chief executive. It was a very uncertain period for the staff. I with NORC proceeded with the special area surveys in Birmingham, Alabama, and Boston, Massachusetts. The studies of the medical prepayment plans in Windsor, Ontario, and the State of Washington under Sinai at the University of Michigan were in preparation. Also, I began to write up a detailed report on the national survey in the form of a book for publication by a reputable publishing house.* It became the first major publication from HIF. And to add to the uncertainty, Williamson, the executive secretary, resigned in March to become head of the Washington office of the American Hospital Association.

By May 1954, a new president had been appointed, and a most fortunate choice, George Bugbee, age 50, executive director of the American Hospital Association. He had held that post for eleven years with previous experience in administering the Cleveland City Hospitals and the University of Michigan Hospital. He held a degree in business administration from the University of Michigan. He had been the "gray eminence" in the formulation of the Hospital Survey and Construction Act (Hill-Burton) in his early years at the AHA. He knew the health services field internally and politically. His acceptance was most fortunate for HIF and for me. Bugbee believed that there was a great need

*Odin W. Anderson and Jacob J. Feldman. Family Medical Costs and Voluntary Health Insurance: A Nationwide Survey. New York, Blackiston Division, McGraw-Hill, 1956.

for improving the base of data and information on the financing and organization of the health services. He apparently saw the Health Information Foundation as such a vehicle. As soon as Bugbee assumed the new position he began to help stabilize the research operation of the foundation. In his view the primary function of the Foundation was research from which there can be a flow of valid and pertinent information for the health services field. In public policy Bugbee was regarded as a moderate to conservative. His main policy prescription was for a generously funded health services system, and it was doubtful that it would be so funded primarily from public sources. Within the public policy framework it can be said that Bugbee leaned toward the conservative side of the political spectrum, I toward the liberal side, but we shared common objectives as to pertinent research to assist in public policy formulation. Bugbee's support of me helped immeasurably to legitimize me to the health services establishment. Bugbee had enormous respect in that establishment. The two of us formed an unusual team sharing dissimilar but complementary skills and rewards--Bugbee among operators, and I among researchers. (We worked together closely for 16 years.)

Almost immediately after Bugbee arrived HIF faced a major crisis. Sinai was being refused access to the medical prepayment plans in the State of Washington because of his past association with Governor Warren's government health insurance bill in California, in 1946, eight years earlier. A prominent physician in the state was objecting to Sinai, not to the project. HIF was under contract with Sinai. Was the Windsor project in jeopardy as well? Breaking the contract with Sinai did not appear to be an option on the part of my administrative superiors, and would, of course, be completely

intolerable to me. HIF could naturally not force Sinai on the Washington state prepayment plans if they did not want him. Bugbee went to Ann Arbor to discuss the situation with Sinai. Sinai gave up the State of Washington project, and retained the Windsor project. He was not a controversial but rather a welcome researcher among Windsor physicians. In order to salvage the Washington project I flew to Settle and conferred with an old friend and colleague in the Department of Political Science, George Shipman, whom we had met in his research summers in the state in 1945 and 1947. Shipman agreed to take on the project and enlisted the interest of a faculty member in sociology, Frank Miyamoto, and in economics, Robert L. Lampman. The Board of Trustees of the Washington State Medical Association invited me to speak to the Board at its annual meeting about the project and change in project direction. The chairman was the Director of the King County Medical Bureau at Jared, who promised me his full backing against a possibly churlish few members of the Board. He wanted a study of his own plan. The Board approved of the study. Next morning I was asked to give an address at the annual breakfast meeting of the federation of county medical bureaus. All went well and the Washington phase of the research project was on its way.

With the nasty situation regarding Sinai settled, HIF proceeded to develop further its research program on the basis of the groundwork laid by the first nationwide household survey of use and expenditure. Several problems were facing the health field, and particularly voluntary health insurance, simultaneously. Bugbee and I were pondering researchable projects in relation to these problems in addition to those already mentioned--the extent to which voluntary health insurance was already paying for services, particulary high

cost episodes, some comparison of performance between the Blue Cross-Blue Shield plans and private insurance companies, and the performance of comprehensive physicians services plans as exemplified by plans in Windsor, Ontario, and the State of Washington. A particularly thorny problem was one of enrolling the segment of the population who were in very small employed groups and the self-employed at reasonable cost and with adequate benefits. The prevailing and effective enrollment mechanism was, of course, through large employed groups and increasingly employer participation in paying all or part of the premiums.

A number of private insurance companies specialized in selling individual contracts at a very high cost--although legal--up to 50 percent of gross premium income, the remainder for benefits. The benefits were very small in relation to actual hospital and physician charges, but consumer knowledge was low to actual hospital costs.

The Blue Cross plans were quite valiantly trying to face this problem in line with their philosophy as a community oriented agency by experimenting with a number of clients for what was known as nongroup enrollment. In various states plans were trying out periods of "open" enrollment when any individual could enroll during a certain stated period. In rural areas there were attempts to make groups out of farmers' organizations created for other purposes, but which might serve as collection agencies for the Blue Cross Plans. HIF suggested that a study be made of these experiments for the edification of the Blue Cross plans and for their evaluation.

I then engaged Sol Levine, a new Ph.D. in sociology from New York University, to head the project. He in turn hired a graduate student in sociology from the same university, Gerald Gordon. Each Blue Cross plan received an extensive questionnaire by mail, and several sites were studied--Maine, Cincinnati and Iowa. The cooperation of the Blue Cross plans was outstanding; there was intense interest in the study. There was 100 percent response from a mailed questionnaire--after a few telephone call-backs. The study revealed the accomplishments and inherent difficulties with individual enrollment if acquisition costs were to be low and benefit levels comparable to group contracts. A realistic assessment of the problem resulted.* Non-group enrollment has had limited success in terms of the need, but it did reach a level of stability and was very useful as far as it could go.

In line with HIF's continued interest in the consumer, the initiator of personal health services, serious thought was given to the possibility of a nationwide opinion survey of adults as to their perception of hospital, physicians, dentists, nurses, costs of services, ill-health, and symptoms. There had never been a survey of the level of sophistication of the public regarding health matters. There were no benchmarks for the health education of the public. Even though the United States was purported to be a consumer oriented society--there was (and is) considerable ambiguity regarding consumer sovereignty in the health field. To what extent was it possible to trust the levels of knowledge and of health services on the part of the American people?

*Sol Levine, Odin W. Anderson, and Gerald Gordon, Non-Group Enrollment for Health Insurance, A Study of Administrative Approaches, Cambridge: Harvard University Press, 1957.

To what extent must there be a degree of professional and governmental paternalism? The National Opinion Research Center was engaged for the purpose under the major direction of Jacob J. Feldman, a staff member there. A national sample of around 2,000 adults (18 and over) were interviewed as were also a sample of physicians who the informants said had attended them the previous year. A symptoms list of about 20 standard symptoms was administered to both the sample of adults and the physicians. The general public was queried as to their having had one or more of the symptoms the previous year, and if so, did they see a physician, and the physicians were queried as to whether or not a person should see a physician if such symptoms were perceived. The convergence of public and physicians' perceptions were reasonably close indicating a rather high level of public understanding of symptoms. As expected, the lower the education and income the less likely was there agreement between the public and physician perceptions. Answers on the part of the public as to "excessive" costs of health services elicited the expected responses, but similar to charges for television repair and plumbers.

