Introduction

I visited the Rockefeller Archives in order to conduct research for my dissertation, tentatively titled “Of the Poor, by the Poor, or for the Poor: Community Medicine and the War on Poverty,” which explores the community health center movement of the 1960s. I hoped to look at the role of private foundations such as the Rockefeller Foundation and the Commonwealth Fund in the promotion and popularization of community medicine in the 1950s and 1960s. I was particularly interested in the partnership between these private foundations and medical schools. While it was clear that medical schools had led the charge in advancing community medicine as a new field of health care, the role of private foundations was more obscured. However, as I dove into the archives, it became increasingly clear that the Rockefeller Foundation and the Commonwealth Fund both played an enormous role in the early history of community medicine. The Rockefeller Archives not only helped to reveal the important roles of these private foundations, but they also shed light on the transnational conversation surrounding the development of community medicine.

Community Medicine

By the mid-1960s, the links between poverty and health were clearer than ever before. Physicians and scholars alike had begun to talk about a “health gap,” pointing out that poor Americans were much more likely to suffer from illness than their better-off counterparts were. Health itself was also undergoing a transformation. In 1948, the World Health Organization had adopted a new definition of health, one unprecedented in its breadth: “Health is a state of complete physical, mental, and social well-being, and not merely the absence of infirmity.”1 By the 1960s, the WHO definition enjoyed wide acceptance among professionals and experts, many of whom believed that reform was imminent.
Their optimism buoyed by the advances of the civil rights movement, medical reformers believed that a more equitable health care system was also within reach.

With change seemingly on the horizon, reform-minded professionals and experts began to put forward their alternative visions for the future of American health care, testing new ways of extending health care to the poorest citizens. Some of the most radical of these visions drew on a field that was just recently gaining popularity in medical schools—community medicine. Though the idea of community had a long history in American health policy, community medicine as a separate field had only emerged in medical schools in the 1950s. By the early 1960s, community medicine departments had sprouted up in medical schools across the country, focusing on the entire community, rather than the individual patient, as the unit of study and proclaiming the importance of rooting out environmental causes of some of the most common diseases.

My dissertation argues that community medicine emerged in the United States in response to the demands that Cold War politics placed on American medicine and American medical schools. The new postwar responsibilities of the United States pushed American medical schools to turn their focus abroad, opening up a transnational conversation among doctors, medical schools, public health experts, and private foundations. These new commitments to foreign aid thus encouraged American medical schools to explore the ways in which they could extend their reach overseas, and many turned to community medicine as a solution.

For medical schools looking to expand their influence after the Second World War, community medicine fit the bill, providing a channel through which medical schools could engage with their surroundings and extend beyond their hospital walls. Similarly, private foundations, rethinking their roles in the new postwar world order, found community medicine projects an appealing way to experiment with new public health innovations on a localized scale. Thus, a partnership
emerged, in which medical schools, funded by private foundations, launched a series of experiments in community medicine in the 1950s and early 1960s. This powerful partnership drove the early years of community medicine’s success in the United States.

The Rockefeller Foundation (RF) had a long history of funding public health programs around the globe; however, after World War II, the Foundation significantly shifted its course, abandoning many of its earlier, broader public health efforts and even shutting down its International Health Division in 1951. While the International Health Division had played a major role in the eradication of global diseases, this space became increasingly crowded in the postwar era, and the Rockefeller Foundation was no longer the only player. In response, the RF reconceptualized its goals—rather than operating its own public health programs, it opted to partner with other groups and organizations, including medical schools.²

Thus, although the RF’s involvement in public health seemed to diminish in the postwar era, my research at the Rockefeller Archives shed light on the ways in which it continued to remain active, albeit in a different way. While the RF moved away from large-scale public health efforts, it turned to funding medical schools and smaller-scale health programs. In this way, it continued to facilitate a transnational conversation between medical schools, doctors, and public health experts.

