Second Interview with Barbara Starfield

Baltimore, Maryland

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Conducted by Edward Berkowitz

Berkowitz: The first question I'd like to review is how you became a doctor

Starfield: This was not a long-standing plan of mine. I think I told you some of the almost accidental things that led me to medicine. My roommate was applying to medical school and she wanted me to take the MCATs with her, and so I did. But I was very ambivalent. In April of my senior year, my boyfriend said to me that he had no intention of marrying a woman who didn't have a profession. On Easter vacation I went home and made an appointment to see the deans of two medical schools. The first one that I went to told me that the class was closed and there was no way I could get into medical school next year. I'd have to apply for the following year. And the second medical school that I went to asked me if I wanted to teach anatomy. I expressed an interest in teaching. He said why don't you come and teach anatomy--you can learn anatomy over the summer--and go to medical school. That's how I got to medical school.

Berkowitz: That was 1954, correct? So you went to medical school and did a residency in Pediatrics. You then took what wasn't a detour but was a departure from pure clinical work.

Starfield: It was obvious to me, during my clinical training, that I was not turned on by the kinds of things my colleagues were turned on by; that is, exotic diseases that we saw in in-patient settings. In fact, I did my third year of clinical training solely in the ambulatory setting of the out-patient clinic, which I saw as the future of medicine. That turned out to be the case. My

professor was courageous in letting me deviate from the standard training. Instead of spending a whole year in the in-patient setting, I spent the whole year in the out-patient setting and, during that year it became obvious to me that I was really interested in population-oriented medicine. He [my professor] suggested that at the end of the year I get an MPH degree. Which I did.

Berkowitz: So you got an MPH and then came back to the hospital to work in pediatrics?

Starfield: Yes. My professor of pediatrics recruited me back to run a clinic for a defined population, which was very unusual at that time. Now it's commonplace in the era of HMOs, but then it was very unusual. And also to do an interesting research project which involved teaming physicians and Public Health nurses to improve the care provided to children in the community. That was my first experience with health services research.

Berkowitz: What did you find?

Starfield: We found that, in fact, incorporating Public Health nurses working with physicians associated with the out-patient department definitely improved understanding of health conditions and improved the quality of care.

Berkowitz: Could you tell me a little bit more about Kerr White? Obviously he made an impression on you. He must have had some intellectual charisma to convince you to come over to the School of Hygiene.

Starfield: I guess it was about 1966 when a dean of the School of Public Health who had a lot of vision realized the importance of this new field of health services research. This was the first School of Public Health, I believe, to develop a unit that was wholly devoted to health services research and recruited Kerr White to head it. Kerr White, over the previous ten years or so, had been writing about primary care. It was a new term for most of us here in this country. He'd

basically reinvented it from some early work that had been done in Great Britain. I resonated *so much* with what he wrote about, in terms of my own experience, my own work in communities of children-- that was the first time I'd encountered anybody who brought a scholarly view to a field that was at that time considered an unscientific field.

Berkowitz: So, since the late 1960s you've been in the field of health services research as a full-time endeavor, more than a clinician in the Pediatrics Department?

Starfield: That's right. I think I'm recognized as a health services researcher. I'm the only woman to date who has won the Distinguished Investigator Award for health services research.

Berkowitz: Could you tell me a little more about the international collaboration on health care utilization in which Kerr White was involved?

Starfield: This was a study in eleven areas in seven different countries in the world. It was Kerr's idea that we had a lot to learn from other health systems. It was a very large project which involved surveys in all these eleven areas. It was an effort to determine what the major determinants of the use of medical care services were in terms of helping policy mavens understand what it was they had to address. Was it the health variables? Was it the social variables?

Berkowitz: By the time that you were involved in that study about health care utilization, you did a lot of health services research in your own right. What have been the points of emphasis in your career?

Starfield: I think my major contributions in health services research are primarily the development of models or theoretical frameworks for looking at problems. The first of these was published in *The New England Journal* in 1973. It was the framework for health services

research, specifying all the different variables and their relationships, and that framework has influenced all of my subsequent research.

The second one was a framework for thinking about and measuring primary care. And that, really, was based on the earlier model. What are the different variables in health services research and which have been more important in defining that particular branch of clinical medicine called primary care? That paved the way for the development of methods to measure primary care on which I am still working. Within the last five years we have developed an instrument, both for children and for adults, that, in fact, measures the extent to which a provider is providing primary care. We also have developed a model of health. Since I'm a pediatrician, we actually developed a model for children. Instead of the standard conceptualization of health as having social, physical and mental components, we conceived of health as having comfort and discomfort components, self-perceptions of health as a component, diseases as a component, development as a component, risks as a component, and resilience as a component.

