HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Milton L. Roemer

MILTON L. ROEMER

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

Sponsored by
American Hospital Association
and
Hospital Research and Educational Trust
Chicago, Illinois

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

Milton L. Roemer, M.D.

CHRONOLOGY

1916	Born Paterson, NJ March 24
1936	Cornell University, B.A. (Biology)
1939	Cornell University, M.A. (Sociology)
1940	New York University, M.D.
1940-1941	Barnert Memorial Hospital, Paterson, NJ (Rotating Internship)
1941-1942	NJ State Department of Health, Medical Officer Venereal Disease Control Division
1942-1943	University of Michigan, M.P.H. (Public Health)
1943-1949	U.S.P.H.S. Medical Officer (to Senior Surgeon) Assignments: 1943-1945 War Food Administration, Assistant to Chief Medical Officer, Dr. F. D. Moh 1945-1947 States Relations Division, Associate in Medical Care Administration to Chief, Dr. J. W. Movatin 1948-1949 W. Va. Public Health Training Center and Monongalia County Health Department
1949-1951	Yale University, Department of Public Health, School of Medicine, Assistant and then Associate Professor
1951-1953	World Health Organization, Social and Occupational Health Section, Geneva, Switzerland, Chief
1953-1956	Saskatchewan Department of Public Health, Medical and Hospital Services, Director
1956-1957	Health Services Coordination Study, NYC, Director
1956-1957	Albert Einstein Medical School, Lecturer
1957-1962	Cornell Unversity, Sloan Institute of Hospital Administration, Associate then Full Research Professor of Administrative Medicine and Director of Research

1962-to date University of California, Los Angeles, Professor of Public Health, School of Public Health, and Professor of Preventive Medicine, Medical School

1962-1964 Division of Medical Care Organization, Head

1965-1967 Division of Medical & Hospital Administration, Head

1967-1970 Division of Health Administration, Head

HONORS

Phi Beta Kappa 1935

Phi Kappa Phi 1941

National Board of Medical Examiners, Diplomate 1941

Alpha Omega Alpha 1945

American Board of Preventive Medicine and Public Health, Diplomate, 1949

Delta Omega 1967

Sigma Xi 1972

American Public Health Association
International Award for Excellence in Promoting and Protecting the Health of the People, 1977

American Public Health Association, Medical Care Section
"Evening with..." Tribute, 1978

Yale University
Henry E. Sigerist Memorial Lecturer, 1980

New York University Medical Alumni
Achievement Award in Health Sciences, 1980

University of Michigan, School of Public Health
Distinguished Alumnus Award, 1983

American Public Health Association
Sedgwick Memorial Medal, 1983

MEMBERSHIPS & AFFILIATIONS

American College of Preventive Medicine, Member

American Public Health Association, Fellow

California Academy of Preventive Medicine, President 1972

California State Department of Corporations, Advisory Committee on Health Care Service Plans, Member

California State Department of Health, Advisory Committee on Health and Medicare Care Services, Member

Group Health Association, Member

Institute of European Health Services Research, Fellow

Institute of Medicine, National Academy of Science, Member

International Epidemiological Association, Member

International Journal of Health Services, Editorial Board, Member

International Labour Organization, Consultant

Journal of Health Politics, Policy & Law, Editorial Board, Member

Medical Care, Editorial Board, Member

Organization of American States, Consultant

Physicians Forum, Member, President 1984-85

U.S. AID, Consultant

U.S. Congress, Office of Technology Assessment, Health Panel, 1975, Member

U.S. General Accounting Office, Consultant

U.S. Peace Corps, Consultant

U.S. Public Health Service, Consultant

World Health Organization, Expert Advisory Panel on Medical Care, Member and Consultant

WEEKS:

Dr. Roemer, in looking at your professional life material I find that you were a graduate of the New York University Medical School but I've been wondering how you happened to choose to go into public health medicine over private practice.

ROEMER:

Well, I guess my story is a somewhat typical one of many people. That is, I went to college in the depression years. My first week in school in 1932 was marked by President Roosevelt announcing a bank holiday and I was quickly reminded of the situation we were in.

As I studied at Cornell, with the depression all around us and with the rise of fascism in Europe, I got more and more intersted in social issues.

It happens that my father was a doctor, first a general practitioner then a radiologist. That consciously or unconsciously was quite an influence on me, that I should go into medicine. But as my time of completing the bachelor's approached, I became more and more apprehensive about it because my interest was more social than medical.

So it happened that I finished the bachelor's degree a little bit before the four years -- I finished in three and one-half -- and I had six months to think and explore other things. I went into starting a master's degree in sociology. But I did apply to medical school and then when I was accepted, I went, but was very, really quite, unhappy the first year when you study the basic sciences. I continued studying, doing the work for the sociology degree during vacations and over the summer -- well, actually the three summers during medical school years.

So as it happened, I earned the master's degree in sociology at the same

time as the medical degree. In the studies for sociology, I discovered public health in reading. My dissertation was on a subject that would never be accepted today, as being too broad and vague -- the "social factors influencing American medicine." But it was acceptable in those days.

Doing this taught me about public health. I resolved the difficulties at the end of my first year of medical school by deciding then that I would go into public health as soon as I finished training. That's what I did.

In contrast, perhaps, to a number of people who go into public health after some years of private practice, I had my mind made up and did simply a one-year internship, rotating internship, and went after a position. My first opportunity was to go into venereal disease control which was very prominent in those days. That was in the State Department of Health of New Jersey.

That kind of resolved the problem as a sort of combination of sociology and medicine.

WEEKS:

Then you did go into the Public Health Service following your New Jersey...

ROEMER:

After a year in VD work, I realized that I should get a graduate degree in public health. Because of my studies in sociology, which included being the first reader, I think, of the volumes of the Committee on the Costs of Medical Care in the Cornell library, I learned about the problems of medical care. I decided that the aspect of public health that I wanted to go into was one that included an emphasis on the organization of medical care.

Well, the school in the United States that was distinguished in that field was here in Michigan with Nathan Sinai. That is why I came to Michigan, to study under Nate Sinai.

I was hardly half way through the program when Dr. Sinai began to explore job opportunities for me. He contacted his friend, Joseph Mountin, in the Public Health Service. So that as soon as I finished school I went to Washington. When I started school, it was just after Pearl Harbor. The University of Michigan, because of the war period, had a summer session for full credit. Instead of starting in September, I was able to start in the previous June. Anyway, the long and short of it was that I finished the degree in February, rather than the following June, and went right to Washington and was inducted into the Public Health Service.

WEEKS:

Before we get into that aspect of your career, would you care to say something more about Nate Sinai?

ROEMER:

He was a very effective teacher. He presented things with enthusiasm and with a certain dramatic quality...a bit of a showman. He taught with lots of gestures and examples and so on. His knowledge in the field of medical care, of course, was very great...I presume because of his work on the Committee on the Costs of Medical Care.

He was good enough to appoint me as a teaching assistant after a month or two, which helped financially. And he was just a very nice person to talk with.

WEEKS:

Had he done the Windsor Study yet, or did that come later?

ROEMER:

No. That was some years later.

WEEKS:

That was some years later. I was trying to picture when Odin Anderson was there. Was he there after you?

ROEMER:

Odin was a graduate student working toward a Ph.D. in the same period. I'm not sure if Odin's primary field was sociology or exactly what, but he was partly in the School of Public Health and partly on the general campus. We became friends in that period.

WEEKS:

I think his major was sociology and I think the way he came to the School of Public Health, as he tells it, was that he had a library degree that he had picked up somewhere along the line and he was working in the university library when Sinai asked if there was anybody over there who could work for him and straighten out all the materials, the literature he had, which was the beginning of the Public Health Library. I think that is the way Odin got into the School of Public Health. But he was a sociologist basically.

ROEMER:

But I think the work he did was in the health field, was it not?...medical sociology?

WEEKS:

Yes. He combined the two after he got in with Sinai. He realized that this was more interesting to him than so-called straight sociology would be.

ROEMER:

He was one of the first sociologists to devote himself fully to the health field.

WEEKS:

Then he went on to Canada and finally came back to the Health Information

Foundation; I think this is the way he got back into it.

As we talked at lunch, when you did get into the Public Health Service, did you work directly with Joe Mountin then or did you work with Fred Mott?

ROEMER:

My first assignment was made by Joe Mountin, to whom I was responsible. He assigned me to work with the Farm Security Administration because Dr. Mountin was told by Nate Sinai -- of course I told Dr. Mountin what my wishes were, and they were very flexible in the Public Health Service in responding to an individual's preferences -- that my interests were to work in some aspect of public health involving medical care. It was Dr. Mountin who said, "Well, the place for you to go is over to Farm Security, because they are running these prepaid medical care plans around the country for low income farmers."

So I was sent to see the man who had just become head of it, who was Fred Mott. He was preceded by Dr. R. C. Williams, who had just retired. I became Fred's assistant in Farm Security. Fred had a wide span of responsibility for both the Rural Rehabilitation Program, which meant rehabilitating low income farm families and there was a medical care component of that, and then there was the migratory labor program -- migrant workers around the country. There was also a medical component to that. My first work was on the migratory labor side. Then later, it was on the prepaid plans. I guess it was up to 1100 or 1200 counties -- about one-third of the counties in the country -- with these plans.

That was a very educational experience for me: getting to know the United States; and travelling around to the different places. They were mostly in the South but also in the Midwest and the far West. And I was able to get

acquainted with the whole question of planning prepaid medical care plans and problems of low income farm families. General questions of agriculture were also involved -- tenant farmers and land ownership and a lot of those things.

It was out of that experience that I began working with Fred -- it must have been about 1945 -- on a book which Fred had been invited to do. It was written originally and called Rural Medicine, invited by the New York Academy of Medicine. I worked with Fred on that weekends and nights and so on, until we finished the book about 1946 and presented it to the New York Academy of Medicine. They liked the extensive body of information we had gotten together on problems of rural health and medical care but they didn't like the conclusions of the book, which were that the only real solution was a program of national health insurance.

So there ensued a controversy with the New York Academy and it even got to the point of a threatened lawsuit, because we had gotten some money from the Academy for writing the book. The long and short if it was that we returned the money, because we insisted on not having the book expurgated with respect to its views on national health insurance. The manuscript was taken up immediately by McGraw-Hill and published in 1948 as Rural Health and Medical Care.

Fred was a marvelous person, an effective administrator, very, very devoted to social values, humane values. I guess I've always felt that what I learned from Fred was not only integrity and high ideals, but also judgment on interpersonal relations, including the sensible way of dealing with people where there was potential controversy. There was plenty of that in the field of agriculture, the Farm Bureau and different farm organizations, the doctors, and so on and so forth.

WEEKS:

Weren't you and Fred Mott labeled Leftists?

ROEMER:

Oh, yes. We were in the black book of this woman who worked for Senator Taft, but we had very good company. Dr. Mountin was in it.

Senator Robert Taft hired this woman to be kind of a private FBI screener for the whole health insurance movement. This was, of course, very much under way then with the Wagner-Murray-Dingell Bill. I think the first draft of it was 1943-44. She drew up -- I can't think of her name now -- she drew up this sort of pamphlet on a kind of "red network" in the medical care field and the health field. Of course it included Michael Davis, Joe Mountin, the Surgeon General, Dr. Parran, was in it; Fred Mott was in it. I was one of the lesser lights that was in it. She had a big chart in there at one point, with branches and so on. One of the lesser branches...

WEEKS:

...tentacles, huh?

ROEMER:

Tentacles. This network idea, I wasn't entered in that.

WEEKS:

Isn't it strange when you stop to think about it that the people you are talking about, Dr. Parran, Dr. Mountin and Dr. Mott, all had, and you and Davis, all had a lot to do with Hill-Burton?

ROEMER:

Oh, well, I can't say that I had a great deal to do with it but Dr. Mountin certainly did. In my view, Dr. Mountin was the most creative figure in the public health field in the period of the New Deal, the period of

the 1930s and 1940s. He died, wasn't it in 1952?

WEEKS:

What was his background?

ROEMER:

He was a young Tennessee doctor who joined the Public Health Service fairly early -- I'm not sure what his very first years were. He simply rose in the ranks of the Public Health Service. He had various local assignments as a county health officer and that type of thing. But he became head of the...at first it was called the Division of Public Health Methods. That was a vague term. I guess it was intentionally vague, which really meant that it was exploring new methods of providing public health services. Then later he became head of the States' Relations Division. That is when I became one of his underlings.

Dr. Mountin was an idea man. He was imaginative. The idea of studying manpower, for example. That there ought to be coverage of the country with enough doctors and enough nurses and sanitarians and so on...that you ought to count where they are and what the ratios are. This seems very obvious now. He was the first one to do it. He got Elliott Pennel to do the detail work on it.

The same thing on hospital beds. Examining the ratios of the population to hospital beds all over the country. They used to speak of Mountin's boys, -- his "boy" on hospitals was Vane Hoge. Vane Hoge and others worked on building up this information on the hospital bed supply and the unevenness and particularly the shortages in rural areas for several years during the war, in the early 1940s. So that the introduction of the Hill-Burton Act in 1946 or '45 was a result of a lot of studies that Mountin had generated in the

previous few years.

The only place that I came into it was in helping Fred Mott. Fred became kind of the spokesman for rural health needs, as head of the Farm Security and the Department of Agriculture's main program relating to poor families in rural areas. Fred was called on to testify and to submit papers and so on, and I did a lot of the work on those papers for Fred. In our book, Rural Health and Medical Care, there is a chapter on that, hospitals and the special needs of rural areas.

WEEKS:

I've read that the tilt of Hill-Burton toward the rural area probably was due a great deal to Fred Mott and possibly you.

ROEMER:

I think that was the politics of it. I'm not sure that Fred and certainly not me, can take much credit. I think the bill passed because it was seen as part of the general rural movement -- the slogan then was parity for rural areas. Here the urban states had six beds per thousand, the rural states had two beds per thousand -- something like that. The pressure was to equalize the rural and urban access to beds.

Incidentally, I'd say that that is one of the real success stories in American health planning, because the accessibility of hospital beds in rural areas is now, not only equal to, but in many ways it's over the level in urban centers. Perhaps the U.S. now has too many beds, not in the cities, but maybe there are too many beds in non-metropolitan areas.

WEEKS:

Maybe a little over-compensation doesn't hurt.

Going back to Joe Mountin and Vane Hoge, my first recollection of hearing

of those two names was the Mountin-Hoge grid, the primary, secondary and tertiary referral system for care. We tried it out a little in Michigan, you know, back in those days. Kellogg put some money into Northern Michigan.

ROEMER:

I think Michigan was one of the trial-balloon states, wasn't it?

WEEKS:

I think so.

ROEMER:

The State Master Plan, it used to be called.