Another rather basic study was arranged with Duncan McIntyre, Professor at the School of Industrial and Labor Relations, Cornell University, on the generic problem at that time of the community rating-experience rating controversy and practices among the Blue Cross and Blue Shield plans and the private insurance companies. An early and spontaneous practice of Blue Cross plans was to charge the same community rate for all groups in an area with no regard for occupational hazards or age composition (benefits being equal as they usually were). Blue Cross regarded this as an egalitarian measure and a

proper community role. Private insurance companies used the experience rating principle, standard and traditional for its purposes. As private insurance companies began to move into the health insurance business, experience rating at times was an effective competitive form of rate setting and the Blue plans regarded this almost as a method of unfair competition jeopardizing their community role. McIntyre investigated the underlying theory and status of the community rate experience role controversy and concluded that unless the Blue plans were accorded a monopoly the community rate method was untenable. Even so, he thought the Blue plans exaggerated the effect of experience rating in its enrollment, the competition engendered by the two rating methods was salutary. Furthermore, the most important characteristic of Blue Cross plans was its contracts with the hospitals and the consequential advantage of Blue Cross enrollment cards being honored with no deposit necessary at time of admission.

Another generic problem was the special position of the aged in health services and health insurance financing. In the latter fifties increasing public attention was being paid to the aged because of their relatively low income status, high sickness rates, and consequently high health services costs compared to the rest of the population. The voluntary health insurance system found it difficult to load the extra premium rate necessary to the overall premium rate. Both employees and employers were restive about rising premium costs. Proponents of government health insurance saw the aged as the politically palatable opening for some form of government health insurance. As usual, opponents de-emphasized the gravity of the problem and proponents over-emphasized it. Studies of the aged and their health care and costs were

frequent but fragmentary. HIF saw a possibility of providing an overview of the problem and putting it in its proper perspective. This was in 1958. This study was a very timely one, and acceptable to all parties at interest. The National Opinion Research Center was engaged to conduct a nationwide social survey of persons 62 years of age and over as to their use of and expenditures for health services, living arrangements, income levels, sources of health services, and health status. This was the first and still only nationwide survey of its kind. Ethel Shanas of the staff of NORC became the project director.

It was difficult to present the emerging studies in a strict sequence because they were being proposed, authorized, and launched in an overlapping manner. There was an attempt to propose research in a certain sequence for strategy and building block purposes. A case in point is the study of employed groups carried by a group practice prepayment plan (Health Insurance Plan of Greater New York) and a fee-for-service comprehensive physician services plan quite like the Windsor plan and the State of Washington Bureau (Group Health Insurance) both in New York City.

In 1956 I was approached by HIP as to HIF's interest in making a survey of labor unions enrolled in HIP and GHI who had selected one or the other when the principle of dual choice among employees was adopted. HIP wanted to know why employees selected one or the other. I said I was interested if I could also study utilization and expenditure patterns of the enrollees in the two types of plans. Both HIP and GHI agreed. HIF funded the study and access was obtained to the necessary records and the household informants. After surveying the State of Washington and the Windsor plans, it was now opportune

to compare a group practice and a fee-for-service plan. This study received wide attention because it showed lower hospital use and less surgery among group practice members than in the fee-for-service plan.

Returning to the study of the elderly, I worked closely with Shanas. (It was first intended that this be an HIF publication authored by me, but I became heavily involved in other matters. After sensing that Shanas would do a first rate job, I offered the entire project to her.)

It took literally a large scale social survey to show that the great majority of those 65 years of age and over (85 percent) at any given time were functioning normally. The popular opinion seemed to be that most of them were helpless, sick, and senile. By means of a six point scale of well to very sick Shanas revealed that at any given time 10 percent of the people 65 years of age and over needed total care (including those in institutions and not interviewed. The overall total became 14 percent). One of the strong implications of the study, and as pointed out by Shanas, was that the usual proposals for government health insurance for the aged were not really devoted to the hard core of the problem.* The study provided a broad perspective of the health care of the aged and a basic underpinning for the factual universe for this age group. It was widely quoted.

One of the basic objectives of the sponsors of the Health Information Foundation was the widespread dissemination of the information and findings from the research projects to those who would use it for the health services system. It will be recalled that originally there was a director of public relations and information but not enough ongoing research to keep such a person

*Ethel Shanas, The Health of Older People: A Social Survey, Cambridge: Harvard University Press, 1962.

fully occupied. A year after Bugbee became the President, this person was released, and research was given the larger share of the budget. In his place there was hired a writer and publicist, Michael Lesparre, who assisted in developing publication media for HIF. The emphasis was on dignified, low-key kinds of publications in keeping with a research organization which sought validity and credibility at the risk of the usual academic dullness.

In addition to the annual inventory of social and economic research in the field mentioned earlier, there were established two publication series in 1956. One was called Progress in Health Services, a ten months a year largely statistical bulletin on trends in the health field, and the other a research series which became the outlet in monograph form for the results of the various research projects conducted and sponsored by HIF.

Progress in Health Services was directed by Monroe Lerner, who was hired from the statistical department of Metropolitan Life Insurance Company. He had worked on Metropolitan Life's Statistical Bulletin for a number of years, established by the late Louis I. Dublin. Lerner was trained as a sociologist-demographer at Columbia University (later obtained his Ph.D. there). It was my concept that there was a great deal of hard data on trends in vital statistics by age, sex, and diseases that needed to be assembled and organized as one of the chief indicators of success (or need) in the health field, trends in use of services and costs and trends in growth of facilities and personnel. In a short time this publication became very popular in the field. It was sent out monthly free-of-charge to 60,000 recipients cutting across all interests in the health field. The publication was also used on occasion to highlight some of the research findings for wide dissemination and

quick absorption. The research series was for the audience who wanted details and thorough documentation. After five years of work on Progress in Health Services many of the reports were reworked and assembled in a book.* It had wide sales and was reprinted.

As is well known the health field continued to be a very dynamic and politically controversial one. After the first household survey on use and expenditures was completed by the end of 1954 (after release of preliminary results) it was written up in book form and published.** The staggering magnitude of the first survey seemed to indicate that another one would not be undertaken. It was presumed that a benchmark had been established. The rapidly changing characteristics of the health field were not anticipated--i.e., continually rising use, cost, health insurance benefits, enrollment. Another benchmark was needed. So in 1958 the Foundation and NORC formulated another household survey more or less comparable to the first, and the sponsors of HIF readily authorized the appropriation, a considerable portion of the annual budget. The survey was to cover the twelve month period from mid-1957 to mid-1958. The crucial data were the extent to which voluntary health insurance had made progress in enrollment and in paying for a larger portion of the medical dollar and high cost medical episodes. This time, however, the same drive for publicity of the findings was not necessary--for one thing Bugbee did not like fanfare, but preferred a steady

*Monroe Lerner and Odin W. Anderson. Health Progress in the United States: 1900-1960. Chicago: University of Chicago Press, 1963.