What we've done in our recent work with children, because we have an instrument to measure health services to children, is to develop profiles of health. I think an individual who has a low score on all the domains requires a different kind of intervention than an individual who has a low score on one or two of them. I think that this provides a way to better tailor interventions *vis-a-vis* the people, not just according to specific problems that they have, but according to patterns of problems that they have.

Berkowitz: This can be applied at an individual level so that a health care provider would be able to take this inventory of a person and score them on this?

Starfield: Yes. It's administered on an individual level. However, we think that its major utility

is at the group level.. My basic philosophy of medicine is to think about individuals in the context of the group or in the context of society.

Berkowitz: Let me ask you where you see the field of heath services research going. At one time, it seems to me, everybody was laying the groundwork for national health insurance. Are we now going in a different direction in which people are saying, "OK, we don't think the government is going to have national health insurance any time soon, so therefore we have to improve the existing system?"

Starfield: Yes. We tried for about 10 years or so to have some impact on reform, but none of it has been effective. A lot of that is because we have certain biases within our own health care system that prevent us from coming to grips with basic, underlying problems in the health care system. One of the powerful ones is the market motivation, the imperative to sell technology. It's very lucrative, and it's fueled by specialists, so that, the society, being market-driven and profit-driven, will tend toward having a health system that is oriented toward specialty care, rather than primary care. Specialty care is much more technology intensive. For 85 years, we've been moving toward increasing "specialism", when it's really clear that, to do what has to be done in terms of the populations' health, both in this country and the world over, is to become more oriented toward improving health of populations. And to improve the health of populations, you have to be concerned about equity. You have to be thinking about equity in health services. You cannot improve the health of a population unless you do something to reduce the disparity between the rich and the poor, which in this country is getting worse. So my recent work is pretty much focused on how we can bring people's attention to the problems of increasing inequity in health of social groups and then getting policy makers to come to grips with the fact that the health of the

country is not improving and that is at least in part due to the heavy specialty focus of our health services system rather than a focus on high quality primary care. We have seen in international comparisons of health services and health in western industrialized nations that the United States really performs very poorly, near the bottom. We've probably gotten worse because of increasing inequity among population groups and the fact that our health system does little to compensate for it.

Berkowitz: But aren't many of the things that concern you exogenous to the health care system itself?

Starfield: Yes. Well, that's true. We're probably not going to make much basic change unless we address that. However, there are lots of changes we can make to improve health at the margin, with appropriate health services. We *can* improve the health of socially deprived population groups if we focus our attention on the kind of health services that they especially need, and that's *primary care services*, not inappropriate specialty care---ongoing care with physicians who appreciate and recognize their problems.

I've now begun to think about putting all the work I've done in the past, like the importance of primary care, in the context of improving of equity across population sub-groups.

Berkowitz: Do you express these ideas in your teaching?

Starfield: I try to. We spent from 9 o'clock to 4 o'clock yesterday trying to express those ideas. It turns out to be really hard to communicate these ideas within this health care system, because people are so used to thinking about health care as disease-oriented, that is, dealing with problems disease-by-disease. But lots of times, people don't have particular diseases to which you can attach a name. So if you're going to focus your attention on diseases, you will never take care

of patients' problems. That's a primary care function, not a specialty function. In fact, as I said before, it's hard for people to understand why specialty care, while important if appropriate, is dangerous if inappropriate. People assume that specialty care is better than primary care. But that's true only if that specialty care is appropriate, and lots of times it's not.

Berkowitz: Are there others in the health care field with whom you are particularly *simpatico*?

Starfield: Yes. I think lots of people. I don't think a lot has been written about it, and there's a lot of resistance against it. But I think the biggest barrier is that the population has come to believe things that in fact are not true about our health care system. I think most people think that we have the best health care system in the world except it's too expensive. And I think they have a blind faith that by going directly to a specialist they will have even better care. That's not true. So I think that's the biggest barrier. We have to just educate the population to the realities. We have to somehow break down the barrier toward solidarity which is hampered by hundreds of separate advocacy groups each one of which is disease-oriented. Until we get that sense of solidarity in the population, I don't really think there can be much change.

Berkowitz: It sounds in some ways as though the health services research establishment agencies are better for the public's health than NIH, which is disease-oriented.

Starfield: And yet these agencies, like the Agency for Health Care Quality and Research, have a budget that is so much smaller than that of NIH.

Berkowitz: Thank you very much.