WEEKS:

Yes. Well, Kellogg had a project going in Upper Michigan, up around Traverse City and Petoskey and up in there. They discovered one thing about this referral process -- that it has to work both ways or it doesn't work. The tertiary hospitals wanted it all to come their way but they didn't want to refer any patients back to the secondary or primary. This book that McNerney and Reidel wrote...

ROEMER:

McNerney and Don Reidel, yes, I was thinking of that. Regionalization and Rural Health Care.

WEEKS:

Yes. This is a story of failure. But it is valuable because it explains why it failed, and this is basically it.

ROEMER:

That idea of regionalization, I think, had an awfully good impact on the country, even though it didn't work as it was expected to or as it was hoped it would. It did provide a basis for planning and for providing a hospital

where there was a need. It provided some criteria for what kind of equipment and staffing there should be in a small rural hospital, for example, as against an intermediate or a central hospital.

Even though the patients -- the so-called two-way flow from the periphery to the center and from the center to the periphery -- even though that didn't seem to work out, nevertheless it did get the hospitals built there in areas where they weren't there before. And it introduced the concept of planning, which in general had been considered a very radical idea. But it was accepted in this hospital construction field.

WEEKS:

There are two or three things about Vane Hoge. He is now dead, isn't he?

ROEMER:

I frankly don't know. I've lost track of him for many years.

WEEKS:

I think he is dead. Some things here and there I pick up. I was told one time that he was sent to the University of Chicago to take their course in hospital administration so that he'd be prepared to run the Hill-Burton program, which he did. He was the first director, wasn't he?

ROEMER:

Yes.

WEEKS:

Then later, in talking to Karl Klicka -- this was some years later -- Vane Hoge was going to Chicago to start a new planning agency. Because of family unwillingness to move to Chicago, Hoge had to give up this idea and he called Klicka and suggested that Klicka might apply for the job because Klicka had had some experience....

ROEMER:

Was this the Hospital Council?

WEEKS:

It wasn't the present Hospital Council but it was a planning agency, I think supported by industry rather than hospitals.

ROEMER:

Yes. These early hospital councils were designed to advise industry where to give their money -- whether they should give it to hospital A or hospital B.

WEEKS:

Yes. Something like they had in Pennsylvania later on.

Klicka took the job and I think then Hoge went to Washington to work under Kenneth Williamson in the Washington office of AHA. I believe that's the way it was.

I wanted to check one thing about Fred Mott -- one or two things. Was it during this period that they developed the mobile medical office and the mobile dental office for these itinerant...

ROEMER:

Migratory workers? There was a little of that, yes. But I wouldn't say it was very significant. The main component of the migratory health program was some 250 clinics that were set up around the country, staffed by nurses who were full time with the Farm Security Administration. Later it was called the Office of Farm Labor of the War Food Administration. Then a doctor would come in from that community, maybe one hour a day or three hours every other day or some such schedule, to treat the migrant health people. That was a federal program which terminated somewhere around 1947-48 and then was not reactivated until some years later. A new program was created in the 1950s,

providing federal grants to the states for migrant health services. I think the law is still in effect -- I believe, as one of the many Public Health Service grant programs. I think they call them Family Health Clinics.

WEEKS:

The reason I brought up the mobile medical and dental units was that Nelson Cruikshank said that he was working in that program in New England when war broke out, and the military took all those mobile units and used them in the war effort.

ROEMER:

It may well be, but I just don't happen to recall it as being a very important part of the story.

WEEKS:

After you had worked with Dr. Mott, then I have you here as an associate under the Chief, Dr. Mountin.

ROEMER:

Well, after my period of assignment for two and one-half years with Agriculture, the war was over, and it was rather an unstable period that happened to be in my life because I wanted to get overseas. I had not been overseas. So I, with Dr. Mountin's permission, signed up with UNRRA, the UN Relief and Rehabilitation Program. I was being trained, even to the point of studying some language records to learn Chinese and to be sent to China. That was a period that used up perhaps two or three months. First there was the discussion of going to China. At another point, I was going to be sent to Poland, then to Italy. It was an unstable period, until toward late 1945 Dr. Mountin had the idea that I was maybe the person that they needed to work on the Wagner-Murray-Dingell Bill instead of going off to UNRRA.

So I was pulled out of the Dupont Circle Building, where UNRRA was, and put to work as the staff person for an inter-departmental committee on planning a new version of the Wagner-Murray-Dingell bill, national health insurance. My physical base was an office next to that of Dr. Ig Falk. My task, along with another chap whose field was political science, Howard Kline, was drafting the regulations that would be necessary if the Wagner-Murray-Dingell Bill passed.

The feelings were running very high at that time that there was going to be some type of national health insurance. The Wagner-Murray-Dingell bill of 1945 or 1946 -- I can't remember because it went through four or five different versions -- created a great deal of interest. The committee, to which Howard Kline and I were staff, was composed of the Surgeon General and Martha Eliot, head of the Children's Bureau, and Arthur Altmeyer of Social Security and so on. It was a high-powered committee. One of the little prides in my library is the volume of a couple of hundred pages of those "regulations." It was top secret, you know, every copy was numbered. What would be necessary in the way of action at the federal level, state and local levels, if this national health insurance legislation was enacted.

I was on that for just about a year...late '45 to late '46. I may have that wrong. Something in that period. I know it was twelve months.

Then at another point, I was pulled back into Dr. Mountin's office. They gave me a new title after this year's work, which had been essentially desk work on regulations. It involved talking with a lot of people in Washington.

Dr. Mountin decided he wanted to have somebody who would be a promoter of activities by health departments in the field of medical care. He gave me a title of "Associate in Medical Care Administration" in this States' Relations

Division.

Well, for a year and a half, or thereabouts -- it was all of '47, but I can't quite exactly remember the dates, into early '48 -- I would be sent around the country in response to requests from state or local health departments on such questions as a health department getting involved in working with the welfare department on the medical care of the indigent. That was long before Medicaid, but there were many states that had medical care programs under the welfare department. Or I would be sent where there were problems, say, in a county hospital or even a city hospital, and some local figure decided that the health department should be brought into the management of this public hospital. As I recall, one such place was St. Louis County in Missouri.

I remember a visit to a college town, Hamilton, New York, where the college wanted to develop a student health service, but they thought they could do it more effectively if they made it open to the townspeople as well. That didn't involve the health department, but it was a medical care question.

Issues of this kind. Another aspect of it was getting the health department more involved in occupational health, because most of the occupational health work in the states was under departments of labor. There was quite an active movement for the development of these fringe benefit health programs in industry. Could health departments develop any expertise to advise industry -- the way they were advising industry on smoke pollution or whatever? Could they advise industry on developing a better health insurance program for their workers?

There were all kinds of things -- that was more of Dr. Mountin's creativity. He had Vane Hoge as his hospital person. Do you know who his

tuberculosis person was? (At this time, most of the TB work was done by the National TB Association and not by Public Health...in the early '40s.) Herman Hilleboe. Dr. Hilleboe became later the Health Director of New York State. Unfortunately, he died a few years ago. A very fine, distinguished public health leader.

Herman started in the Public Health Service as one of Joe Mountin's boys on tuberculosis. Dr. Mountin believed that that should not just be turned over to the Christmas Seals people, the TB Association, but that TB work should be done by public health agencies.

Another was John Knutson on dental. The idea that dental health should be part of public health was new. You see, the "basic six" of Haven Emerson, did not include these things.

Mental health was another field. Bob Felix was Dr. Mountin's associate on mental health, before the National Institute of Mental Health was established, which was around 1946.

Well, on a maybe more modest level, I was Dr. Mountin's associate on the promotion of interest by public health agencies in medical care problems.

WEEKS:

These were all Mountin boys.

What did Dr. Mountin do? After this, what happened?

ROEMER:

He was Assistant Surgeon General for States' Relations, it was called -- the relation of the Public Health Service to the states. As I say, he was really successful. He got the National Mental Health Institute and the Hill-Burton program and the whole chronic disease field, incorporated into public health.

Another one of his boys was Al Chapman, who was on multiphasic screening as the approach to chronic disease. Nobody talked about risk factors in those days for heart disease and there was nobody talking about smoking and lung cancer. But what everybody did talk about was early detection. We knew about serologies for syphilis and other such tests. Well, why not put them all together and have a battery of tests and try to pick up diabetes and glaucoma and so on and so forth? The slogan of multiphasic screening or multiple testing for early detection of chronic disease was another Mountin product. That was promoted through special grants to health departments and other agencies.

WEEKS:

All the time was Dr. Parran the Surgeon General?

ROEMER:

Yes.

WEEKS:

He, himself, was quite an innovative person, wasn't he?

ROEMER:

Yes. I think so. And as far as I know -- I don't know the inside details -- but as far as I could tell, he backed up Mountin and all his efforts.

The last few years of Dr. Mountin's life I really don't know the details of. In 1952, he died.

Another thing he did for me, which I was very grateful for, was to send me to a local job. I had been in Washington, by February of 1948, for five years, all of those years being under him, directly or indirectly. A lot of it was indirect, like being assigned to Fred Mott and so on. Half of it was assigned to Fred Mott and half of it was directly under him.

Dr. Mountin agreed that I really had a peculiar kind of background, because I had been a VD officer for a state for one year, been in Washington for five years, but had never been at the local level. He was good enough to assign me as a federal public health employee, to be a county health officer in West Virginia. The Public Health Service was always getting requests from the states: Can you lend us someone for this job or that job?

I guess a request came in at that time and they wanted a county health officer. It was a relatively important county in the state of West Virginia because it was the state training center for new public health personnel, as well as having a regular county health department. That was Monongalia County in the northern part of West Virginia, where the University of West Virginia was located.

I was sent there by Dr. Mountin, still theoretically under his supervision. I was there for a year and a half. I was able to enjoy myself as a county health officer and work at the grass roots, which I thought everybody in this field should do.

Then another request came to Dr. Mountin, that they wanted someone to teach medical care at the Yale School of Public Health. C. E. A. Winslow had just retired and Ira Hiscock had come in as the director. Ira Hiscock asked Dr. Mountin, "Do you have any young officer you could send to teach about medical care?"

Well, I was delighted that Dr. Mountin thought of me. They sent me up to try me out with a couple of lectures. The long and short of that was that in July of '49, after I had been barely a year and a half in West Virginia, I was sent up to New Haven, again still on the PHS payroll, to teach about medical care to the school of public health people there.

WEEKS:

Oh, you were on the Public Health Service payroll all of this time?

ROEMER:

Yes. I was on the Public Health Service payroll. I think maybe Yale contributed a little, I'm not sure, to just play that role.

After two years at Yale, I was invited to -- it was actually while I was at Yale -- to lead a tour of people who wanted to study European health systems. Columbia University Travel Service somehow learned about me, that I knew something about medical care, although I had never been to Europe except as a child. At the age of five I spent a year in Germany while my father was studying radiology. But I really knew nothing about Europe except from what I read. In the summer between my two years at Yale, I took a group of fourteen people to Europe to study the health systems -- the British National Health Service had just started. We visited also the Swedish system and the French.

Anyway, part of the tour was a stop in Geneva to see the World Health Organization, which had just gotten started the year before, 1948. The Assistant Director General of WHO at that time was Martha Eliot, whom I knew from her having been on that health insurance committee. I guess they were looking for staff. The first thing I knew, as soon as I got back to New Haven, there was a cable from Martha Eliot: Would I do a job for WHO, a survey in El Salvador?

Well, I had never been in an underdeveloped country at that time. But it was very challenging and I, of course, accepted. The long and short of that was, after the El Salvador project, they liked my report well enough that they asked me to do another one in Ceylon.

Then in 1951, I was invited to join the staff of WHO in Geneva. I asked

if I could stay in the Public Health Service and be assigned to WHO. That was going too far, they couldn't do that. Although I have since heard that that is now being done, but in those days it wasn't acceptable.

So I had to resign from the Public Health Service. I joined WHO. I was in Geneva for, I guess it was six months but it seemed like only a few days, when one day Dr. Mountin came over for a visit -- not a visit, he came over for a meeting. It was very exciting for me to see my old boss and we put on as nice a dinner as we could, and so on. He was made a member of a WHO Expert Committee on Public Health Administration.

At that dinner I said -- he had been such an influence on my life -- I would be grateful if he sent me a photograph. He said, "Sure, as soon as I get back I'll send it to you."

A few weeks later, I got a photograph with a letter from Dr. Mountin's wife saying that he had meant to send the photograph but he had died before he could sign it. Well, I still have that picture, of course. That is why I know very vividly that it was early 1952 that Dr. Mountin died. But that last six-month period, I am not sure what his contributions were.

WEEKS:

How old a man was he when he died about?

ROEMER:

Not that old. I'm sure he must have been under 60...in his fifties would be my guess.

WEEKS:

Is there anything more about your WHO experience....

ROEMER:

The WHO story is another long story. Maybe we shouldn't get off into

that. In terms of my present interests I might have more to say, but in those days WHO was brand new and very bureaucratic and so on.

WEEKS:

That was before they built the present beautiful building, too, wasn't it?

ROEMER:

Yes. We were in the building that had been built for the League of Nations...the Palais des Nations, Palace of Nations. But I only remained on the staff of WHO for two years. The bureaucracy I found was pretty heavy. When I was invited to go to Saskatchewan to head up the medical and hospital program of Saskatchewan, I went.

WEEKS:

I'd like to hear you discuss that because I don't have any history of the Saskatchewan project. I have read about it somewhat. Would you describe that?

ROEMER:

The Saskatchewan story is really pretty dramatic. It has been written up. A lot of people have published on it. I did one paper on it. Some very thorough writing has been done by Malcolm Taylor and some other people in Canada.

I guess the essential basis of the Saskatchewan health story was the depression and the drought, and the rise, as a result of those two things, of the Cooperative Commonwealth Federation Party.

This was a political party that really grew out of the cooperative movement among the farmers in the West, the wheat co-ops as they used to call them. The wheat co-op people, in the prairie provinces, Saskatchewan, Manitoba and Alberta, believed that really there should be a cooperative spirit in the whole society -- a cooperative organization, not just on wheat

but on other things.

After the suffering of the depression and the collapse of the world price of wheat, seven years of drought in the late '30s and early '40s, in 1944 the CCF was elected to power, which was the first party of that degree of liberalism to govern a province in Canada. Part of the campaign program of the CCF was to introduce -- and this was the language they used -- "a program of socialized health services." They called it that. That didn't scare the farmers at all.

So as soon as the CCF party was elected, as soon as that government took over in '44 or '45, they invited up Professor Henry E. Sigerist from Johns Hopkins, who was known as quite a left-thinking person in the health field. He had studied Soviet medicine, written a book about it in 1938-39. He was invited up, incidentally, by someone else whom maybe you have already interviewed...Cecil Sheps.

WEEKS:

I haven't interviewed him yet, no. I have him on my list.

ROEMER:

He is certainly worth talking to. Cecil and his wife, who was also a doctor...Mindel Sheps, were members of the CCF party. They were, let's say, the health braintrust of the CCF. It was they who arranged for Dr. Sigerist to come up. In order to pay his expenses and so on, they set up what was called the Health Services Commission, and he was made the head of the Commission. He was asked to give advice on what to do to introduce socialized health services.