**Odin W. Anderson and Jacob J. Feldman, Family Medical Costs and Voluntary Health Insurance: A Nationwide Survey. New York: McGraw-Hill Book Co., 1956.

development of an agency which would be recognized for its breadth and depth rather than flashiness. (This was also congenial with my temperament.) The findings were published in a routine manner with preliminary findings published in Progress in Health Services and the Research Series. Eventually a book was published.* A significant finding in the context of the time was that in the short period between 1953 and 1958 there was an appreciable increase in the proportion of people with insurance who had 50 percent or more of costs in excess of $500 covered. There was also a decrease in the coverage of costs below $50.

As the data from the various studies began to appear, revealing various patterns of use of hospitals and physicians over time in the country as a whole and between delivery systems, I was unable to find any common reference points to make sense of the different patterns of use. Blue Cross plans revealed hospital use rates with differences as great as 75 percent. High use plans consequently cost a great deal more than low use plans. High use plans felt inclined to believe that their hospitals were overused. (There was no expressed contrary opinion of underuse among low use plans.)

Late in the fifties I suggested that I look into the possibility of making intensive studies of the British health services and financing. A usual method among the social sciences, given no systematic reference point as can be found in the physical sciences regardless of time and place (e.g., human body temperature of 98.6F), is to engage in comparative research of similar phenomena in other social, economic, and political settings. Obviously, the

*Odin W. Anderson, Patricia Collette, and Jacob J. Feldman, Changes in Family Medical Care Expenditures and Voluntary Health Insurance: A Five-Year Resurvey. Cambridge: Harvard University Press, 1963.

United States needed some reference points beyond the internal operation of its own system (or range of systems) if for no other reason than to demonstrate, that each system has its own range of operating indicators peculiar to the system. I also wished to investigate what problems are more or less solved by some form of government intervention and what problems are inherent regardless of ownership, sources of funds, and the structure of the delivery system.

HIF backed this venture and my first foray was a three week visit to Great Britain in February 1958. Through previous visits as early as 1951 when I was a WHO Fellow in Social Medicine to northern Europe and Great Britain, I had contact with the late Richard Titmuss, Professor of Social Administration, London School of Economics. I made an appointment with Titmuss. He was most helpful in advice and arranging for contacts in the health system, particularly the Ministry of Health. One contact created other contacts. Also helpful was Brian Abel-Smith a young graduate student and protege of Titmuss, having studied economics at Cambridge University. Further assistance was given by a graduate student of Titmuss from the United States, Frank Honigsbaum. In three weeks I had contacted the major persons and agencies in Britain: the Ministry, labor, medicine (Left and Right), and the Nuffield Provincial Hospitals Trust in the person of Gordon McLachlan. All source material relating to the National Health Service* was assembled. Fortunately not long before (1956) there had been published a Government Committee Report on the National Health Service stimulated by the great in-

*Great Britain, Ministry of Health, Committee of Enquiry into the Cost of the National Health Service. Report Presented to Parliament by the Ministry of Health and the Secretary of State for Scotland. London, HM Office, 1956. (9336).

crease in expenditures since the inception of the Service in 1948. Titmuss and Abel-Smith had written a seminal research report for the Committee on the trends in the costs revealing, among other things, that Britain had actually used a declining proportion of the gross national product for the National Health Service, a simple fact not known to the policymakers. Such was the state of analysis of the operation of the National Health Service.

Abel-Smith was working on the history of the British hospitals and nursing profession. This important research would be facilitated by a modest grant which apparently was not forthcoming from British sources. Honigsbaum was also conducting research for his Ph.D. dissertation under Titmuss at the London School of Economics on the history of general practice in Britain. On my return to New York I recommended that a grant of $20,000 be made to Titmuss toward the support of the work of Abel-Smith and Honigsbaum. In due course Abel-Smith published two books, one of the hospital and the other on nursing. Honigsbaum, on the other hand, had considerable difficulties in finishing anything he did.*

As a result of this trip my interest in some type of comparative research in the British National Health Service deepened. I wrote a short in-house brochure on the service. Possibilities for further research remained to be explored. In 1959 I went over again but this time together with Osler Peterson, M.D., formerly of the Rockefeller Foundation, and then (as now)

*On a later visit Titmuss had me evaluate the draft of the dissertation that Honigsbaum had submitted. I deemed it unpublishable, as did Titmuss. Years later Honigsbaum published a small volume on general practice and also a few articles. He never completed the work on his degree and he had a falling out with Titmuss. But in 1980 Honigsbaum finished his dissertation and published a first rate book on the split in the British medical profession.

at Harvard Medical School (Preventive Medicine). Plans were also made to confer with Swedish health authorities. Peterson had been stationed for a number of years in London as a European representative of the Rockefeller Foundation (office in London School of Hygiene where I first met him in 1951). Peterson accordingly had personal contacts and entree to the health authorities in the two countries. Possibilities for collaborative research between the United States, Sweden, and Great Britain were broached to the chief medical officer, in Great Britain, George Godber, M.D., and in Sweden, Director General of the Swedish National Board of Health, Arthur Engel, M.D.

In Great Britain further contacts were made with Titmuss and McLachlan. (The latter controlled private foundation research money. There was, for all practical purposes, no money from public funds for research in the National Health Service at that time.) Contact was also made with Robert Logan, M.D., who directed one of the few health centers in Britain in Manchester, and who was interested in research in the health services. There was interest in collaborative research in principle. It was clear that there would be difficulties in agreeing on choice of research projects and funding.

In Sweden the atmosphere was fortunately very different. Peterson and I arrived at a time when the Swedish health authorities were becoming interested in some sort of evaluation of the operation of the Swedish health services. Only five years previously (1955) Sweden had inaugurated a universal insurance scheme for physicians' services. The hospitals had been owned and supported by the counties since 1862 and at no charge to the patients at time of service. At the same time the first Professor of Social Medicine, Ragnar Berfenstam, had been appointed in a leading university in Sweden, University of Uppsala, 40 miles north of Stockholm.

Director General Engel expressed interest in some form of collaborative research supported by the Swedish government with a grant to Berfenstam, should he be interested. Berfenstam had not yet (fall of 1959) moved from the University of Umea in the north of Sweden to his new post at Uppsala. Peterson and I returned to the United States to lay the ground work for some sort of collaboration between the British, Swedish, and American researchers in health services. I also took the occasion to assemble all existing Swedish material on the health services as I had done in Great Britain. The concept of some sort of large-scale comparative systems study was beginning to occupy me. Peterson was more interested in specific medical practices such as diagnosis-related hospital admissions and length of stay, and surgical rates by types of surgery.

The general research strategy that Peterson and I worked out was concurrent nationwide household surveys in the United States, Sweden, and Great Britain (England and Wales), in order to establish intra- and international benchmarks of use and expenditures by the usual demographic categories and studies of hospital patients and surgical rates. Very little was known about the mix of patients in different systems and comparative admission rates and length of stay. Similarly, very little was known about comparative rates of surgery for types of surgery.

It was assumed that "need" in developed countries like the United States, Sweden, and Great Britain was relatively the same, the differences in how this "need" was expressed or met were of great interest. This was the beginning of research on the relationship between "need" and health services delivery systems characteristics.

I returned to Sweden and Great Britain to begin discussions of the operational and collaborative aspects of what was now being called the three country study. My major interest was the comparative nationwide household surveys and a total systems approach, comparisons of the three countries. I accordingly took charge of that aspect. Peterson was in charge, so to speak, of the aspects that required a dominant medical expertise, i.e., hospital patients and surgery.