He recommended many things -- one thing was regionalization. That the province should be divided into fourteen regions. Up to then there were just

hundreds of little rural municipalities, which were so tiny they really couldn't do much of anything. They didn't have enough of a tax base. But if you grouped maybe twenty or thirty of them together into a region, you had a better foundation.

He recommended that the people in the region should elect a board of health, a regional board by election, and the regional health board should make decisions on what would be done.

Well, one of the first regional boards to become functional was in region number one, which was Southwestern Saskatchewan, and one of the poorest of the poor. I mean the drought had been particularly tough on the farmers there. That regional board, very soon in 1945, voted to tax people to finance a general medical care program.

The regional board, it was called the Swift Current Region, or Region Number 1, voted for the farmers to pay a land tax to finance a comprehensive program of medical and hospital services, to be based on the existing doctors and hospitals who would be paid on a fee basis, but the money would be derived from this compulsory tax.

So the Swift Current Region Medical Care Program was really the first innovative action in Saskatchewan and the first program of social insurance for medical care in North America. Perhaps I shouldn't say North America because there was a similar activity in Mexico in the 1930s. But take it to mean northern America, meaning the United States and Canada. That Swift Current program is operating to this day. It became so firmly entrenched that even with subsequent events -- you might think that it would be absorbed by the other programs that came later -- it still has a separate identity.

A year later -- that was 1946 -- the government decided that the best

course of action to extend health benefits to the people was not to do it on a region by region basis, although some people thought it should be done that way -- there were fourteen regions. Rather action should be taken on a province-wide basis. And the decision was to start with hospitalization.

I think from the point of view of political science it is very interesting that that was the decision, insofar as it was technically, you might say, not the way to start. That is, why pay for hospitalization but not assure preventive services and primary care and so on? If you ask any young public health student, what is the basic health need, he will say, "Well, you start with prevention; you start with access to primary care."

However, the way the CCF reasoned, which I think was politically sound, was that it was a lot more feasible to get going on a hospital insurance program than on a program that involved changing the patterns of payment of the doctors. Moreover, for many reasons, the hospitals were in bad shape financially. They needed money. There were maybe 200 - 250 hospitals in the province which were a lot easier to deal with than something like a thousand doctors.

From the point of view of the people, a hospital bill was dramatic; it was big; it could break a family's financial situation. So for all these reasons, the CCF government decided to start with insurance for hospitalization.

At that point, in 1946, Cecil Sheps came down to the United States to look for a bright and dedicated person who would take on the job of setting up the first mandatory hospital insurance program in the continent. He came to Washington. He met Fred Mott, among others. Fred agreed to go up there essentially to set up that program. He kindly invited me to join him but I didn't want to at that time. Fred went up and he did take another American

with him, Len Rosenfeld, who is now professor at North Carolina in medical care. Fred Mott and Len Rosenfeld set up the hospital insurance plan, did the tremendous work of figuring out how to relate to the hospitals; how to relate to the provincial government; how to collect the taxes, which meant a process of working with three hundred rural municipalities. They had to do the tax collection -- what to do to enforce the tax collection and so on.

So the program got off the ground in 1947 after hardly a year's planning. And it was an immediate success. The hospitals loved it. The first two years had plenty of headaches for the administration of the plan, because the payment system to the hospitals proved to have a lot of difficulties, as it was first set up. It was first set up to pay hospitals the way Blue Cross was paying hospitals, namely so much per patient day.

WEEKS:

Sort of an inclusive rate, was it?

ROEMER:

Inclusive rate or so much per patient day. The rate was varied with the size of the hospital. I mean whether it was a type one or type two...a big hospital or a small one.

It turned out that some hospitals got more than they really needed and some got less, because there was very careful accounting.

It seems to me someone who deserves more recognition than he has gotten -- I doubt if you have ever heard his name, Glyn Meyers -- was the Canadian accountant. As a matter of fact, people around here might have heard of him because he eventually left Saskatchewan and came down here to work with Fred Mott on the Community Health Association of Detroit. Glyn was the chap who did the very imaginative accounting, to work out these rates and so on. But

they didn't pan out -- paying per diems.

Well, what happened was that immediately every hospital filled up. There were a lot of beds anyway, because every little farmhouse was turned into a hospital -- if it had more than three rooms in it.

So then they called in Harvey Agnew from Eastern Canada as a consultant. He proposed another method of payment to hospitals. I guess it was a method based on examination of the budget of each hospital, and working out a more flexible rate -- not type a, b and c, but each hospital having its own budget...though still using the per diem, so much per patient day. That was better, but the hospitals were still filled to the gills and there was never an empty bed.

It was finally the third stage, that I think Meyers deserves major credit for, which was to pay on a prospective budgeting basis. That really meant that you should look upon the hospital as a community institution that was ready to serve the public. The term "readiness to serve" was widely used. The slogan was that the hospitals were going to be paid for readiness to serve. That was the formulation that was used to explain that the hospital budget would be prepared according to certain guidelines, and then would be reviewed by the provincial government, based on what was considered reasonable occupancy -- I think it was 80% or 85%. How many nurses do you need if you have 85% of your beds filled? How many people in the kitchen, etc.? Then, divide the annual budget into twelve parts and pay the hospital one-twelfth per month. It came out later to be twice a month -- that is, twenty-six payments a year.

It was a little more complicated than that. I think it was to pay 85% of budgeted costs on that flat basis and then 15% was varied with the patient

days, to take account of variable costs, which are only about 15%, I'm told -- as against fixed costs.

That immediately stabilized the situation. If you look at the curve of utilization in those years -- from 1947, it went up and up and by around '49 or '50, it stabilized, at a high level indeed, because they do have a high use of hospitals for a lot of other reasons in the prairies. But it stabilized the relationships between the provincial government and the hospitals. It stabilized the financial situation. If the hospital, at the end of the year, turned out to have a deficit -- if that formula did not pay its full expenses -- if they could justify this -- let's say they had 90% occupancy instead of 85% and they could justify that that was necessary because of a flu epidemic....(The statistics kept, incidentally were marvelous. There was knowledge of every single patient discharged, the average length of stay of every gallbladder case and every broken hip or whatever.)

WEEKS:

Even a regular PAS?

ROEMER:

Yes. It was really magnificent data. You could judge whether a hospital was out of line from the provincial average in its length of stay for gallbladder cases or for something else, or for the number of admissions for the common cold or something, or tonsillectomies.

So a judgment could be made, with a decision on whether or not the hospital should get a supplemental appropriation to make up this loss. On the other hand, if the hospital ended up with a surplus, they did not have to return it, they could keep it. And that was, you might say, their reward for efficiency. However, if it was a very heavy surplus, if it was a large

surplus, the hospital soon learned that that wasn't such a smart idea, because it would affect the next year's semi-monthly rate. So it was a balanced situation that I think was very successful.

The Saskatchewan program was so successful that other provinces began to beat a path to their doorstep. The first province to emulate it, which was just two years later in 1949, was British Columbia. The interesting thing about that is that British Columbia was a government under a very, very conservative party...the Social Credit Party.

WEEKS:

More English than the English over there.

ROEMER:

More English than the English, but also much more conservative. More conservative than the central parties of Canada. There are five parties in Canada and it's the extreme right-wing. But I think it is especially interesting that this idea of providing people with assured hospital care was so attractive. It was attractive to the most left-wing party and the most right-wing party.

WEEKS:

Did the national government enter into the financing of this too?

ROEMER:

Not a bit at this time. As I mentioned, I went to Saskatchewan after being in Geneva for two years, which was in 1953. In 1954 - '55, that was when the national government became interested. I had the pleasure of going to Ottawa to a number of conferences. I was director of what was called the Medical and Hospital Services, which included the hospital plan. Also, it included the division responsible for hospital standards, licensure, it

included medical care for the indigent...medical services for the indigent; it included the airplane ambulance service; rehabilitation, and a number of other things.

The head of the whole health department, including preventive services and so on, was Burns Roth. Burns and I went on three or four different trips to Ottawa for meetings, where Saskatchewan was in center stage, to explain how this thing worked and what the benefits were -- not only political benefits, but it added to the success of the classical public health programs. Through the hospital we identified infectious diseases, and mothers and newborn babies, and connected them with public health nurses. We had unified laboratory services. There were a lot of ways that we linked together the hospitals with the public health services.

So the federal government took notice, after these two provinces were doing it and a lot of other provinces were interested. The federal legislation was enacted around 1957. The '57 law was a grant-in-aid program. It was 50/50 eventually, but it didn't come into effect immediately, because the politics of Canada are such that unless the two big provinces, Ontario or Quebec, are involved in the program it would not be politically acceptable. So the way the law was passed in '57, it said that when a time is reached when fifty percent of the provinces -- there were ten provinces -- with at least 50% of the population have enacted such laws, then the federal government will match 50/50, roughly 50/50, a little more for the poorer provinces. I think that point was reached around 1958 - '59, a few years later, when the federal government matched.

The last province to actually enact the law and respond to the attractive offer was Quebec, and I think that wasn't until 1961.

WEEKS:

Now all of this time were the physicians on a fee-for-service?

ROEMER:

The physicians weren't involved in this.

Saskatchewan had, long before the CCF program, movement, going back to 1917, had what they called these "municipal doctor plans." The Committee on the Costs of Medical Care has one thin volume on the Canadian Municipal Doctor Plans.

WEEKS:

I haven't read that yet.

ROEMER:

It was sufficiently unique. There were simply these little rural municipalities, of which I said there were 300. A number of them, I think the number came to 30 or 40 of them eventually -- it started with the Municipality of Sarnia -- simply said, "We have to assure that we are going to have a doctor out here in this bleak prairie. Living is not terribly attractive on this flat land with very few trees. The way we will assure it is to pay a doctor a salary." In fact, the way the Sarnia program started was -- it may have been only a year or two, a short time, that it was done this way -- to pay the doctor a salary for which he takes care of anybody who cannot afford to pay. But those who can afford to pay, will pay. It soon changed to be "we'll pay a salary and he takes care of everybody." He was a general practitioner.

These municipal doctor plans -- that was another one of my responsibilities when I went out there -- concerned another little division in the department. When the CCF got in, they decided to strengthen the municipal

doctor plans by subsidizing them from the provincial level, through the rural municipality, so that they could pay a little higher salaries to these doctors.

The full drama of the municipal doctor plans has not been written, because there were some wonderful stories of very idealistic and dedicated doctors who worked on a flat salary to serve the population. The rural municipalities that had these plans would typically have a population of two or three thousand people, very small. One GP doing everything. If it was something he felt he couldn't handle, he would send the patient to -- there were only two main cities, Regina and Saskatoon -- to some other city.

Those were the only doctors in the province -- the municipal doctors -- who were not on a fee-for-service. They were on salary. I don't believe they exist any more. But that situation did not change until 1962, when the CCF was still in power -- it was in power from 1944 to 1964. In 1962, the point had been reached where there was sufficient economic prosperity in Canada, and the hospital plan now was getting 50% subsidy which it never had before, that the province considered: What should be done with all this extra money? Well, the decision was to introduce a plan for physician's care insurance.

A commission was set up in 1961, and it had the usual composition, a representative of the doctors and the university and the politicians and the farmers and so on. They recommended this insurance for doctors' care. That law was enacted in 1962 to take effect July 1, 1962. And July 1, 1962, the doctors decided to go on strike.

WEEKS:

This is what I was leading up to...were they going to be offered a salary on this new insurance or just fee-for-service?

ROEMER:

They were to be just fee-for-service.

WEEKS:

But a schedule of fees?

ROEMER:

Yes, a schedule of fees which would be negotiated and would be paid by the government Medical Care Commission.

WEEKS:

They had to accept it if they participated.

ROEMER:

Correct. They didn't have to participate, but they could hardly not participate, or they wouldn't make a living.

The reason for the strike was that the doctors said, even though they negotiated, they did not want the government paying them for their services. They didn't want a fixed fee, even though it was negotiated; they wanted freedom to charge whatever they wished. There were good doctors and bad doctors, and the good doctors should be able to charge more.

Well, the strike was on for 23 days. It wasn't a complete strike. The doctors were smart enough to offer services to emergencies. So you might say it was a strike with respect to non-emergency care. But elective surgery was stopped. The hospitals always had a doctor on duty in that difficult period to handle emergencies, like automobile accidents and what not. They decided then -- after about ten days -- that they had to bring in an arbitrator. They brought in Stephen Taylor, who was a member of the House of Lords of England.

Although he is in the House of Lords, he is a member of the Labor Party. So everybody called him the Labor Lord. Stephen Taylor was also a doctor and

he had written a book called, Good General Practice, in England years before. Lord Taylor served as the arbitrator or conciliator. On the 23rd of July, 1962, they signed the Saskatoon Agreement, which provided simply that there should be four methods of payment of doctors. And the doctors could pick any one they wished.

Method 1 was the method that had been under the law, simply that the government pays the negotiated fee.

Method 2 was that doctors do not accept the fee from the government, but rather from a medical association which doctors would run but which would get its money from the government and still pay the negotiated fee.

The doctor's association would do the reviewing of the claims and the doctors could feel happier that their claims were being fairly reviewed. But they would still be paid the negotiated fees.

Method 3 was that the doctors would be paid by the government, but they could charge the patient anything extra that they wished -- and that the patient was willing to pay.

Method 4 was salary. Presumably, the idea was that there would be some very thinly settled areas, where even if the doctor chose that third method, there were still too few patients for him to make a decent living; if he could get a salary, it would be higher.

The course of events that followed this were, I think, very interesting. Because, at the outset, a high percentage of the doctors insisted on using method 3. That was what they were striking for...freedom to charge the patients extra. What happened was, these doctors didn't get many patients.

WEEKS:

The patients knew the difference.

ROEMER:

The patients knew the difference and they went to the doctors who were choosing methods 1 and 2. Method 2 was all right, having the middle-man doctor association to review claims -- they used to call it a "post office."

WEEKS:

It was face saving?

ROEMER:

Yes. It didn't really amount to anything different. In fact, the association did the work for the government in a sense -- reviewing claims.

Gradually that third method of allowing the extra payments went down and down. I still get the annual reports from Saskatchewan and, as I recall, it has ended up as a trivial percentage of claims, two or three percent are paid under that arrangement.

WEEKS:

I remember reading sometime years ago that Saskatchewan, in their mental health care, innovated in having little villages of small homes, clusters, for patients. Do you recall that?

ROEMER:

You may be thinking of the innovation in the psychiatric service using small hospitals. I'm not sure that I remember their using people's homes. They do that in Belgium. Maybe it is something I didn't know about. They did develop the idea of decentralizing mental patients from those big oversized mental hospitals -- so that almost every general hospital should have a few mental beds.

Just to finish the doctor insurance story...that was in 1962. In 1964, the CCF, which by this time had changed its name -- it is now called the New

Democratic Party, NDP -- the NDP was voted out of office after twenty years, for many reasons. Probably not for this medical care reason, but the economic situation or something. Yet in spite of that, in 1965 the federal government decided to look into the idea of doctor's care insurance.

The long and short of that was that in 1966 a federal law was passed, despite the trauma of the doctors' strike, almost exactly like the national hospital insurance law of 1957. Namely, that the federal government would match any province that had a doctor's care insurance law. And they didn't tie the string to it about having to be 50% of the population and all that. The law took effect in 1966.

To me, it is interesting that the historic development was such that ten years were required for the pioneering of Saskatchewan to become sufficiently successful to lead to national action.

In the case of the second insurance, the doctor's care insurance, it was only four years -- 1962 to '66. The interesting thing is that since 1966, in the subsequent years, what has happened? I got reacquainted with Canada in 1975 when I made a study there for a couple of months. The provinces are now kind of competing with each other to develop insurance programs for other benefits, such as dental care or drugs, or maybe drugs for people past sixty-five or dental care for children, nursing home care, ear appliances and so on. So that if you add up all of the benefits of all ten provinces -- there will be different ones that each has -- they are very, very extensive.

Just a few years ago, in 1978 or '79, a Canadian law was passed, partly due to the rising cost problem, under which the federal government modified the formula on both physician's care and hospital care insurance, to fix a lid on how much the federal government would match. That was understandable. But

to soften the blow of that action, they threw in something like a $20 per capita grant toward these extra provincial benefits, so that for the dental care or the drugs, there is now federal matching -- not exactly matching but a federal allocation.

Canada has managed to do all of this at a lesser relative cost than the U.S., with us still debating national health insurance. They spend about 7.5% of their GNP on health care compared with our nearly 10%.

WEEKS:

Yes, and there are so many variations over there too, aren't there?

ROEMER:

Yes. It's interesting how the different provinces have done it in different ways.

WEEKS:

I was intrigued with a note that I saw. After you left Saskatchewan you went back to New York City?

ROEMER:

I went to New York to do a study -- I was offered what seemed to me like an awfully high salary and an interesting assignment -- to do a study of Jewish hospitals throughout the United States, with respect to their involvement in community affairs, their relationship with nursing homes, home care programs, mental health programs and so on. So I took a job -- it's a little more complicated than that -- with the Council of Jewish Welfare Agencies, whch had gotten a rather big grant from the Public Health Service for a national study of these hospitals.

But the reason I went to New York was that, while I was in Saskatchewan -- and the reason I took this job -- I got an inquiry from Cornell University

about their starting this Sloan Institute of Hospital Administration. And would I be interested in working in it? When I got this inquiry, I had been out of the country almost five years and that seemed awfully attractive.

Between the time I got the offer -- inquiry rather -- from Cornell and the time I was to make a visit on a certain date, the Dean of the School of Business and Public Administration at Cornell, who had written to me, died in an airplane crash. That caused a lot of turmoil. So the offer did not materialize.

In the meantime, this offer to study these Jewish hospitals--Cecil Sheps, incidentally, recommended me for that--seemed like an interesting opportunity. It would bring me back to the States. I must confess I was thinking of the money then, because I had been working at a pretty modest salary. And that position was at about double the salary I was paid in Saskatchewan.

So I went down and started this hospital study. I was in the study for about four months when the Cornell offer--when they straightened themselves out--the Cornell offer came through.

So I stayed in the Coordination Study--Health Services Coordination Study, that's what it was called--I stayed in it about ten months. Then, to my good fortune, Franz Goldmann was at Harvard then, and I guess he didn't have tenure at Harvard, and he expressed willingness to come down to New York. He took over that job and finished it. I guess the salary was also attractive to him. It was an interesting study because the Jewish hospitals are really quite outstanding in the main--Mount Sinai in New York and Cedars of Lebanon in Los Angeles, Mount Zion in San Francisco, Michael Reese in Chicago, the Jewish Hospital of St. Louis--they are all very good hospitals. This was to

see how they related to family service agencies and nursing homes and mental health and so on. It was the question of coordination.

It must have been about June of '57, I went up to Cornell and the Sloan Institute of Hospital Administration.

WEEKS:

I have you down for lecturing at Albert Einstein Medical School while you were there.

ROEMER:

Albert Einstein was just starting, and I was invited to give a course--a series of lectures, one lecture a week--on the social aspects of medicine. It had some very general title which meant, I think, what we would call here in the School of Public Health a course on the organization of health services.

WEEKS:

Was Mr. Sloan still alive?

ROEMER:

Yes. Well, the brother Raymond Sloan. Ray Sloan was really the one who convinced his brother Alfred to give the money for the Sloan Institute of Hospital Administration at Cornell.

WEEKS:

You know there is a corollary story too. You know that George Bugbee was trying to get money at the same time to buy the Choir College down in Princeton, to start an Institute of Health Administration or something? I talked to George and he said, "Ray said I didn't have much chance. He couldn't influence his brother Alfred." Alfred gave the money to Cornell. So they didn't buy the Choir College.

ROEMER:

Choir College?

WEEKS:

There is one called the Westminster Choir College. I don't know how the name came about but it was a small college in Princeton. The President was getting elderly and the board was getting elderly and they decided that they would sell it for a million dollars. It was a fairly small school. George had the idea that the AHA should relocate. They were at Division Street in Chicago and they were crowded so they thought Chicago or New York or Washington would be the ideal spot. But Princeton, being halfway between New York and Washington--in those days railroads were the vogue and there were main lines running through Princeton--and this was a beautiful small city setting, close to Princeton University and they thought it would be beautiful. But the deal fell through some way. One, because of the money. They wanted money to set up this institute besides buying the school.

Then, I think, in the meantime the school decided not to sell, but to continue. I think they are still in existence.

ROEMER:

I didn't know that. I know that the origin of the Sloan Institute at Cornell was a bit stormy. They had trouble deciding who would be director of it. Finally it was Fred LeRocker, who had been working in some managerial capacity at the Sloan-Kettering Institute in New York. So Fred went out to Ithaca and it was he who recruited me, as I say, after I was in New York on this hospital study for about four months.

So it was Fred, myself, and a fellow named Bob Anderson that were the first faculty of the Institute. Fred LeRocker is still alive, but not in the

hospital field anymore. He lives in Northern California. I see him from time to time. His background had been in industry. He was a representative of Standard Oil or one of the big oil companies in the Middle East. A very unusual background. I guess he decided to study hospital administration, when he was in his forties or fifties, and took a degree in hospital administration. I can't remember where it was. But that was how he got into Sloan-Kettering and then there, at Cornell.

WEEKS:

Didn't Ray Sloan teach at Columbia before this?

ROEMER:

That's right. He taught as a visiting professor.

WEEKS:

I didn't realize, until I talked with Bob Cunningham, that at one time he had a position with McGraw-Hill or the predecessor of McGraw-Hill...on Modern Hospital.

ROEMER:

Cunningham or Sloan?

WEEKS:

Sloan.

ROEMER:

I didn't know that. Maybe that explains why Modern Hospital was always very nice to us at the Sloan Institute. I was appointed as Professor and Director of Research. Every paper we sent to Bob Cunningham, he accepted.

WEEKS:

I think there was a connection there. This was, I think, previous to McGraw-Hill buying it. I have forgotten the name of the predecessor. I think

maybe Ray had a financial interest in it too. That is just one of those little asides that may not have any great significance.

Then your next big jump was to California.

ROEMER:

I should say about the Cornell period, since I know your own interest in hospitals is so great, that the Sloan program was very innovative in one main respect--in that it was two full academic years on campus from the beginning. And only the intervening summer was used for hospital residency practice.

As you know, virtually all the other programs required one year on campus and one full year in a hospital.

WEEKS:

Yes. At that time Michigan was that way.

ROEMER:

But Cornell broke the ice on that, and made it two academic years--to get all the instruction in management as well as in the hospital and health field. The role they gave me, which of course I was pleased with, was not hospital administration. I really didn't know very much about hospital administration, except from this macro viewpoint of the hospital insurance plan. My role was teaching epidemiology and general organization of medical care, health planning and all that. So the students got a pretty broad scope of training.

Now that model has been pretty much emulated in the United States. Almost everywhere it is two years. That was an important thing about the Sloan Program.

Another sidelight was that Cornell was the place that I was able to do the studies that led to this so-called "Roemer's Law." It was based initially on

data that I carried back from Saskatchewan. Saskatchewan had so much data on hospital utilization--its relation to the nature of the person, the population, the nature of the hospital, distances--it was marvelous data. Or, it still is.

But we decided to test it out in New York state. New York state has seventy-some counties, as I recall. By golly, we found the same thing on hospital bed supply being the major correlate of utilization rates. Then we decided to study the relationships nationally, state by state, and found again that bed supply had the highest simple correlation to hospital utilization.

WEEKS:

How did you state your Roemer's law again? For the record here.

ROEMER:

It was simply that, under conditions of widespread financial support, such as through insurance, that the major determinant of the hospital utilization rate of a population is the supply of beds--the bed/population ratio--available.

WEEKS:

If you have them, you use them?

ROEMER:

If there is a mechanism for financing, which you don't find in India but you find in the United States.

So, we simply did these very simple, obvious studies of looking at the counties of New York State, looking at the states of the U.S., and then we had the good luck that, in that very county where Cornell University is located, Tompkins County, New York, there had been a tuberculosis sanitorium. With the decline of TB, as in many other places, the TB san was closed down, and it was

decided to convert it into a general hospital.

So on a given day, after all of the cleaning up and renovation, on a given day in 1958, all of the patients from the previously existent hospital in Tompkins County, which was a little, very inadequate hospital but it was the only one there, the patients were all physically moved from the old hospital to the new hospital.

The new hospital--the old TB san--meant an immediate increase of the bed supply in that county of forty percent, or forty-two percent. The obvious kind of inquiry that occurred to me was, let me go to the local Blue Cross plan which happened to be in Rochester. Fortunately, Blue Cross was the main insurance carrier. Most of the people who had hospital insurance had it through Blue Cross. Let me get the data from Blue Cross on the hospital utilization rate of their members in Tompkins County for the year before this day when the new hospital opened and the year after. We allowed them a year to settle down--a year on either side.

What we found was that the utilization of the same population in the same county--incidentally, I got the data on the mortality rate in the county and so on, and the mortality rate actually went down over that time--the utilization rate rose by something like thirty-eight percent. This was parallel with the bed supply increasing by forty-two percent.

Also, I was able to take the patient records from the two years and compare them on average length-of-stay by diagnosis. For all but a few diagnostic categories, the average length of stay for the same diagnosis was a little longer. That was a paper I published with the title, "Hospital Utilization and Bed Supply: A Natural Experiment."

It was very gratifying to do that work because there was a state senator

in New York State, very nice chap, who saw the implications of what we had done and decided to introduce a bill to control hospital bed supply. New York State was ahead of the average state in having these hospital councils on a statewide basis. It started with the Rochester Regional Hospital Council. You remember that...Paul Lembcke was there?

WEEKS:

Yes. There were quality studies and all.

ROEMER:

Right. Well, there was a regional hospital council there. The bill that was introduced was to require that--not just the Hill-Burton hospitals because that was long established--but that any hospital that wanted to enlarge its capacity, or any new hospital to be built, had to get the approval of the regional council. That was introduced in New York around 1961.

I was just able to think of the name of the state senator. It was George Metcalf. George Metcalf came and met with us at Ithaca several times. Then he had me down to testify in Albany. He got the bill introduced around '61 or '62, requiring that any hospital construction or expansion had to be approved. First it had to be screened by the regional council and then eventually, by the state health department. The bill was finally passed in 1964 and they developed the term "certificate of need." The state health department had to issue a certificate of need before any hospital construction could be done.

New York state was the first such state. Between '64 and '74, a number--I don't know how many--but a number of other states enacted the same type of law. Then in 1974, as you know, it was written into the federal health resources and planning legislation. So the certificate-of-need idea has

become essentially nationwide and I think Metcalf deserves more credit than he gets. He appreciated the significance of our research, which seemed rather self-evident at the time. It seemed obvious. If you are going to have more beds--the doctor's judgment is so elastic as to whether to hospitalize or whether not to--it's so easy to swing one way or the other--that judgment is obviously going to be influenced by the availability of the bed. It's that simple.

WEEKS:

May we digress just a minute for me to ask you about Paul Lembcke. I've, of course, heard of him often. I think some of his data-gathering has been reflected in PAS hasn't it? Vergil Slee was affected by him, and his quality assessments probably have affected people like Donabedian and you.

ROEMER:

Paul was one of the really creative people on the medical audit, which is, I guess, what Avedis Donabedian would speak of as a process measurement. He worked on it in very great detail. I guess his contribution particularly was what people call use of explicit, as against implicit, criteria or some such terminology. That is, that there ought to be a written list of criteria for each diagnosis. You don't just leave it to the judgment of the medical expert who reviews the record. You actually specifiy.

Paul drew up a number of--I happen to know that one of them was widely used--a number of manuals, classifying the procedures that should be expected at a minimum for ovarian cysts, hernia, and so on and so forth.

WEEKS:

The first I remember coming across his name was when I first got into this business reading about a study that he did at Barnes Hospital in St. Louis.

ROEMER:

Yes. He did a number of medical audits which had rather dramatic results in leading to a decline in the rate of appendectomies and a lot of these questionable procedures.

WEEKS:

He died rather young, didn't he?

ROEMER:

Yes. In fact it was Paul who proposed that I come to California. He had gone from Rochester to Johns Hopkins and he had gone from Johns Hopkins to UCLA. He was at UCLA for a couple of years and got me invited out there in 1961. I guess he must have gone out there in 1959, something like that.

WEEKS:

Before we get to specific questions, would you care to talk about your tenure at UCLA? You have been there, what, twenty years now?

ROEMER:

Twnety-one years. UCLA was a new school of public health. It had only been accredited in July of '61. I came in January or February of '62. It's a good school of public health. I think the American school of public health, as a concept, is really an important contribution in the world. As you know, I have recently been working a lot with the World Health Organization. I've done work with what they call the Division of Health Manpower Development, and have done studies in a number of countries.

The usual teaching of public health in most of the world is through a department in the medical school--department of preventive and social medicine or community medicine. But those departments are invariably considered very unimportant in the medical school. They have very little time with the

students. They have very low prestige and so on.

So the idea of a school of public health, which is its own master, its own being and so on, I think is very important. You don't find this in many countries. Also having not only independence, put also accepting students from many different disciplines, instead of being limited to doctors, is important.

Some of these medical school departments of preventive medicine do accept people other than doctors, but they never feel welcome. They feel like odd-balls. And the departments accept very few of them. So I think the idea of a school of public health, as a center for teaching and research and consultation in public health, is a very solid contribution.