Although this was 1960 and the national household survey covering the twelve month periods for 1950 was only nearing completion, another such survey was indicated for 1963. HIF was now regarded as a primary source of data for household expenditures and use of health services. The National Center for Health Statistics was not yet making surveys of this area of health care in the detail that HIF and NORC were carrying out. In fact, the National Center for Health Statistics was pleased to have HIF engage in this type of survey as a detailed supplement to the large sample surveys of morbidity. It was an interesting example of public and private division of labor in research. The lead time necessary for planning and monitoring a national survey in the United States was about two years. It was assumed that the lead time necessary for three international surveys would be longer, and 1963 (five years from the 1958 survey was not far away). The discussions with the Swedish health authorities, mainly Engel and Berfenstam proceeded smoothly. Berfenstam was interested in both types of projects and the Swedish government was prepared to finance the Swedish aspect of the research. Fortunately, Berfenstam also had a young physician on his staff (who commuted weekly from Gothenburg until the research project was established) who was interested in

health services research, Bjorn Smedby. (Over the next few years Smedby wrote a dissertation required for an academic M.D. degree in Sweden on the basis of the research that got underway.)

The British situation was a very complicated one. Peterson and I tried to sell the concept of a nationwide household survey, similar to the American and Swedish, to the British but with very discouraging results. It appeared that the Chief Medical officer was sympathetic and interested, but the Ministry itself was not. Louis Moss, the director of the government social survey agency, was very interested. In order, however, for the government social survey agency to engage in a social survey of some type, the appropriate Ministry's sanction had to be obtained, in this instance the Ministry of Health. Titmuss was interested since he saw a social survey as an evaluation of the impact of the National Health Service on equalization of access. McLachlan and Logan were skeptical of large scale surveys and preferred small scale local surveys which then could be added up! (They did not really understand the social survey methodology.) McLachlan was important as a possible source of British funds and as a private sector sanction as was also true of Logan, for the household survey. The Ministry of Health at that time was interested in operations research, how to make the system more effective. I had the impression that there was hardly any interest in the impact on the consumer as such, as was the case in the United States and Sweden. For about three years discussions continued with the British, mainly George Godber, the chief medical officer, who I was convinced, was interested. I also offered to pay the entire cost of the survey from HIF funds. In fact, in order to by-pass the government social survey and its entanglements with the

bureaucracy, a reputable social survey firm owned by Mark Abrams was contacted as a possible survey agency. Abrams was very interested, having engaged in many social surveys relating to public policy. He even wrote up a proposal with a price. He and the NORC staff knew each other well and cooperation was possible. The same was true of Louis Moss, as well. Finally, George Godber wrote me a very short, but polite letter saying that the Ministry was not interested in collaboration and the matter of a social survey in England and Wales ended. The research projects under Peterson, however, proceeded rather well, between him, Berfanstam, and Logan.*

While I was trying to get the three-country studies underway, beginning in 1958, the Foundation was interested in a study of patient and physician decisions leading to hospital admissions. This study was inspired by the increasing concern with rising use of hospital services leading to accusations of "abuse" of hospital care by both patients and doctors. This kind of a study required access to hospital records and to physicians as well who attended and/or referred patients to hospitals. An opportunity came in Massachusetts when Blue Cross of that state and the Massachusetts Hospital Association approached HIF to do a study of the differences in costs between

*As a final move I broached the possibility of a social survey of Scotland to the chief medical officer of Scotland, John Brotherston. He had been Professor of Biostatistics at the London School of Hygiene where I first met him in 1951. Brotherston was very sympathetic and would sanction the survey from the side of the Scottish Department of Health. Scotland is one administrative unit for the National Health Service with its own budget, but a similar system structurally to the one in England and Wales. The national agency to conduct this survey in Scotland was the Department of Social Medicine, University of Edinburgh. The incumbent, Professor Murray, was not congenial to large scale survey, but only to "hard" data epidemological studies. His associate, Dr, Last, was interested and competent, but to no avail.

Blue Cross and patients whose hospital care was paid from other sources. There was a dispute between Blue Cross and the hospitals that Blue Cross per diem reimbursement was too low. (In Massachusetts all third party payers paid the hospitals the same rate.) This dispute could be settled by a study of comparative costs of Blue Cross and non-Blue Cross patients. Blue Cross of Massachusetts would pay all costs. I said that this was a service type of research in which I did not engage HIF; but I was complimented by the confidence expressed by this request. If I could regard this service research as an opening for large scale research in hospital discharges of the type I was interested in, I would supervise the study of comparative hospital costs. Agreement came readily from the Blue Cross of Massachusetts, the Massachusetts Hospital Association and the Massachusetts Medical Association. Sol Levine, Ph.D., formerly with me in New York and now on the faculty of the School of Public Health, Harvard University, agreed to be the project director in Boston for this phase of the work. Blue Cross lent its top statistician. The NORC and I began to work on the specification for the study of hospital use in Massachusetts.*

The Massachusetts study of hospital use was a fantastically complicated one for the survey research method. Months of pretesting was done to perfect the survey instruments. Discharged patients were asked to recall the first instance of illness leading eventually to hospital admission and time intervals between physician contact and hospital admission. The fact of hospitalization itself was collected from a sample of records of 2,000 dis-

*In four months Levine finished the study. I sat with the appropriate committees in Boston to present the findings. There was no difference in costs between Blue Cross and other patients!

charges for one year. Attending and referring physicians were interviewed. One of the major set of findings was some quantitative knowledge of the extent to which physicians felt, after the fact, their patients had to be hospitalized, in all likelihood needed hospitalization, could possibly have been treated outside of the hospital, or could as well have been treated outside of the hospital. Patients were classified into surgical, medical, and diagnostic categories. This study predated the current concern with hospital utilization review committees and PSROs.*

The contributions from the pharmaceutical, chemical, and drug industries continued to come in annually at a rather even amount, around $500,000 a year. The supporters seemed to be quite satisfied with the research and information program of the Foundation, at least sufficiently to continue their contributions. HIF had reached a degree of stability in its support and program. Bugbee was a very stable influence. The Board of Directors set up a publication review committee at Bugbee's request in order for the Board to know about publications before they were released. There was really no presumption of censorship, rather one of sharing responsibilities, and helping to alert the Board to reactions to certain research findings should there be any. In time even this type of review was desultory as the operation of HIF became more routinized and the Board, Bugbee, and I became familiar with each other.

*Odin W. Anderson and Paul B. Sheatsley. Comprehensive Medical Insurance: A Study of Costs, Use, and Attitudes Under Two Plans. Research Series No. 9. New York: Health information Foundation, 1959.

In 1959 the late Senator Kefauver of Tennessee started his Senate investigations of pricing practices of the pharmaceutical industry. There were allegations of collusion among companies to keep prices up. Quality standards themselves were not at issue. Top representatives of the industry were summoned to testify in Washington. The role of HIF in this matter was under consideration by the Board. HIF was about the only agency the industry was supporting which could be pointed to as being a direct public service. To involve HIF in the price controversy might well jeopardize its neutral stance in the field, not to mention its tax-exemption status. I privately decided to refuse to participate if asked. It really never became an issue. The Board decided to keep HIF out of this controversy altogether and rely mainly on the Pharmaceutical Manufacturers Association (PMA) to muster the forces of the industry. As part of its overall research role HIF did publish a statistical study of the trends in pharmaceutical prices which indicated that the unit prices for drugs were declining. Visibility to prices was given to the enormous increase in absolute expenditures for pharmaceutical drugs and the occasional stories of high prices for some life-saving drugs. The issue was really restraint of trade with the presumption that prices could still be lower were there not alleged collusion.

It is difficult to determine whether or not the inappropriateness of the Foundation to assist the pharmaceutical industry in the price controversy had any subtle effect on the industry's concept of HIF's usefulness either for the private sector of the health field or for the industry's image itself. HIF was riding high in the latter fifties on its reputation for even-handedness and source of reputable and pertinent data for the health field. It seemed to

me that the members of the Board of Directors constituted a private club which became neutral territory for competitors to meet in a common endeavor. (I believe that the degree of competition between pharmaceutical companies has been underestimated.) There were really no indications that the industry would not support the Foundation for the indefinite future. After nine years of support there were elements of a routine in the continuing contributions. These contributions were still on an informal Tom, Dick, and Harry finance committee basis, however. Still, Bugbee and I could not realistically believe that HIF as organized could possibly go on indefinitely without a more formal structure such as an endowment or a long-term contract for ourselves, such as, 15 years. Bugbee and I were not getting any younger. In 1960 we were 56 and 46 respectively, and we had no desire to be caught in a dying agency in our declining years. We decided to evaluate the status of HIF in the eyes of its sponsors when it was operating at its peak and weigh alternatives.

Accordingly, another appraisal of the operation of HIF was made by another consulting firm, Cresap, McCormick, and Paget, early in 1961. There was, of course, much more to evaluate since the first such endeavor by another consulting firm in 1953. By 1960 it was possible to evaluate the work of HIF in terms of its publications and their possible impact on the field. Contacts were made with over 800 people in all areas of the health care field, voluntary insurance, and government agencies and appraisals and opinions were solicited from the financial supporters of HIF.

To the gratification of the HIF staff the consulting firm reported unequivocally that HIF had an outstanding reputation in the health care field for quality of research, validity, and general relevance, particularly among

research oriented people. HIF had clearly established itself as an honest, reliable, and quality research agency. Its weakness lay in insufficient dissemination of the research findings to pertinent audiences, particularly policymakers and mass media. Progress in Health Services, the monthly bulletin sent to 60,000 persons was regarded as too "dry." The research reports were, of course, even less readable, but it was recognized that they were necessary for the complete documentation of the research projects. It should be possible, however, to improve HIF's dissemination methods. There were also recommendations from the field that HIF should engage in more practical research such as the cost of medical education, enrollment of hard to reach groups, methods of controlling volume of service, and costs. The consulting firm recommended "short-term" and "long-term" projects, the latter type being more basic. Operationally, the consulting firm recommended that a position of Director of Information be established parallel with the Director of Research (Anderson) and that there be close collaboration. Finally, on observing correctly that the research policy emanated almost exclusively from Bugbee and me and that we were very knowledgeable in the field and had wide contacts, it was recommended that HIF consult more directly with health care administrators, voluntary health insurance agencies, and the like as to pertinent research areas to investigate.

This was a very interesting report, and although in the main it was laudatory, Bugbee and I still found it very disturbing from the standpoint of operational viability of an agency of the nature of HIF. It became even clearer that such an agency needed long-term guaranteed funding. The very qualities that HIF had achieved and acknowledged profusely by the consulting

firm were the very ones which could not be maintained by the kind of high pressure and possibly "jazzy" methods of research project choice and dissemination of findings recommended by the consulting firm. Bugbee and I believed that the objectives were incompatible and neither wished to jeopardize the basic function of HIF--the production of high quality and relevant research in the health care field, as by general opinion, had been achieved. But would the industry continue to support HIF as now constituted? Bugbee and I decided to force the issue: long-term commitments by the sponsors or liquidation. The Board members were very unhappy with these alternatives. They were really quite pleased with things as they were, and particularly if the dissemination problem could be solved.

The report from Cresap, McCormick and Paget was submitted in the early fall of 1961. Bugbee and I moved the Board toward some sort of resolution, even liquidation if necessary, and throwing ourselves on the labor market. There were ripples through the health care field that HIF was in trouble. Then two events took place, fantastic coincidences, while HIF was pondering its future. The late Ray E. Brown, Superintendent of Billings Hospital and Clinics, and Director of the Program in Hospital Administration resigned to become Vice President for Administrative Affairs of the University of Chicago. Simultaneously, Walter J. McNerney, Professor and Director of the Program in Hospital Administration, University of Michigan resigned to become President of the Blue Cross Association. Both of these programs were based in schools of business in the respective universities.

Both universities began to negotiate with HIF to move its staff, program, and resources to them. Bugbee could become director of either hospital administration program and obtain a faculty position, and I could continue as research director in the program, and obtain an appropriate faculty rank. Both Bugbee and I preferred the University of Michigan as a place to live, but leaned definitely toward the University of Chicago professionally. Both universities were outstanding, but the Graduate School of Business of the University of Chicago was among the first three in the nation. Furthermore, it had gone through a period of improvement and expansion under Dean Allen Wallis, and the Program in Hospital Administration was due to be geared into this change if the proper personnel and resources were available. The Graduate School of Business decided that the Health Information Foundation and its senior staff filled the bill. Within three months all negotiations between the University of Chicago and HIF had been completed. (The University of Michigan was unable or unwilling to move fast enough to compete with the University of Chicago negotiations.)

In one fell swoop the Univerity of Chicago acquired a full-time director of the Program in Hospital Administration and a full-time director of research. Bugbee was given a professorial title. I was given an associate professorship for five years, with a joint appointment in sociology. Within two years (1964) I was promoted to a tenure professorship. The University also obtained the reserve funds that had been accumulated by HIF (close to $1 million) and a research momentum that did not require a three to five year tool-up as is normally the case with a new agency. An experienced research

associate, Gerald Gordon, also accompanied the move, and a research assistant, Sue Marquis . Gordon became assistant professor. His main interests were in organizational research.

In the New York office it was eerie to see the erosion of the staff from January to April, 1962, as preparations were made for the move. All but the aforementioned individuals were released from a total staff complement of 25 to 30. Lerner could have made the move as a research associate, but he decided not to go because of inability to obtain a senior faculty appointment in the Department of Sociology. (He moved to the Research Department of the Blue Cross Association in Chicago, later on the faculty of the School of Hygiene, Johns Hopkins University where he eventually obtained a tenure professorship.) At the very time it seemed HIF was disappearing was, of course, the time when it was being strengthened by an academic base and broadened functions. The joining of graduate training in hospital administration plus the relevant academic disciplines and the research functions enriched the activities of HIF. By July 1962, the senior staff and resources had made the move. Teaching began in the fall quarter of 1962.

Fitting into the university structure was a fascinating experience in a university as seemingly unstructured as that of the University of Chicago. Quite adequate space was obtained on the second floor of the remaining wing of the Chicago Home for the Incurables on 56th Street and Ellis Avenue. The main classroom was in the board room of Billings Hospital, as had been true during Ray Brown's directorship. (The Board room was in the wing called destitute and crippled children!) We were to determine our own courses and the kind of research program to continue.