So many of the ideas for improved health service have come from Europe. The idea of health insurance; the whole idea of public health; the idea of planning; so many things have come from other countries. But I think the school of public health is one idea that can really be attributed to American thinking.

I went out there to UCLA as head of the medical care program, and Paul was at that time head of the hospital administration program. Unfortunately, it was hardly two years after I had been there when Paul died of a brain tumor.

So the hospital program was assigned to me and we called it—we used the term "divisions" rather than "departments"--the Division of Medical and Hospital Administration. Then a few years later, the decision was--there was a separate Division of Public Health Administration--in 1967 or '68, to unite the three divisions, which I think is quite logical and is the conventional pattern in most schools--not at Michigan but in most others. So it was then called the Division of Health Administration and included medical care,

hospital administration, and public health administration. I remained as chairman until 1970, eight years. Then I had my fill of administration and simply became a professor, and had freedom to do other things--particularly the international.

WEEKS:

You told me a little about your beginning--your first ventures into international health systems when you were doing them for WHO back twenty-five years ago--El Salvador and so on. Would you like to talk about the development of this interest?

ROEMER:

Yes. I'd like to talk about the development of the international health field maybe. My work in it is just one small example.

When I joined WHO in 1951--that's more than thirty years now; it had started in '48--the focus was very technical. There were so many political undercurrents in starting an international organization of any kind that the strategy of the leadership--and that included people like Tom Parran in this country and the famous, distinguished Yugoslavian, Dr. Stampar--there is now a Stampar Institute that was funded by Rockefeller in Zagreb, Yugoslavia--and people like Evang from Norway and others--their judgment, and I'm sure it was sound, was to keep WHO on a very technical level. The work of the organization should focus on the proper kind of vaccine for diphtheria and the proper kind of dosage of drugs, maybe the proper way to drill a well or build a latrine or whatever.

So, when I joined it, I was given the assignment of--they called it the Section on Social Medicine and Occupational Health. What it meant was, virtually everything in the field other than the classical and highly

technical public health activities. There was, for example, a large Division of Malaria Control, a large Division of Tuberculosis Control. There was a Division on Education and Training--how do you set up a nursing school, or a medical school, whatever. There was a Division on Laboratory Services, a Division on Statistics.

Almost everything else that wasn't in what you might call the classical role of public health was shoved into my little unit. After I was there a few months I got one other person, a Chinese doctor, to help me. But I had responsibility for everything relating to medical care, which they called social medicine, the medical aspects of social security, as it was called by the International Labour Organization, ILO, which had been in that field since World War I; hospitals--everything relating to hospital administration, hospital planning; all aspects of chronic diseases that were not communicable, heart disease, cancer; accidents--I had a committee on road accidents, as they called it. Occupational health was in the title; rehabilitation of the physically disabled. There was another unit on mental health. Any question relating to manpower, not education but numbers and distribution of manpower. After the war, there were a lot of problems on migration of manpower from the war-torn countries....doctors from Austria, for example, or from Sweden, which wasn't wartorn but it had a lot of doctors who wanted to help out in South America--things of that kind.

That was the reason I said I got fed up with the bureaucracy--I had so much to do and so many procedures to go through, I couldn't take it after two years. I mention this because the story now, and I have been now working with WHO since about 1960, is very different. I work now as an outside consultant, usually on assignments of two or three months at a time, over the summer or

when I'm on sabbatical or something. Policy didn't change that abruptly. In 1960, it was still highly technical but--by 1960 when they began to use me as a consultant, they had a separate unit that was called "organization of medical care"--that was the name of it.

There was another unit on occupational health. There was a separate unit on what they called "non-communicable diseases"--cancer, cardiac and so on. The Education and Training Division had changed its name to the Health Manpower Development Division, and they began tackling questions of the supply of doctors and nurses, not just the education of them.

I can't give the exact year but around 1970, the World Health Organization reached a point where it recognized that the most important problems in international health, and in improving the situation in the developing countries of Asia, Africa, and Latin America, were not these technical questions so much as broad questions of planning and general political policy. It realized that what was needed by these countries was a structure, an infra-structure of health services organization at the local level, the provincial level, and so on--it wasn't just the question of how to drill a well.

That reached a high point in 1978 or maybe 1976. But the really high point was in 1978 when the World Health Organization, in cooperation with UNICEF, which has a lot of money--relatively--held a conference at Alma Ata. Have you heard of the Alma Ata Conference? Alma Ata is a city in eastern Soviet Russia. At the Alma Ata Conference almost all the countries in the world were represented and they came out with a big splash which was called the Declaration of Alma Ata, which basically says that the task to be faced by all the countries and the World Health Organization is to achieve a structure

of primary health care, accessible to everyone in the world, and that that should be achieved by the year 2000.

So the slogan that grew out of Alma Ata, and is now on every other line of any WHO document that you look at, is "Health For All by the Year 2000." That was the slogan.

This has meant that the interests of WHO--the technical interests of course continued--but the major push is what they call--well, they are very frank about it--promotion of "political commitment to health for all." And they use phrases like social justice, equity for all--concepts that would have been considered very politically unwise, very radical prior to 1970.

Since my interests are general health care organization, my own work with WHO has increased exponentially. I mean that they have so many things they want done, that they call on me to help on. I just came back last week from a three-month assignment which included work in Turkey, and then in Geneva. I'm going on Sunday night to New York to the United Nations Development Program, UNDP, which is a source of money for WHO activities, to present a report on advice on how primary health care can be strengthened by contributions from the UNDP, based on a study of six countries of which my study of Turkey was one. I previously had studied Egypt, and other people had studied four other countries, Malawi, Benin in Africa, Nepal in Asia, and the Dominican Republic in Latin America. In each of these studies, we followed sort of a general format of personnel for primary health care, and then how they were operating, what the problems are, and what the recommendations are.

My task was to integrate the six country reports into a general document. That is just an example of the changed orientation of the World Health Organization.

The interesting thing is that other organizations, like the USAID, are following that type of policy as well. The USAID program, which had been overwhelmingly on family planning--which is very important--you know, it's been reasonable--but now the big pitch in AID is on promoting primary health care, finding methods of community participation in development of local health centers, and so on.

In other individual country programs--Germany has a strong program, Sweden has a strong program which is bilateral--they are all following this leadership of emphasizing the development of general health services particularly for the rural population, and focusing on primary health care as distinguished from hospitals.

I guess the point has been that the big money in the poorest countries, just as in the wealthiest countries, has gone to hospitals.

WEEKS:

How about the foundations like Rockefeller? Have they converted? They were a great family planning project too.

ROEMER:

Yes. Ford Foundation was famous, Ford was very strong for family planning. I guess maybe they still are. I'm not that sure about them.

The recognition that the fundamental issue in health improvement is a local structure of health services has become very widely accepted. The malaria program was part of the education experience, you might say. That was in the 1960s, when there had been this effort to eradicate malaria, the way smallpox was in fact eradicated. But malaria is a much more difficult problem.

After it went down and down, eventually the mosquito developed resistance to the DDT and it swung way up again. So it was a great frustration. A lot

of people who studied the situation of malaria said that the real problem was that there was not proper follow-up at the local level. The team, that was spraying the houses with DDT, would come in and sweep through, malaria would be wiped out for the next few months, a year maybe, and then it would come back, because there wasn't the structure there to keep it under control.

WEEKS:

This is a point that I was wondering about. What is the mechanism? WHO decides that the thing to do is good health for everyone. Do they have enough money themselves? What do they do? Send teams, as you suggested? They have to put pressure on the local government?

ROEMER:

I think the way an official at WHO would answer--they may in fact put pressure on governments but they would never answer that way--I think the answer would be that policy is made by the Assembly, which meets once a year, every May. In the Assembly, all the countries send typically their Minister of Health, often someone from their Ministry of Foreign Affairs. From the U.S., the Surgeon General or the Assistant Secretary for Health will go. The agenda of the Assembly has been prepared by an Executive Board, which meets twice a year at times different from the Assembly.

The Executive Board is made up--when I was there years ago it was eighteen people. I think it's now thirty people--it's made up of thirty countries that are selected by the Board itself to be representative of all the different interest groups in the world. I mean there is always an Arab country, there is always at least one Communist country, and there is always Western Europe and so on. The Executive Board prepares the Assembly agenda and they are really the power. They are, how shall I say it, they are selected by their

governments but they are not supposed to be representative of their governments. They are supposed to be technically independent. So Egypt will be asked to select a member for the Executive Board and they will pick Professor Hassouna or someone who is a technical expert. He is free to vote any way.

I think in reality they tend to reflect the ideology of their governments, but theoretically they are free, they are independent.

The Executive Board throws out the ideas and the implementation and staffing for them is done by the Secretariat, by the staff.

A lot of the formulation of ideas, I guess realistically one must say, coming from the Executive Board have grown out of conversations, informal meetings with the members of the Secretariat. Everyone knows that on the Secretariat there are very competent people, who are experts in this and that field. And of course, there is the Director General and his immediate staff, with whom Executive Board members have endless conversations.

I don't know what the exact facts were that led to the Alma Ata Conference, but my guess would be that Dr. Mahler, who is Director General--a Danish physician, very top quality both technically and philosophically --played a large part. I think he is the son of a missionary, a very idealistic type of person. I presume that out of some conversation, Dr. Mahler must have said, "Well, it would be a good idea to have a conference somewhere and see if we can talk about the whole issue of reaching the rural people, the poor and getting an infra-structure of primary health care."

So, I'm just thinking out loud, someone would bring up at the meeting of the Executive Board that there ought to be a conference on primary health care. So that would get on the agenda of the Assembly which was meeting the

following May. The Assembly has to pass a resolution before any significant action is taken.

I think that the resolution that led to the Alma Ata Conference was passed in 1976. Then the conference was held in 1978.

So it goes with issues. For example, the importance of recognizing (someone raised this question at the meeting yesterday) traditional healers. There is a policy in WHO to encourage the upgrading of traditional healers. That grew out of a resolution where someone proposed--I guess the common course of events is that a resolution calls for a study--a study to be made on the different types of traditional healers. What do we know about them? How much do we know about whether they do harm or good or how much harm or how much good? After the study they arrive at a policy, and the policy they arrived at was to promote actions by countries to give training to the healers, first in very obvious things like immunizations. Maybe with respect to common diseases like malaria, to give them some clue of how to identify malaria. First of all, it is always known geographically that malaria occurs in a certain area. And to give them access to chloroquin which can treat it. There is a lot of promotion of educational upgrading of midwives. They don't call them midwives any more, they call them traditional birth attendants, TBAs, to distinguish them from the midwife, who in most of the world is like a nurse, a trained person.

WEEKS:

I see. It isn't just a euphemism then, it's a distinction.

ROEMER:

Yes. It is really a distinction. The United States and Canada, of course, are the big exceptions. In all of the rest of the world, including

England and Western Europe and all of the developing countries, the vast majority of obstetrical deliveries, in hospitals, not to mention those in the home, but in hospitals, are done by midwives--trained midwives. Of course their record is very good. It's better than the U.S. record as far as maternal mortality goes.

WEEKS:

Isn't there a move in this country now among nurses who are certified in midwifery to be allowed to practice in hospitals?

ROEMER:

Yes. There has been a movement, I guess, in the States for several years, but the progress has been pretty slow.

WEEKS:

One point I didn't get clear in my mind is, when you explained the process of getting a resolution of WHO passed in the UN. In this promotion of health for everyone, what would be the mechanics of WHO? Do they help finance any programs? Or do they recommend to private sources that they put their money into it, or maybe both?

ROEMER:

Unfortunately, the budget of WHO is so small. It's now about four hundred million dollars for everything. If you break that down to 160 countries and all of the fields, it is very little. So they do practically nothing in the way of what you would call direct financing. USAID has a much bigger health budget than WHO. USAID does direct financing of specific programs, mostly family planning but also primary health care recently.

What WHO does is mostly advisory services, an occasional demonstration, a pilot program in one little area. They issue an awful lot of documentation

based on Expert Committees. The issue of training community health workers, like barefoot doctors, well, there have been two or three Expert Committees that have met on that.

I was on an Expert Committee recently that was dealing with health services research, and then they changed the topic just shortly before the meeting. (I was the coordinator, the planner for the meeting. I did what they call the working paper.) We changed it to health systems research. What can be done by countries to carry out research on their health systems, that might improve them so that they can achieve health for all. We developed a framework of, I guess it was nine, different spheres in which there could be research in a country on health needs and manpower, on patterns of delivery of different services, methods of financing, methods of management, to develop a more effective health care system.

Most of the work with countries is done by regional offices. WHO has six regional offices throughout the world which are, you might say, a mini-replication of the headquarters in Geneva, with people in all of these different fields. There, the work with countries involves an awful lot of just education, workshops. There are all kinds of workshops on planning, management, etc.

WEEKS:

I was wondering, for example, USAID, would they be likely to be influenced by findings that WHO had come up with in their demonstations or study sections?

ROEMER:

I think they are now. I'm not sure if they always were. But in the last few years--I'm chairman of the International Health Committee of the APHA, which has had a long-standing contract with AID of about a million dollars a

year, so I do get some contact with AID projects through that--AID is now talking a similar language about primary health care, village health workers, getting community participation. That's one of the slogans. If you want to get an infra-structure that is stable, you've got to get people in the community into it, on the board, and so on. Making use of community health workers with minimal training instead of using doctors for everything. Of course, the big emphasis is on environmental sanitation, on nutrition.

Primary health care was defined at the Alma Ata Conference as including eight elements. I mean it is not that mysterious, but it includes things like control of communicable diseases, clean water supply and sanitation, maternal and child health, health education on the main local problems, adequate nutrition.

One of the eight, I'm not sure if I can recite all of the eight, but one of the eight, the last one, is treatment of common ailments. Even though it is only one of the eight, in my opinion it is the very significant one, because it means that WHO proposes that the local infra-structure, the ministry of health -- incidentally, the constituency of WHO and, in fact, of AID as well, they always work with the ministries of health; they don't work with the medical associations--the ministry of health should engage in treatment...and its provincial and local subdivisions should work on treatment of common ailments. Then there should be referral of patients to the hospital when necessary.

WEEKS:

I was wondering, while we were talking, about how these things could be financed and how they could be put into motion and still recognize the cultural differences in the medication between the donor and the person who

receives this care. I was thinking of the baby food fiasco here a few months ago.

It would seem to me that we, as an affluent nation, which is likely to give millions of dollars to many of these projects--are we really knowledgeable enough about that particular country in order to do a job that is good for the people, not according to our standards but according to theirs?

ROEMER:

They are very sensitive. Everybody at WHO is very sensitive on that issue of one country trying to impose its values on another.

First of all, the staff at WHO is very representative. They speak of balance of the geographic distribution. I mean there is kind of a quota on how many Americans they will take, how many British and so on.