There were now two major endeavors that HIF was concerned with rather than one: responsibility for the program in hospital administration was added to the research program. Both, of course, could be projected on a momentum which had been built up for a number of years. Since this report is concerned mainly with the strategy of research this aspect of HIF will continue to be emphasized although the program in hospital administration, particularly the Ph.D. level to follow, will be described in relationship to the research program.

By the time HIF moved to the University of Chicago in 1962, the second nationwide household survey in which it had been engaged was completed. Lerner and I had also completed the book Progress in Health Services in the United States: 1900-1960 stemming from the monthly bulletins mentioned earlier. Both endeavors were being considered by university presses, the first at Harvard and the second at Chicago. (Subsequently, both presses, respectively, accepted the manuscripts.)

The health services field was continuing to expand rapidly in use and expenditures, and voluntary health insurance was still under sufferance as to whether or not it was inherently able to be the main mechanism for meeting the costs of health services on the part of families. Another nationwide household survey was then indicated. The last one had been done for the calendar year 1958. By 1963 another five-year period would have elapsed. Conceivably such a study could be funded by HIF with the funds it brought with it from New York, but by this time the U.S. Public Health Service was interested in funding such a study as a major adjunct to its periodic large-sample surveys of morbidity. The National Center for Health Statistics

staff appeared to be pleased with the prospect of a smaller sample but intensive survey of health services expenditures and use which it was not practical to incorporate in its larger scale multivariable morbidity survey. Further, it seemed that surveys of health services expenditures, use, and voluntary health insurance performance were still somewhat controversial for a government agency to engage in. Accordingly, a generous grant was made to HIF late in 1963 for a social survey to go into operation in 1964, for a retrospective study of 1963-1964 twelve month period. In addition, funds were obtained from the same source to finance coordination of research among colleagues in Sweden and Great Britain (the latter was still under negotiation). This coordination fund was to be mainly for travel between Sweden, Great Britain, and the United States for collaborators in these respective countries. (As it turned out the collaboration was between Swedish and American research staffs.) NORC was retained as the field agency, and Feldman of NORC was also retained as a consultant to the Swedish collaborators.

Since this was to be the third national household survey with which I would be involved, the novelty had worn out, and also, wishing to devote more time to other endeavors, I decided to find a project director who would formulate the project and work closely with the NORC staff. After some effort, I found such a person in Ronald Andersen, a graduate student in sociology, Purdue University, who had been working on field projects in heart disease among farmers in Indiana, with Robert Eichhorn. R. Andersen had completed his comprehensive examinations, and needed both a job and data for his dissertation. He was then 24 years of age, unseasoned but certainly able

and ambitious, and at first, I felt the responsibility for a survey of this magnitude was an unreasonable expectation. R. Andersen, however, was clearly and insistently interested and he became the project director. Subsequent events and developments proved that the selection of R. Andersen was an exceedingly fortunate one.

From my previous relationships with the American Tuberculosis Association while in New York as a member of its Research Committee, I obtained a grant from the Association for a study of the history and development of the syphilis control program in the United States and a grant to Gerald Gordon to survey the development of social research in epidemiology. Eventually these were published. I regarded the study of syphilis control as an example of the strategy of disease control. Each disease requires a different strategy.* Gordon, in the course of compiling information on 250 research projects in social epidemiology, sent questionnaires to the researchers in different settings and tried to determine the influence of research settings on creativity and productivity.**

After HIF was moved to Chicago it was assumed that the monthly bulletin Progress in Health Services and the annual inventory of social research in health would be continued. There was concern about funding these relatively expensive activities. It will be recalled that Progress in Health Services was mailed out to about 60,000 people free of charge. This was reduced to

*Odin W. Anderson, Syphilis and Society, Problems of Control in the United States, 1912-1964, Research Series No. 22, Chicago: Center for Health Administration Studies, University of Chicago, 1965.

**Gerald Gordon, Odin W. Anderson, Henry P. Brehm, and Sue Marquis, Disease, the Individual and Society, New Haven, Connecticut: College and University Press, 1968.

30,000 in Chicago. The Ford Foundation was approached to provide support for these two activities which helped to disseminate research findings and provide a clearinghouse for information on research projects. It will be recalled that HIF was criticized in New York by the consulting firm for not successfully disseminating research findings widely. The Ford Foundation gave a generous grant for three years to support these activities. Further, the Ford Foundation also added on $75,000 to be used by me to support startup research endeavors and incidental expenses for researchers in universities who had difficulty in obtaining modest grants, such as $1,000 to $5,000 for worthy endeavors. This might also include graduate students.

In a university setting the production of the statistical bulletin and the inventory proved to be a heroic job. It was difficult to find qualified personnel who would devote full time to the bulletin in an academic setting unless there was also opportunity for graduate work and research. At first bulletins were assigned (or volunteers sought) among the staff to be responsible for single issues. This was awkward. Eventually an economist from the staff of the AMA was obtained, K. K. Ro accepted the position. He had received a B.A. from Yale University and an M.B.A. from Chicago. He was with HIF for two years and left for Blue Cross in Pittsburgh. The inventory was carried on by the librarian. After three years of struggle, and Ford money running out, it was decided to terminate the bulletin and the inventory in 1965. My judgment was that the regularity required for this kind of activity was not practical in an academic setting. Necessary deadlines pressed too hard on the responsibilities for research and teaching. The U.S.

Public Health Service was starting a clearinghouse of information on research projects in the health field, and it was felt that this was an appropriate government activity.

In line with my interests in the macro aspects of health services I continued to develop my contacts in Sweden and Great Britain. These contacts were very extensive from academic colleagues to health service administrators and politicians. I went over a few weeks every year. R. Andersen became the main operating contact with the Swedish group. I began to develop a course in the history of the American health services, the relationship between the private and public sectors, and the matrix in which public policy emerged. The main content of this course resulted in the book Uneasy Equilibrium.* As data were accumulated from the Swedish and British health systems the course became increasingly one in comparative systems. In the fall of 1966 I conducted extensive interviews about the problems and issues regarding the health services in Sweden with a wide range of relevant individuals in Swedish health services, interest groups, and politics--40 to 50 individuals. I interviewed similar individuals in Great Britain in the fall of 1967. From 1960 to 1971,

I regarded the project on comparative systems as my major personal effort, concurrently with the book Uneasy Equilibrium. After 1968 I started to write the book on comparative systems completing it in 1971. I regarded it as a synthesis of my thinking, research, and writing up to that time.**

**Odin W. Anderson, The Unease Equilibrium: Private and Public Financing of Health Services in the United States, 1875-1965, New Haven, Conn.: College and University Press, 1967.

From both an institutional and financial standpoint, 1964 was a very important one for HIF two years after moving from New York. The name was changed from Health Information Foundation to Center for Health Administration Studies (henceforth CHAS) by action of the Board of Trustees of the University as recommended by the Graduate School of Business to the Provost's Office. On the financial side CHAS was awarded a seven-year programmatic research grant for the seven years of about $1 million by the U.S. Public Health Service. This type of grant was awarded several universities. It enabled a research agency to stabilize staff and formulate an overall research program in health services with no commitment to specific projects, and which also enabled the seeking of additional funds for specific projects. On the hospital administration program side, it was decided to phase out the nine-month residency program in hospitals after one academic year on campus, and make the program a two-year on-campus program. This was in line with the trends in the field. But in particular, the program then also was geared into the normal academic requirements of an M.B.A. in the Graduate School of Business. In addition, and very symbolic, CHAS enrolled its first Ph.D. student, Duncan Neuhauser. He was a graduate of the Program in Hospital Administration at the University of Michigan. While I was still in New York and preparing for my move to Chicago Neuhauser paid me a visit at my home to inquire into Ph.D. possibilities at Chicago. Neuhauser enrolled in the Ph.D. program at Chicago after his residency.

*Odin W. Anderson, Health Care: Can There be Equity? The United States, Sweden, and England. New York: John Wiley & Sons, Inc., 1972

Another symbol of increasing stability was the acquisition of a building exclusively for CHAS in 1966, negotiations had been completed in 1965. The National Opinion Research Center was vacating its inadequate quarters at 5720 S. Woodlawn, owned by the University of Chicago, to move to newly constructed and larger building on Ellis Avenue across the Midway. CHAS had the first bid on the old building because the original investment had been financed by NIH, the mortgage for which stipulated that any tenants would have to be in health related research or the university must take over the mortgage. The acquisition of this building proved to be a boon to CHAS. The building was large enough for its total staff, a classroom, library, and a small kitchen. In addition the third floor was adapted for the occupancy of Ph.D. students. The building facilitated an informal academic community of several disciplines engaged in a variety of research projects and courses.

CHAS needed an economist with faculty status to enrich the teaching and research content. Already present were Bugbee in hospital administration, Anderson and Gordon in medical sociology, and R. Andersen would take on specific courses in medical sociology. After a search with the Graduate School of Business and the Department of Economics one was found in Robert Rice, a recent Ph.D. in Economics, Columbia University. He was with CHAS for two years and suddenly died.

Another economist was sought and it was hoped that perhaps a senior economist could be found. Melvin Reder of Stanford University, a labor and industrial economist, was being sought by the Graduate School of Business and he had some interest in health economics. He visited the Center when he was

considering a Business school offer. He decided not to come,* but suggested one of his graduate students, Lee Benham, who came in 1968.

Benham had not completed his dissertation in nurse manpower problems and was appointed as Instructor. Upon completion of his dissertation three years later he became Assistant Professor. After being unable to get tenure he left for Washington University, St. Louis, in 1974, for a joint appointment in the Department of Economics and the Medical School. During Benham's incumbency, Reuben Kessel, a senior economist in the Business School, was very supportive of both the Center and Benham, and continued to be so (Kessel died in 1975).

From the first class in hospital administration which Bugbee and I were associated, J. Joel May decided to return to Chicago for a Ph.D. He was from the class of 1963. Bugbee and I inherited that class from Ray Brown in the summer of 1962 while they were still on campus and prior to their nine-month residency to be completed by the summer of 1963. May returned after his residency in 1964. CHAS was badly in need of an administrative assistant for the general management of the agency and the program in hospital administration. May became that assistant and resumed his graduate work in the Business School, a most invaluable person. In the meantime, R. Andersen completed his dissertation based on the data from the national household survey of which he was the project director. He was awarded his Ph.D. from Purdue in 1968. I was appointed to his committee even though from an outside university. Thereafter he became active in teaching having been given the

*Reder had a standing offer from the Business School and finally accepted in 1973.

status of Research Associate (assistant professor), i.e., a certain faculty equivalent. Later he obtained faculty equivalent of Associate Professor in both the Department of Sociology and the Graduate School of Business. In 1974 he was given a five year appointment as Associate Professor with full faculty status.

By the end of the 1960s and the beginnings of the 70s CHAS was fortunate in attracting Ph.D. students in addition to May and Neuhauser, already mentioned, also William Richardson, Stephen Shortell and Charles Phelps. Richardson was in the M.B.A. class of 1964. Shortell came from the hospital administration program at U.C.L.A. All the Ph.D. level students did some teaching with the title of Instructor. A more recent addition was Richard Foster.

In 1972 Richardson was offered an attractive post at the University of Washington, Seattle, as Assistant Professor and Director of the newly established Program in Health Services Administration based with the School of Public Health.

Shortell in due course earned his Ph.D. at the University of Chicago and was appointed to the regular faculty. May had been working away at his Ph.D. greatly hampered and delayed by his administrative duties at CHAS. He was given leave with pay during the academic year 1972-73 while Shortell served as Acting Director of the Program in Hospital Administration and the Assistant Director of CHAS.

At this point it is necessary to backtrack to 1970.

George Bugbee, the Director of CHAS, was approaching retirement in 1970. He could have remained on an interim basis, but he decided otherwise. The

preceding year there was much consideration given to the successor. I was a logical successor, but there was concern in the Dean's office and in CHAS that the assumption of duties and responsibilities of the directorship would interfere unduly with my research productivity. I was not keen in assuming the directorship, providing a successor to Bugbee could be found of whom he approved.

Another factor was that Bugbee (and apparently the Dean) believed it would enhance fund raising possiblities if CHAS would be headed by an appropriate type of physician with appropriate status in the medical complex. Robert Daniels, Professor of Psychiatry, and Associate Dean for Community Affairs in the medical school had been associated with CHAS in teaching and consulting for a couple of years. He embodied the appropriate medical administrative style to bridge the Graduate School of Business and the Division of Biological Sciences, the division of which the medical school is a part.

Daniels became Director in July 1970. His incumbency became short-lived because he was made a very attractive offer by the medical school of the University of Cincinnati within eight months of assuming the directorship of CHAS. He left for Cincinnati in July 1971. Daniel's leaving appeared to be due mainly to his being attracted to the Cincinnati offer, because the internal relationship in CHAS was harmonious.

Nevertheless, CHAS was left leaderless, and the then Dean of the Graduate School of Business, Sidney Davidson, became Acting Director while the School set up a universitywide search committee to find another director.

I was not on the committee because I was regarded as a candidate, although I did not regard myself as a competitive one. I would be willing to serve, if appointed, and if no suitable candidate could be found. I assisted in producing names of prospects.

Nine months elapsed and no suitable, available candidate was found. In the middle of March the Dean made the offer to me and I became the Director on April 1, 1972. In September 1972 I spent a month in the USSR with Daniels sponsored by HEW.

So I assumed the directorship. It hasn't been too onerous because Ron has been with me all the time and he's been building up his own staff. Also Joel May is a whiz of an administrator. Two years ago he resigned and he left quite a hole.

To hold the place together while we were trying to think through a replacement, I volunteered to be the director of the program as well. Rich Foster had been working with Joel May and knew the ropes. He was interested in becoming Associate Director with me. It was fortunate for me because he is a very good administrator.

Ron became a professor. This was about three years ago. That stabilized his position.

In order to have a base to work from after I leave, in looking for another person to be the director of the program, we thought of bringing in an assistant director. Reed Morton came on not more than a month ago (late 1979) to take on all the detail duties. He also has the title of Lecturer.

I don't know what more to say. We have continued, of course, with our reputation as "big data gatherers," with our access study, our evaluation

study under Ron's aegis (and feel the access study is a cutting edge project to develop educators). The evaluation studies for the Johnson Foundation is another example of developing evaluation research methodology. The support from the Business School and the Dean is very strong.