In the regional offices, it is even more so. The regional office people are virtually all from the countries of that region. If you go to Washington to the Pan American Health Organization, the main language spoken is Spanish. Then they take great pains in the same way with consultants--although they are a little bit easier on appointing consultants. I mean there will be a heavy concentration of Americans as consultants, or British, or French. You know, the highly developed countries. But they take great pains to avoid this domination of one culture over another.

There is a constant emphasis that only the country itself can do anything. All that WHO--and AID takes the same position, at least it tries to--all that the outside agency can do is make suggestions, maybe help with some resources. WHO doesn't give funds — but they will give some equipment. But a lot of the money for that doesn't come from the WHO budget of four hundred million, but comes from the UNDP. Excuse me, I'm wrong. The four

hundred millions includes money from others, UNDP and UNICEF.

The UNDP and UNICEF give money and sometimes bilateral money -- like Germany happens to be giving quite a bit of money to WHO -- a lot of which will be used for equipment, for vehicles, for microscopes and so on, drugs.

But I suppose if you really took a very hardnosed view of what they do, I would think that the largest proportion of WHO activities would fall under the heading of consultation and education. Education—a lot of workshops. I have been coordinator of several on planning. There was one in Mexico a couple of years ago on financing of health services. A lot of developing countries don't know what they are spending, and where the money's coming from, what it's being spent for. Which obviously means that their planning is not very effective.

WEEKS:

It must be a very difficult time to do something in these so-called underdeveloped countries, where there isn't anything to work with and so much to be done.

ROEMER:

Well, one way of putting it is really that everywhere, virtually everywhere, there are some dedicated, hard-working people. And what the international agency does is to try to get in touch with that type of person and back him up in some way. I mean, if you can refer to some Expert Committee which has said that you should do it this way -- if you want to build a rural hospital, it shouldn't have an elevator. You show that this was said in an Expert Committee meeting at such and such a time. Or if you want to train nurses, they should't have to be high school graduates. It's enough if they had six grades.

So, I would put it, the more enlightened people in any country are the ones that WHO tries to work with. There is always an old guard that doesn't want anything changed.

WEEKS:

Yes. This is so often the case. You read about a hospital being built in an underdeveloped country, and technological material sent in that no one there is trained to use, this kind of thing.

ROEMER:

Right. One of the big issues is to put minimal money into complicated equipment, and to send people away for training on equipment maintenance.

One of the slogans that we haven't mentioned is "appropriate technology." Every country should have appropriate technology, appropriate to its ability to maintain it.

WEEKS:

Dr. Roemer, I think sometime that you made the statement that you are optimistic about the future prospects for health systems in the country. Did I state that correctly?

ROEMER:

Yes. I would say that in relation to a goal of equity or equitable distribution of health services to the whole population, I think we have made tremendous amounts of progress in the United States, even though there may be temporary setbacks.

Right at the present period, when there are cutbacks in government funding and this strong move against regulation--regulation has become regarded as an evil force--many people feel pessimistic about social improvement. But if we take a long enough view, let's say roughly fifty years and go back to 1933, we

can see that in many, many ways the availability of health care is much better than it was. Look at a few examples.

At the time of the Committee on the Costs of Medical Care in 1928-32, they studied the various arrangements for financing health services. Well, first they studied needs and showed that there was more illness among the poor, yet less services received by the poor. There was great deficiency of many types. They also studied where the money was coming from--various special programs for financing health care. The idea of insurance was so rare that it wasn't even counted, when they set out to examine the distribution of sources of money. Insurance wasn't even on the chart.

In the recommendations of the CCMC in 1933, they recommended that there should be the development of voluntary insurance, not mandatory or social insurance but voluntary insurance. Even that proposal was greeted as communistic and revolutionary by the American Medical Association. As were other proposals, such as improved education of doctors and public health services and so on.

Well, we know what has happened in insurance, that voluntary insurance has grown tremendously. Today, eighty percent, thereabouts, of the population has the protection of insurance for most hospital costs and many other high costs of physician's care. Not that it's adequate, not that it's comprehensive, and not that it's run in exactly the way public health people might envisage. Nevertheless, there has been tremendous progress. There is a great deal more health protection economically and therefore access to hospitalization and to many elements of the rest of medical care, through insurance.

Consider the question of group medical practice--in the Committee on the Costs of Medical Care one of the recommendations was that doctors should work

in groups and as teams rather than as soloists. At the time, perhaps three or four percent of physicians--I'm not sure if it was that many--were engaged in group practice. It didn't grow very rapidly in the 1930s. But after 1945, after World War II, it grew very rapidly. And it is continuing to grow. We are now at the point where somewhere between thirty-five and forty percent of doctors in clinical, office-based practice--not in hospital practice or in medical schools and so on--are in groups. That is a tremendous improvement in the efficiency of delivery of physicians' care.

The ratio of physicians...We now have so many, the general notion is that we are beginning to have too many physicians, more physicians than the economy can support. I think that's debatable. Not in the '30s so much, but in the '40s and 1950s, there was a lot of discussion of doctor shortages. As a result of government subsidy of medical education and action by state governments, there has been an enormous increase in the output of physicians, and we have roughly one to five hundred in the United States today.

Public health -- there has been a tremendous increase in the coverage of the country. There used to be a measurement of the availability of public health, in terms of whether there was a health officer in a county. I forget what the figure was in 1933, but it was certainly less than half of the counties that even had a health officer who was devoted full-time to the work. Today, I don't know exactly, but it would surely be more than 90% of the population who are living in places where public health coverage is available.

And the scope of public health is not just the so-called "basic six" of communicable disease control, maternal and child health, sanitation, health education, vital statistics, and so on. It now includes matters like mental

health, early detection of chronic disease, operation of community health centers for general medical care, hospital planning at the state level, and so on.

Care of the poor -- medical care for the poor -- was really very inadequate fifty years ago. Whatever was done was done at the local level. If it was a poor city or a poor county, there was very limited service. Or there might be a so-called poor doctor, a doctor appointed to take care of the poor--a general practitioner, who would make an occasional home call. But whatever care the poor got was mostly in the cities, in hospital outpatient departments which were usually overcrowded and understaffed.

Well, Medicaid was not the first action. It was actually a culmination of many previous actions. But since 1965 we have had a Medicaid program which, despite all of its problems, and it's got plenty of them, is financing an awful lot of service to something like 25 or 30 million people who qualify nationally.

And there are new mechanisms being developed to reduce costs and so on. But, still, availability of care for the poor is enormously improved.

This kind of progress is seen in a country where the general philosophy is very, shall we say, laissez-faire. Government is, in fact, expanding its scope with respect to achieving equity through various support programs—grants to the states for services, etc.

Certainly the hospital situation has shown tremendous improvement. In 1933, there was very little in the way of professional standards in the hospitals. The American College of Surgeons had a program of inspection, but only a small percentage of hospitals even participated. After the Hill-Burton Act in 1946, there was established in 1952 the Joint Commission on

Accreditation of Hospitals, which has had an enormous influence in improving medical staff organization and other standards in hospitals. Hospital bed supply has been virtually equalized among the states, because of the Hill-Burton program. Maybe we have too many hospital beds now.

There has been a great expansion of organized ambulatory health services, not only in community health centers but in public health clinics and school clinics, industrial health services, and special programs for mental health. These organized ambulatory services tend to make medical care more readily available to people.

So I think one can go down the list of the components of the American health care system and find that there has been great progress, which results in increased accessibility of health service to people on the basis of need, with constant improvement.

The same kind of examination on a world level, seems to me, justifies optimism. Even though most of the world's population lives in countries that are poor and developing--mostly rural with tremendous problems in lack of sanitation and so on--nevertheless, if you examine the indices of health, such as life expectancy and infant mortality from diseases like tuberculosis, there's improvement on a world level--even in Africa which undoubtedly is the poorest continent.

There are some countries in Africa where things have indeed gotten worse, but in Africa as a whole, the health record is showing improvement. Not only because of health service. I'm not suggesting that only medical care makes the difference, but health depends on improvement in nutrition and housing and transportation, electricity and so on.

Within the sector of health care, the supply of personnel, the

doctor/population ratio has improved in virtually every country. Even more has been the expansion of allied personnel--nurses and particularly the new types of community health workers who have relatively short training, three months, six months, but are trained to treat common ailments and carry out those eight services that WHO defines as primary health care.

Hospitals -- tremendously increased availability -- health centers. I would say on a world level the standard resource for ambulatory health service is, not the private doctor, but the health centers where there are doctors and medical assistants and nurses and sanitarians and nutritionists and so on.

So, I feel optimistic on a world level too. If you examine how much money is spent--it's been only in recent years that studies have been done in developing countries--in developed countries, we know that the percentage of Gross National Product devoted to the health sector has been rising. Not just in the United States, where we know that from 1930, when it was about three and one-half percent of GNP, to today, it has risen to around 10%. That's a tremendous increase, both absolute and relative.

But that same kind of expansion is found in Europe. One country that has kind of held the line--there has been an increase but it hasn't been as rapid--is Great Britain. Which in my opinion is unfortunate, because it really has created a lot of problems in the National Health Service, in which they haven't allowed the expenditures to rise to the level that really would be necessary to meet the demand.

But even in the developing countries, more money is being spent on health. Historically, when they were first studied in the 1950s and 1960s, there were financing studies by WHO--Brian Abel-Smith, whom I mentioned before did some of these studies, the main ones--it used to be that the poor

countries were not only poor in their per capita income, but they were spending a very low percentage of their available wealth on health. It was typically in the developing countries two or three percent, at a time when it was five or six percent in the industrialized countries.

Well now, studies have been made--and I have made one such study in Thailand and another in Guatemala but many people have made studies in different countries--it tends to run five and six percent of GNP for health even in the developing countries. This really means that of all the things on which a society can spend money, a higher priority is being assigned to expenditures on health services. I think that's ground for optimism.

Planning is another field that I regard as kind of a weathervane, that was considered very, very controversial as recently as twenty years ago, say 1960. But now the idea of systematically planning the availability of resources, personnel, facilities, the availability of certain kinds of services for children, or rehabilitation or whatever, is accepted everywhere. Every country in the world has a national health planning capability of some type. It may be in the ministry of health. It may be in the national center for general planning. But planning is simply regarded as necessary, if there is to be health coverage of total populations.

WEEKS:

In line with this planning, I think it was Rufus Rorem or someone else of his thinking, who said that he favored funding hospital depreciation in a community pot, regional pot, and then have a regional planning board decide when someone needed to spend some of that money. His thesis was that most community hospitals are built by the communities, they are owned by the community, so the money should go back to the community to portion out to the

various facilities--particularly in a metropolitan area.

ROEMER:

I think he is absolutely right. In fact, I made a little study of this question when I was in Saskatchewan and recommended that the province should stop paying depreciation to hospitals, which it was doing. The province should put the money in a general provincial pot, to be used at the judgment of some provincial body, which says this hospital should be expanded, that hospital should be contracted, a new one should be there, and so on. The payment of depreciation to a hospital is like trying to guarantee it a perpetual life, without any relation to the population needs.

I prepared a long memo on this--it was one of the last things I did in 1956. Frankly, I am not sure what happened. It may well be that, in the federal hospital insurance law, that funding is not paid for depreciation but I'm just not sure. I think it would be totally reasonable to regard capital expenditure quite differently from operating costs. It ought to be subject to central planning involvement.

WEEKS:

It seems like a very sensible idea to me. Possibly he got the idea from reading what you have written.

ROEMER:

Oh, I doubt it.

WEEKS:

It's a good thought. Whether it will ever be put into effect unless it's some situation like it is in Canada, where the provincial government can dictate this.

ROEMER:

What is the policy of Blue Cross, for example, on depreciation?

WEEKS:

Well, they are allowing depreciation and they expect that it will be funded. I don't think it is always funded. I think some hospitals, that are marginal, are using this depreciation money for operating expenses.

ROEMER:

Well, I think that was true in Canada too, when it was paid in Saskatchewan. The hospitals were not necessarily funding it and just using it for expenses.

WEEKS:

But as far as Blue Cross is concerned, depreciation is an allowable expense. And I suppose the different plans have different methods of...they allow certain methods of depreciation, meaning fast over slow. But generally speaking, depreciation is an allowable expense. I don't think that Blue Cross really dictates what they can do with it, or what they should do with it, or what they must do with it.

ROEMER:

No, that wasn't the case in Canada either, but it was paid and many of us thought it should not be. It should be treated the way you treat capital grants, and capital grants are given anyway for hospital construction.

WEEKS:

Before we leave the public health service entirely, how are you holding up now?

ROEMER:

I'm fine.

WEEKS:

There are a couple of things I have often wondered about. Let me sound this off you to see if I'm right. Back in the '40s I used to read about the study sections under the Public Health Service--maybe the '50s and '60s. Then out of that I understand the National Center for Health Services Research and Development evolved, from this study section. Am I right in that?

ROEMER:

Well, I guess it evolved from the first grants in health services research which were given out of a fund authorized under one of the amendments of the Hill-Burton Act on hospitals. I know I had such a grant at Cornell. You mentioned George Bugbee before. I think he was the person who came up to Ithaca for the site visit. I forget what these grants were called, but it was something related to hospital planning. That was one of the predecessors.

Then there was something else called the Institute or Division of General Medical Sciences of the NIH. There were a lot of research proposals at the NIH--coming into the NIH--which didn't fit under cancer or heart or metabolic diseases. So they created this division or this institute of "General Medical Sciences." Research requests that involved health services research would go to that. They had to set up a study section.

Then the final action to set up a National Center for Health Services Research came under Lyndon Johnson. I don't remember the precise stimulus. I know I received a letter, as did many other people who had been doing health services research. The Public Health Services sent out lots of these letters asking opinions. They must have sent hundreds of them to different people. "If there were such a center, how do you think it should work?" That was in the Johnson years, in the early 1960s.

WEEKS:

Then I have wondered about the origin of the medical care division. Has that always been?

ROEMER:

The medical care section of APHA?

WEEKS:

Medical care section, yes.

ROEMER:

I can speak a little about that. I had a small hand in it. The American Public Health Association was very attractive to me and other young public health people as a place for discussions, exchanging ideas. At the annual meetings people of common interests would get together--I joined the APHA the very year that I got out of medical school in 1940. So I had my forty-year membership status several years ago; that means you don't pay dues any more.

Through the 1940s, and especially with the prominence of the Wagner-Murray-Dingell bill debates in Washington, there were a lot of us interested in the organization of medical care. If we did any work in the field and tried to prepare a paper, which would justify getting your expenses paid to the convention, it was awfully hard to get the paper accepted. The usual place that one would send a paper on some study of medical care would be to the Health Officers Section. Almost always they would turn it down, on the ground that medical care was not public health, it was "socialized medicine," it was controversial, it was political. Public health was prevention and so on.

So a number of us -- I say us: myself and Sy Axelrod here at Michigan who has just retired, Paul Lembcke would have been in that group -- sort of

agitated for a "medical care section" in which we would have an opportunity to spread our wings, to develop that field.

I was in Washington from the years 1943 to 1948, and one of the little sidelights of some interest in Washington was that the Wagner-Murray-Dingell bill was officially supported by the U.S. Public Health Service, because that was the position of the Administration of President Truman. It was first Roosevelt and then Truman. So it was not at all improper for a Public Health Service officer in uniform to be in favor of the Wagner-Murray-Dingell bill.

There were many people in the Social Security Administration and the Childrens' Bureau, which was then in the Department of Labor, and the U.S. Public Health Service who had this interest in promoting national health insurance. To express that interest--I don't know who the founder was--but a group got formed of people from these different agencies interested in national health insurance--interested in medical care generally, but national health insurance in particular.

The group contained people like Dr. Mountin; Louis Reed, who had been on the Committee on the Costs of Medical Care; Ig Falk; Fred Mott; Palmer Dearing -- I don't know where Palmer is now; Margaret Klem; if he was ever in town, Michael Davis; Martha Eliot, if she was free. Being a young Turk, I was secretary at one point. It had been going for a year or two, when it got to be big enough that they wanted a secretary to send out notices of meetings and so on.

It must have been about 1945, I became secretary. It got dubbed the "100 Percenters Club." The reason they called it this was that these people were 100% for national health insurance--which was kind of a snide criticism. I mean, as if to say that they didn't want any compromise—100%.

Well, the 100 Percenters Club would give us an opportunity to discuss all kinds of questions. I have very vivid memories of meetings where Dr. Mountin would speak up on something. I remember when the bill passed authorizing the Federal Employees Health Benefits Program, that is that federal agencies could pay for health insurance for their employees, through a multiple choice of different plans. The man who was in charge of this came to the meeting, and Mountin, creative and great as he was, was not diplomatic. The man who was in charge of the new program described it. The meeting was devoted to that program, which had just been enacted. Mountin said -- after this man just gave a very nice talk -- "What are you talking about? That is just for federal employees. What are they, one percent of the population? What are they doing? They are just buying private insurance."

He just belittled the whole program, especially because the speaker tried to imply that this was going to be an opening, an entree to national health insurance. Mountin pooh-poohed it.

Anyway, the 100 Percenters gave an opportunity for people in Washington to talk about a lot of things. One day, at one of the meetings that I happened to have arranged, there was discussion of a medical care section in the American Public Health Association. I argued that it was necessary to have that forum. To our good fortune, Martha Eliot, who was then President-elect of the APHA, came to that meeting. (Oh, Dean Clark was another person who was prominent in the 100 Percenters. He died recently, you know.) It was a happy coincidence that Dr. Eliot was the APHA President-elect, and she heard the discussion and became convinced that it was a good idea.

As President-elect, naturally, Dr. Eliot had a lot of influence. At the next APHA meeting, -- this 100 Percenters meeting was sometime in 1947 -- it

was in 1948 that the action was finally taken to have a Medical Care Section. It was brought up as a resolution at the Governing Council of APHA. It was a close vote. There was a lot of opposition because the health officers were opposed to it on the ground that it would make public health too controversial, and therefore the support of its traditional preventive programs would be jeopardized. Also, it would be divisive. There would be people making APHA into a political debating house. Various objections.

But the resolution passed. The section was founded.

There was more to it than that, because Dr. Mountin played a key role in it. Mountin was head of what was called the Subcommittee on Medical Care. This was a subcommittee of the general Committee on Administrative Practice. The Committee on Administrative Practice was dominated by or almost entirely made up of health officers. It was working on the problems of public health administration. It was a technical committee of the APHA, not a section--they had no membership. It was an appointed committee.

The Subcommittee on Medical Care had existed for some years; it had gone into questions like national health insurance, and had issued statements on quality in a national health program, studies on chronic disease, studies on the relationship of hospitals to health departments, etc. The subcommittee had a staff person, Milton Terris, who later came to be president of APHA.

Terris was the staff of the Subcommittee and therefore reported to Dr. Mountin. As a result of this meeting of the 100 Percenters and the debate that evening with Dr. Eliot and so on, Mountin, who was also at the meeting, decided to have his staff man Terris, on behalf of the Subcommittee on Medical Care, send out a questionnaire, with a return postcard, to a list of people around the United States who might be interested in a medical care section in

APHA.

The responses came back overwhelmingly "yes." So that survey actually had a big impact on the passing of the resolution. I don't know who introduced the resolution at the Governing Council, but he could say that out of 500 questionnaire responses, 450 favored it, or whatever. So that was the birth of the Medical Care Section.

The sequelae was that it rapidly, within, I think, two years, became the largest section in APHA. It soon outranked the Health Officers' Section. It continued from 1950 maybe up until 1960 or after as the largest section. It was the only section that people, outside of conventional public health departments, felt comfortable in.

Well, one year, for example, I did a survey of Medical Care Section membership, just to see what was going on, and hospital administrators were the largest category. That was the only way a hospital administrator, who was interested in public health, could join APHA, because he wouldn't feel at home in the Health Officers' Section or the others.

Then around 1960 or 1965, other groups that were in the Medical Care Section, because they didn't feel they belonged in any of the others, sort of broke off. The social workers broke off. Mental health people broke off. They didn't feel that they belonged anywhere, so they were in medical care. Then they broke off into a Mental Health Section.

Then when the Planning Act passed in 1967, people who were in health planning broke off.

So now the Medical Care Section, because it spawned so many other sections--I think there are now 25 or 26 sections in APHA--now Medical Care is maybe the third or fourth in the numbers of its members, although it is still

quite large.

It's, I think, a nice story of the changing character of the public health field. There had been this very sharp definition that public health is prevention, organized prevention. And if it gets into medical care, it's getting into dangerous waters. It's not only jeopardizing public health, but it's getting into a financially draining field because medical care is so much more expensive than prevention.

But the fact is that the public health scope has broadened to include treatment, particularly of special groups like the poor.

WEEKS:

George Bugbee told me a story and I have to repeat it to you as well as I can. He was kind of "Puckish" when he told it. He was kidding I know. He was talking about research. He was talking about you and he was very complimentary of you and your ability.

He said, "There's only one thing I don't understand about Milton. He has very firm and good ideas about collecting data, about analyzing data, but I don't understand when he says that you should interpret your data according to its plausibility."

Do you remember using that word?

ROEMER:

I don't remember. I guess sometimes you have data where a correlation of one subject to another is not statistically absolutely valid. I've used the concept of plausibility on the question of cigarettes and lung cancer. The tobacco companies argue that cigarettes do not really cause lung cancer. They say that both cigarettes and lung cancer are correlated by some unknown factor, which is the real cause--something in the metabolism of the body or

whatever. People who smoke have this factor and therefore they get lung cancer, but the smoking merely indicates that they've got this enzyme or something.

I've argued that, no, you have to consider the mechanics of what happens. Smoke is going into the lungs and it hits the bifurcation of the bronchi, and it is just at that point where the lung cancer usually develops, at the branching of the bronchi. And it's plausible that, since we know that smoke contains tar, and we know that tar causes cancer, it's a plausible relation, not merely a statistical correlation. I have used it in that sense.

Whether I've used it with respect to any social issue, I frankly don't remember.

WEEKS:

Well, George, as you know, can be a little Puckish and has kind of a twinkle in his eye when he says something.

ROEMER:

Yes. You can get into trouble with plausibility. You know the old story about the typhoid fever and the straw hats. You have more straw hats on people because it's summer and then in summer typhoid develops. So you blame typhoid on the straw hats. I say that isn't plausible. You have to think of some ingestion of something to get the bugs in the intestines.

But I don't know if I've used that argument on a social issue. I may have used it on the hospital bed question. I frankly don't remember. But just thinking out loud, I can imagine that one might use it reasonably on that issue. If you find a correlation between bed supply and bed utilization, one might argue that it's plausible that one causes the other. It's not merely statistical, but it's plausible because we know enough about medical practice

and the incentives of fees and the whole situation. It means that if there is a bed available, it's plausible that the doctor should use it, especially since the judgment of whether to use the bed is very fluid.

I might have said that. Frankly, I don't remember.

WEEKS:

Would you care to think a minute on the direction we're going as far as delivery of hospital care or the multihospital systems, the HMOs, the position of the proprietary hospitals? I'm sure your class has asked you that question many times.

ROEMER:

Well, on the question of the multihospital systems under corporate ownership--that's a very prominent aspect of it--I think it's unfortunate. I think the idea of hospital mergers, achieving the economics of scale, is great. I think there should be as much achievement of the economics of scale as possible.

Countries that have national hospital systems, like the British National Health Service, where in effect each region is like a multihospital system, undoubtedly achieve economies in supplies and in services and so on.

But having a multihospital arrangement under a corporation that operates for profit and is selling stock on the New York Stock Exchange, I think has some very hazardous aspects to it. I think it runs the severe hazard, the severe risk of introducing measures which maximize profits, so as to pay dividends at the expense of not serving the community optimally. For example, not accepting difficult cases, overservicing in some fields in order to draw their money, not engaging in profit-minimizing services like outpatient departments, which are not very lucrative or maybe actually lose money.

So I think the introduction of the profit motive into the hospital world is hazardous.

WEEKS:

Someone has said that most of our discussion about multihospital systems or mergers or shared services have all been about efficiency in management, nothing about the care of patients.

ROEMER:

Efficiency? I can't be opposed to efficiency. But that's a good way to put it, I think.

WEEKS:

To focus on management rather than patient care.

ROEMER:

Right. The next step to efficiency means that, for the same input of resources you make more money, so you make profits. To me the danger is the profit motive. I don't find efficiency a danger. I'm not afraid of bigness. Some people are afraid of bigness per se. They say, well, if it's too big it becomes impersonal; you lose that sensitive personal touch. I don't share that feeling. I think if you can do something more efficiently by doing it on a larger scale, I think that's fine. And you can still break it into small enough units so as to not lose sight of the individual.

But the business of being on the stock market, as are organizations like AMI, American Medical International, National Medical Incorporated and--I don't know the names of them--is different. This motor boat company runs a lot of facilities. They are operating hospitals now in the Middle East, in Saudi Arabia, and making enormous profits.

WEEKS:

Yes, I often see ads in the APHA journal or even the AHA journal, asking for administrators or specialized personnel at very high wages.

ROEMER:

Several European countries have laws that prohibit operation of hospitals for profit. It's just not permitted. Belgium, which has a lot of private hospitals, prohibits profiteering, but they are church hospitals.

HMOs is another questions. I think the HMO is a great idea. There are admittedly hazards in it. There are HMOs that have been corrupt and have underserved people and so on. We've had a lot of experience with those in California. I was on the state advisory board to try to clean up the situation through passing regulations. But, given standards that are reasonable on minimal ratios for the supply of doctors and laboratory facilities and so on, access to hospital beds, preventive services and all of that, the HMO is a great innovation. Both from the point of view of patient care and prevention, and from the point of view of economy.

I think the growth of HMOs has been mostly because of their cost-savings aspects. But the value is both cost-saving and orientation to primary care and preventive services.

WEEKS:

We are coming into a period now, in this economic condition we are in, that employers, particularly large employers, who have to look at the fringe benefits cost to them, are either trying to find some alternative to what they have: straight insurance. Maybe an HMO or self-insurance, another thing that is developing a great deal. It would seem to me that if we could have some options, some competition, that possibly this would be a factor that will help

regulate, informally at least, so that if an HMO is competing with a similar HMO, it isn't only the money but the service they are offering which will be looked at. Because the average subscriber will look at the service before he will at the money probably.

ROEMER:

I agree that there ought to be HMOs competing with other HMOs, as well as with the free market in medical care. However, I think there is a real question about the consumer being adequately informed. It's very difficult to get the message out on what is accomplished by HMO (A) or HMO (B) or Doctor A or Doctor B or hospital A or hospital B. The information is so subtle in the health field that very few people can be expected to -- well, it's not issued. You don't find mortality data or data on disability days or whatever issued. And even if it is issued, most people wouldn't understand it.

WEEKS:

No. They wouldn't understand it. I often think of watching television commercials on insurance for the 65+, life insurance or supplemental Medicare insurance--the claims that are made, and the fact that they talk about the low premium rather than the benefits, life insurance particularly. They say for $6.75 a month you can have insurance. Can you afford to go without insurance? But they don't tell you how much insurance benefits there will be. I'm always a little bit suspicious of that.

ROEMER:

I like the HMO idea in general, aside from its having a competitive impact on other parts of the health system. I like it because it does modify the incentives of the payment system toward maximum prudence in delivery of care. It may modify them too much, so that patients get inadequate services. But

the fee system, whether it's for doctor's care or for per diems in the hospital, dental care, or whatever, the fee system has so many hazards -- what the economists call perverse incentives -- that it should be changed. One way to change it is to put everybody on salary, which would be flagrantly unrealistic in the American culture.

But the HMO is an acceptable form in the American culture because it's non-governmental, it's private, it's locally initiated.

WEEKS:

For the physician it's a nice way to practice. He has regular hours probably. And he has malpractice insurance, probably paid. He has all of the office work done. He doesn't have to worry about it.

ROEMER:

Yes. He doesn't have to waste time on all of the paperwork.

WEEKS:

This may bring about a willingness on the part of younger men, as they come out of medical school and see these things, this may be an inducement for them to join with an HMO. Particularly if we have an oversupply of physicians. It would be much nicer to have a fixed income or at least a guaranteed income.

ROEMER:

What you say is very true in terms of what I've heard at Kaiser. I've been a personal member, as a patient, of the Kaiser Health Plan for more than twenty years. They tell me that for years they had trouble recruiting doctors. Now they have more applicants than they can possibly use.

WEEKS:

Are the men working there...they must be satisfied?

ROEMER:

Oh, the turnover is very low. The general story, as I get it, is that in the first year or two, maybe ten to fifteen percent will not like it and leave. If they stay for two years, they are practically permanent.

WEEKS:

I often think that maybe the wives of physicians would like this better. They could have their husbands home for some kind of regular family life.

ROEMER:

Well, that is, of course, also an argument just for group practice. Even without HMOs.

WEEKS:

I've talked with English physicians who work in groups where they can spell each other off, and take a vacation. The other man would cover for them. This sort of thing.

ROEMER:

The English groups are GP groups. The majority of English general practitioners are now in groups, the great majority of them.

WEEKS:

I haven't been to England since '72, I guess, but the last time I was there I know this was the growing thing. Some of the people I met with come to the States on visits since then. One of them is a GP from up in Lincolnshire and this is a point that he made. He was working with three or four other men and they were spelling each other off for vacations and long trips like this.

ROEMER:

There have been really interesting developments in group practice and in

health centers in Britain. The local authority builds a health center, it's staffed with nurses and social workers and clerks and so on. Then doctors can come in and pay rent. They still are in private practice. They have their capitation list, etc. There are always more doctors applying to rent those premises than openings.

WEEKS:

The so-called auxiliary services are all theirs.