We are financially stronger than ever now. When the programmatic grant folded up, which we had for twelve years, because of change of policy in Washington, we were really self-supporting. When that came about, the Dean, wanting to preserve the viability of the Center and the Program, came in with hard money for the supporting staff. So we have a viable base to seek money.

Now I am retiring in 1980; it's a different stage of my life. It's hardly a retirement because I'm getting a full professorship at the University of Wisconsin, part-time, on a four year contract*. It gives me great flexibility. I have worked with the University of Wisconsin, I have worked at the University of Chicago, and, in a sense, I'm returning home in a spiral staircase, you know.

I have a farm north of LaCrosse, Wisconsin in the area I grew up in. I have many contemporaries there; I have a circle there. When the farm was for sale, I bought my relatives--the neighbors were afraid it was going to go to some damn guy from Chicago. There were Chicago people who came up and bought small farms and the local people never saw them. They came up, they never mixed with the community. So when I bought the farm, I was told by a neighbor, "We are so damned glad no damn guy from Chicago bought the farm."

*At that time I did not know that I would be offered a parallel half-time professorship by the Graduate School of Business, the University of Chicago.

I think that's a very telling story of identity. I was talking about marginality, which I'm making a lot of. I hope I don't make too much of it. I feel that I made my career on the basis of marginality--being between several reference groups. Even with sociology, being in medical sociology, I haven't got too high a status in sociology although that's the biggest section in the association. Then health services administration in a business school is a partial anomaly. I have a joint appointment in the Department of Sociology but my base is in the business school. I have been in a school of public health, a school of medicine, and now in a school of business. Also the Health Information Foundation. Now I am curious to see if it makes any difference that I will have a base in sociology per se after I have been so used to being marginal, for which I have been rewarded. I have been very well rewarded for not being a pure type like an economist, or a chemist, you know. But, it has required a lot of vigilance in calling my shots and being able to live between sectors. In a sense I feel I have created my own center. I am certainly not marginal in the health field or in the health sevices research field, you see. I think this came about because of my growing up in a family I told you about, my being bicultural.

I should also add that at the University of Wisconsin in sociology and economics there during the Depression I got exposed to professors who were interested in public policy. Public policy oriented. I have always been interested in public policy problems. So, when I got into sociology and then got in with Nate Sinai, my idea then was to work in an applied area. I didn't much care whether I was called a sociologist or not as long as I had a proper base to work from, you know.

My going to New York with HIF was a long shot. Did I tell you about my negotiations with Admiral Blandy and that he gave me everything? It was a fantastic experience. It just changed my life. He was such a straight shooter and he carried through. But I felt very insecure all the time in New York because this was sort of a floating base. We were a creature of the drug industry. I wanted to get back into academic life, not realizing that when I got back I'd take the whole agency with me.

I came into HIF with the idea that the least we have got to do is to evaluate, to study, the existing. I wanted to work with the existing and push out the edges. That's the concept I have been working with all my professional life. Ideologically I have no fundamental quarrel with what exists, but presuming it can be improved, because we are going to have this form of government for a long time to come, this kind of government to work with. The political system is an incremental system. To throw in a name, because I heard him the other day, Rashi Fein is very bothered by the inadequacies of our system. He wants to transform it. He criticizes, friendly enough, the incremental outlook of people like Eli Ginzberg and myself. I don't know what the choice is other than incrementalism. I believe in incrementalism itself, when I think about it.

WEEKS:

I have wondered how you happened to write the Blue Cross book.

ANDERSON:

It was fairly simple. I suppose it was in about 1968 or 1969 Walter McNerney approached me as to whether or not I could find an historian who would be interested in writing a book on the Blue Cross plans.

I said, "I'll inquire. How about me?"

Maybe that was what he was angling for, I am not sure.

He said, "If you would do it, that would be great."

So, nothing happened. A couple of years went by. All of a sudden he called me up in a sort of a great rush.

He said, "I have the Blue Cross board behind me now and I am anxious to produce a volume on Blue Cross. Are you interested?"

I said, "Yes."

He said, "Write a proposal for the budget."

So I wrote a proposal on how I would approach it.

Then he also added, because I wouldn't have thought of that, "I want you to interview all the Blue Cross starters."

I said I certainly would but that it would be an enormous travel budget. I hadn't thought of doing it because of the expense.

He said, "Never mind the expense."

So I worked up the proposal it came to $25,000 altogether.

He wrote back and said, "The proposal is fine, but you didn't ask for enough money. I want to make sure you don't lack for money in doing a good job."

I said, "O.K." So I did another proposal for $30,000 or was it $32,000?

He picked up the proposal on his way to the airport. He was going to go to a board meeting. This was when you could fly out of Midway. He was going to fly to Carolina where the board was meeting. So in ten days I had a check for $32,000 sent to the Center for this work.

That was really a fun job. I spliced long trips between lectures and my other work. I'd fly, say, to Alabama and back the same day. I'd spend two or three hours with somebody there and then fly back.

McNerney said, "It's going to be your book. We are going to find a publisher."

I should also add--maybe it needn't be a part of the record--I had about $10,000 left. I wrote to McNerney and said I had $10,000 left and that I would like to keep it and use it for the general intent of the grant: that is, to feed into my project on the development of the American health system, which, you know, is being published by the Health Administration Press.

In a week or so his finance officer wrote back and said, "Keep it."

I think that brings us up to the present in December 1979. Now I am looking forward to part-time teaching at Madison while keeping some ties with the University of Chicago.

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Since my remarks were taped in December 1979 I wish to add some new items (April 9, 1981) which are pertinent to my story. When I was taped I had an offer from the University of Wisconsin-Madison, Department of Sociology, for a half-time tenured professorship until 1984 which I accepted. My successor to the directorship of the Center for Health Administration Studies and Program in Hospital Administration had not yet been named. In February 1980 Ronald Andersen was named as my successor. He then requested the Dean to make an offer for me to stay on either full-time or part-time. The Dean had discussed this possibility with me earlier, but, as I recall, full-time. I

accepted the part-time offers from both the University of Chicago and the University of Wisconsin and cleared with both universities as to appropriateness. Both said it did not matter.

Late in June 1980 I moved my household effects to my Madison house, and retained a room in my Chicago house. The rest of the house was rented to a young physician, wife, and small child. I now commute almost weekly between Chicago and Madison. I give a course each year in each university.

In May 1980 I received a research development grant from the Kaiser Family Foundation of $28,000 to formulate a large-scale research project in the Twin Cities to study the impact of the HMO plans there. These plans were penetrating close to 20 percent of the market. I collaborated with the University of Minnesota Center for Health Services Research in this endeavor and brought forth a joint project. The overall proposal was turned down, but my part was funded This part was to look into the history of the development of the HMOs in the Twin Cities for two years with a budget of $85,000. The project started officially on April 1, 1981.

During the past year, as well, I have been writing a book on the development of the American health services since 1875 to be completed in the summer of 1981. I have a contract with the Health Administration Press, University of Michigan for the publication of that book. I also have a contract with Wiley, New York City, to write a synthesis of cross-national health services systems. I expect to start that book by the end of 1981.

Interview Chicago

December 18, 1979

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