I visited a public health services office in England but they didn't have the physicians there at the time. All the services were there except physicians. But I suppose since then, since these health centers have started, they would all be together.

ROEMER:

Oh, yes. This health center movement is definitely attractive for general practioners.

WEEKS:

One thing we haven't talked about--I think I'm near the end of my questions and I didn't think I would ever get through them today with all these things I marked down. Would you care to say something more about your studies in quality assurance? You did a study on quality assessment or quality...

ROEMER:

I haven't been very deeply involved in that field the way Avedis Donabedian has. But I've done a little. I guess the study that I got the most gratification out of, and that I felt made a little contribution, was an attempt to quantify the quality of hospitals by examining the mortality rate of the hospital. If you look at the death rate of a hospital--that is the

number of deaths over the number of admissions in the course of a year, the hospitals that have presumably the highest quality, the highest technological development -- university hospitals, very good hospitals with excellent staffs and so on, the death rate is higher than in small weakly staffed, and often proprietary hospitals, that have very weak standards.

Well, that seems like a paradox, but of course it isn't when anybody thinks about it and realizes that it's because the big, university hospital attracts the difficult cases. So I simply reasoned that, if we could find a way of adjusting for the average severity of the patients entering the hospital--if we could adjust for this, then the adjusted death rate would give us a measure of quality. What is now called case-mix, the more common name, I called at that time "average case severity."

Well, we based the study on a sample of 33 hospitals in Los Angeles County, on which I was able to get quite accurate data on admissions and deaths. I tried to make adjustments also for the fact that some hospitals had maternity departments, where you could expect just the problem of infant mortality, while other hospitals didn't even have a maternity service. So we ruled out newborn deaths.

Then we examined a lot of factors, such as proportion of patients who were admitted with the diagnosis of cancer, the proportion of deaths that were due to severe trauma like automobile accidents, age composition, we examined a lot of things, percentage of minority races, poverty, ethnic groups, and so on. We found that the highest correlation, the highest simple correlation with hospital mortality was the average length-of-stay. The hospitals that had the longest length-of-stay had the highest mortality, which was simply another way of saying that hospitals that attract severely ill patients, complicated

cases, are hospitals where the patients stay a long time.

So it was a simple statistical matter to take the average length-of-stay and the length-of-stay at Hospital A, and adjust the death rate upward or downward according to the relation of the length of stay at Hospital A to the average length-of-stay for the whole series of thirty-three hospitals.

Then, just using common sense, I reasoned that, although length-of-stay might be a good indicator of the severity of patients entering, it could be distorted by the hospital's being of low occupancy or of high occupancy. That is, given the same case severity, if a hospital had a lot of empty beds there would be a tendency to keep the patient a day longer. And if the hospital was very fully occupied, there would be a tendency to discharge the patient as soon as possible.

So I entered a second adjustment--beyond the severity adjustment -- I forget the words I used -- but the second adjustment was occupancy adapted or adjusted, to derive a coefficient by which you would multiply the death rate. You would multiply that coefficient and the death rate to get a death rate which was adjusted both to average case severity and hospital occupancy.

What I found, which was gratifying, was that this particular relationship ...

Oh, there was one more stage. I examined every hospital's resources to give it what I called a technological adequacy score, in order to distinguish the big university teaching hospital or the highly developed hospital of any sponsorship from the mediocre place that had nothing but a laboratory...hardly anything for a difficult case.

I was then able to show that, using the <u>crude</u> death rate, hospitals with a high technological adequacy score, meaning the big university hospitals, had

the highest death rates and those with a low score, meaning the mediocre little hospitals, had low death rates.

When I introduced the adjusted rates, then it all reversed...very pleasingly. It then became consistent with one's expectations--maybe plausibility would be the word there. You would expect that, if you were now adjusting for the severity of the patients coming in and the impact of occupancy on the physicians to discharge, then the hospitals with the high technological adequency scores would have the lower death rates and vice-versa. And it also turned out that the voluntary, non-profit hospitals then had lower death rates than the proprietaries. The simple measure of accreditation.

By the unadjusted figures, the accredited hospitals had higher death rates than the non-accredited, and again the adjustments reversed the relationships, so that the accredited hospitals had the lower death rates than the non-accredited.

That was, I guess, the most serious study I have done on quality assessment in terms of outcomes.

In terms of process, I guess we did one other study that comes to mind -- a study that we did in California that was directed toward a lot of objectives, one of which was quality. It was to compare the three main types of health insurance plans, the Blues...Blue Cross/Blue Shield, (In California, Blue Cross insures for both hospital care and physicians' care and Blue Shield does likewise.)

WEEKS:

There's some competition there, isn't there?

ROEMER:

(So there are two Blues, Blue Cross and Blue Shield, and they both cover both physicians and hospitals.) The two commercial plans and the two largest HMOs in the state -- except at the time we did this study they weren't called HMOs, we just called them prepaid group practice plans, which were Kaiser and Ross Loos.

What we found was, of course, a familiar story -- lower hospital utilization in the HMOs. We found higher patient satisfaction, interestingly enough because many people seemed to think that there was a lot of dissatisfaction with Kaiser. But, in fact, there was more dissatisfaction with the doctors under the ordinary insurance plans, private practitioners.

The quality side, that was examined in that study, was by process measurement. We took a sample of patient charts. We had a very clever staff member who was able to persuade doctors, go into private offices and persuade doctors to let him make photocopies of records and so on. It was easy to get photocopies of records in hospitals and in clinics like Kaiser. I think we got a sample of about a hundred patient records for one year in each of the six types of insurance plan.

They were reviewed by medical audit technique -- by doctors and by scoring various factors on diagnostic workup and reasonableness of therapy, whether the patient, for example, if it was a child, got preventive immunizations. Various things were examined and a score was given on this process measurement. It was again found that Kaiser and Ross Loos rendered higher quality care by process measurement.

I guess those are the studies that come to mind. I think Avedis, as he mentioned it, has used one of these in the chartbook -- the one on severity

adjusted hospital death rates.

It seemed to me that hospital quality ought to be scored by outcomes. In fact, at the time we did it, I sent the results of our study to John Porterfield who was head of the JCAH at that time, suggesting that JCAH ought to have some measure of its accreditation that could be called an outcome measure, instead of having accreditation totally based on process. Not even process measures, but just measures of input.

WEEKS:

Sort of an inspection, huh?

ROEMER:

Inspection, whether the staff is meeting...and so on.

WEEKS:

Someone, in talking about the Joint Commission, remarked how difficult it would be to recruit people to do these surveys, to be away from home and travel and do all these things. It wouldn't be a condition that would be very favorable for living.

ROEMER:

I think that's true. The few people that I've met, doctors I've met over the years who do these inspections for JCAH, all have a rather unusual life situation. They are divorced or something's happened, they don't have a family linkage of some kind.

WEEKS:

I can see where that might be different. Maybe you would welcome the fact that you'd be on the move all the time or away if you didn't have a family that you wanted to be with.

I think the Joint Commission is probably -- I don't know -- but I would

assume that they are beginning to wonder if their role isn't going to change with many of the new measurements that are coming in. Will they be as necessary as they have been in the past? With the PSROs and the descendant of the old PSROs. We don't know what they will be like yet but maybe they will come to a point where the Joint Commission won't be as necessary in our picture as they have been.

ROEMER:

Maybe so. Although I know that they still have a disciplinary effect, judging by my daughter who, as I mentioned, was a hospital administrator. Shortly before she knew she had to quit work because of having these twins, she got herself assigned to the regional office of the northern part of California, for Kaiser. Her task was to help the hospitals get ready for the JCAH visits.

She wasn't too happy with the job. She said, "I hate to be a policeman."

But when the hospital knew that a JCAH person was coming on a certain day, they'd scurry around and see if everything was in ship shape.

WEEKS:

I can remember being in this hospital that we did the progressive patient care study in, when they were preparing for the Joint Commission visit. And I can remember the great relief when it was over and they had the results back and they could announce to the local newspaper that they had the seal of approval and this sort of thing. But it was an anxious period while they were waiting.

ROEMER:

One of the things that I've been working on in recent years, that most recent book I published on ambulatory services, was to think of the

development of ambulatory services with the degree of discipline that we think of for hospital services. I mean, historically, one can say that hospitals have become more and more group organizations, where it's a teamwork situations. Everybody's looking over everyone else's shoulder. There is a systematization to it.

Some people say that's terrible, that it makes everybody into a mechanical machine...mechanization and so on. I don't share that view. I think that group discipline is a good thing for quality and for anything. You can have complete sensitivity along with discipline.

But in the ambulatory services, the norm is still the individual, private practitioner and so on. Well, this book, this study (actually this study was on the back burner for about ten years and I finally finished it in '81) found that there has been an increased organization of ambulatory services also. It isn't nearly as prominent as hospital services, but there has been this increase in group practice clinics, public health clinics and neighborhood health centers and special clinics for mental health, for occupational health, as I mentioned before. This is bringing to ambulatory care some of the discipline and structure that has been long established in hospitals.

I think if you're looking at the trends, one can say that within another thirty years or so the solo medical practitioner will be an anomaly. There will be very few. More and more service will be given in a group situation. Not necessarily under government. Group practice is not under government...90%. But under some form like the HMO movement. That's part of the trend. I think that is a very good thing for improvement of the quality of ambulatory care. Hospital care gets so much measurement. I mean, there are so many reviews...the JCAH and so many tissue committees and pharmacy

committees and so on, which do not exist for ambulatory care. As it becomes more organized in a team situation and in health facilities, it will be more subject to that kind of surveillance.

WEEKS:

Are there any other points you would like to put on record?

ROEMER:

You have been very thorough in exploring the whole health field.

WEEKS:

I think we've covered most everything.

Bernhard Stern, you mentioned...

ROEMER:

Yes, I was mentioning people who have been an inspiration to me and whose pictures I have on my study wall...Dr. Mountin, Fred Mott, Bernhard Stern, who was really the first medical sociologist in the United States. I have Dr. Ernst Boas, who was the first president of the Physicians' Forum, which is the liberal organization of doctors that still exists. It has been for national health insurance and so on for years. I have Tom Bentley, who was my boss in Saskatchewan. He was the Minister of Health. He was a Nova Scotia lumberman who went west and became a CCFer. And then I have pictures of my parents and my wife.

In the case of Stern...he's a man I think hasn't had sufficient credit. He was a professor at Columbia Unversity, but I don't think he ever had a full tenure because he was considered too radical. In the medical field, he wasn't particularly radical. He was just a good sociologist who examined problems of medical care. He's the author of three or four of the volumes in that New York Academy of Medicine series called Medicine and the Changing Order. One

of them is American Medicine in the Perspective of a Century. One is called Government in Medicine.

WEEKS:

Wasn't there one on aging too?

ROEMER:

There was one on aging but he didn't do that one.

But his first book was called Society and Medical Progress. It was a history of great innovations in medicine, going back to Harvey and the circulation of the blood, Jenner and smallpox, Semmelweiss and puerperal sepsis. And showing how each of these innovations was very bitterly opposed by the medical establishment at the time...particularly Jenner. And Semmelweiss also; all the obstetricians opposed him. Any ideas that was new and that was somewhat threatening to the established way was opposed.

I was doing the sociology master's while I was a medical student, and one summer when I was up in Ithaca, my professor, Julian Woodward, said, "You'd better go and visit this Professor Stern at Columbia."

Dr. Stern told me about his work. I spent a day with him and he was very nice to me. He introduced me to a lot of literature in sociology that was related in some way to medical problems.

The generation of sociologists -- Stern was back in the Depression, this was 1930s -- the generation that came after 1945, the new group of sociologists were very much more, I would say, psychologically oriented and less socially oriented.

So I regard Bernhard Stern as a great figure who hasn't had sufficient recognition.

The other person, Ernst Boas was a cardiologist. He was the first

director of Montefiore Hospital before E.M. Bluestone. Boas was a cardiologist and then became a hospital administrator. He wrote the first book -- I think it's the first significant American book -- on chronic disease as a problem for public health. It was called Chronic Disease -- the Unseen Plague. It developed the whole notion that you need special rehabilitation resources for the aged. He was the first to try to dispel the notion that aging itself was a disease. He claimed that there was no such thing as senility as such. There had to be some arteriosclerotic problem or cerebral problem or something.

He became the first president of the Physicians' Forum when it was organized. I think I joined it in its second year in 1941 or 1940 when I joined APHA. I joined the Physicians' Forum because it was composed of the liberal doctors, the 1% or whatever, who were in favor of national health insurance.

Dr. Boas was very courageous. He used to testify whenever they had these various hearings on national health bills. There was no other medical group that was willing to testify in favor of this kind of bill. These are some unsung heroes in my opinion.

WEEKS:

Your speaking about the books on the pioneers, Harvey and Semmelweiss, reminds me that when I was quite young I used to just read like novels the books of Paul DeKruif. Do you remember those? They were fascinating.

ROEMER:

Oh, sure. They were very exciting. Microbe Hunters....

WEEKS:

And Against Death.

ROEMER:

He also wrote Kaiser Wakes the Doctors, when Kaiser was getting started, before it was very well known in the rest of the country.

WEEKS:

He was a Michigan man too.

ROEMER:

Was he?

WEEKS:

Yes. He lived over along Lake Michigan at the southern tip of Michigan, about where Carl Sandburg used to live. You know Carl Sandburg lived along there in Harbart, Michigan.

ROEMER:

I didn't know that. I always think of Chicago for Carl Sandburg.

WEEKS:

That's not far from Chicago, of course.

I had an interesting experience. I went down to talk with Dr. Crile, the man at Cleveland Clinic. George Crile, Jr., of course. He's now our age. He married Carl Sandburg's daughter. So before the afternoon was over, she came in with her guitar and sang a song like her father used to sing and showed me movies that they had taken. She is very artistic. I had quite an afternoon there after the interview.

Of course, Dr. Crile is quite controversial, as far as his being against fee-for-service on surgery.

ROEMER:

Oh, was he? I didn't know that. It's interesting that in most of the world surgery is not paid by fee-for-service. The United States and Canada

are exceptions. The great majority of surgery in Europe is done by salaried doctors employed by the hospitals, the way we employ pathologists.

WEEKS:

I knew they did that in England but I wasn't sure....

ROEMER:

In England it's 95%. In the Scandinavian countries, it's almost 100%. In Germany, it's maybe 75%. France - 75%. In France, there is a private sector which is larger. Most doctors get paid by the insurance on a fee basis, but the great majority of patients go to the public hospitals, where the doctors are on salary.

That's the thing, as I tried to show with that over-simplified chart that I put on the board yesterday. All of these elements, the delivery patterns, the financing patterns, the methods of planning, administration, the methods of training, they are all getting more and more organized. I think that's the central lesson that one learns from studying the history of public health and medical care.

WEEKS:

I enjoyed the talk you gave yesterday, as I leave this interview. Thank you for granting me the time.

Interview in

Ann Arbor, MI

March 23, 1983

INDEX