For example, throughout the 1950s, the RF, through its Division of Public Health and Medical Education, continued to fund fellowships and training programs for individual physicians who professed an interest in social medicine. Through this support, the RF maintained an important presence in the field of medical education and, ultimately, played an important role in the development and evolution of community medicine.

Most notably, in 1957, the RF funded a training opportunity for Jack Geiger, a young physician interested in social medicine, to travel to South Africa to study
and work with Drs. Sidney and Emily Kark at the University of Natal in Durban, South Africa. The Karks had pioneered the model of the community health center: in the 1930s, they had established the Pholela Health Center in a tribal reserve in South Africa with the assistance of the RF. Unlike traditional hospitals and health centers, the Pholela Health Center considered every resident of the surrounding community to be a patient. Instead of focusing on the individual doctor-patient relationship, then, those at the health center strove to develop a comprehensive program that provided primary care while also treating the social and environmental roots of disease. By the 1950s, the Pholela Health Center had gained an international reputation, and the Karks became known as the pioneers of “community-oriented primary care.” A medical student at Case Western Reserve, Geiger was interested in community medicine and anxious to see how it worked in practice. With the help and mentorship of Warren Weaver at the Rockefeller Foundation, Geiger applied for and received a training grant from the RF to travel to South Africa. There, Geiger spent five months studying community health under the supervision of the Karks. While in South Africa, Geiger also spent two weeks at the health center in Pholela, where he observed the operations of the community health center model.

Geiger returned to the U.S. “firmly committed...to the social and ecological aspects of medicine.” After graduating medical school, he did his internship in internal medicine at Boston City Hospital, then attended the Harvard School of Public Health, where he got a degree in epidemiology. In 1963, he became involved in the civil rights movement and joined the Medical Committee for Human Rights, a professional organization that soon became known as the “medical arm” of the civil rights movement. Geiger’s work for the MCHR soon drew him to Mississippi, where he was astonished by the lack of healthcare access in many of Mississippi’s poorest areas. As the MCHR sought to address this urgent need, Geiger recalled his experience with the Karks in South Africa. The Pholela Health Center, he argued, could be used as a blueprint for a new health center in Mississippi.
In 1965, Geiger and his colleague Dr. Gibson petitioned the newly-formed Office of Economic Opportunity for funding to establish community health centers in Mississippi and Boston, based on the community health center model established by the Karks decades earlier. These centers, in turn, formed the basis for a larger, nationwide program of community health centers during the War on Poverty.

The history of the first community health centers in the U.S. thus reveals the continuing role of the Rockefeller Foundation in the development of community medicine. Through a variety of short-term funds and fellowships, the RF facilitated a transnational conversation that linked social physicians in the United States to community health centers in South Africa, allowing ideas about community medicine to diffuse across international borders. As we can see with the OEO program, this transnational diffusion had a tangible impact on U.S. healthcare policy.

In addition to the RF, other private foundations also had a significant impact on the early history of community medicine. The Commonwealth Fund (CF), for instance, encouraged the development of community medicine through its partnerships with medical schools throughout the United States. Through its funding and advocacy, the CF helped to promote community medicine and legitimize it as a distinct field of medical education.

Even before Jack Geiger started the first community health centers in Mississippi and Boston, the CF was actively promoting the teaching of community medicine in medical schools. In 1961, Dr. Kurt Deuschle approached the CF, which had a history of funding medical school programs, with a request to fund a new kind of program. Deuschle had been hired by the University of Kentucky’s new medical school to design an outreach program that could bring health care to rural, economically depressed regions of Kentucky. In order to fulfill this objective, Deuschle developed an innovative program, which he labeled “community medicine.” The proposed program consisted of a curriculum that emphasized an interdisciplinary approach, blending epidemiology, health organization and
administration, preventative medicine, and even healthcare financing. In addition to this curriculum, the department established a field component, setting up satellite centers throughout the state to provide comprehensive health services to the surrounding communities. In total, Deuschle created sixteen “community wards” throughout the state.

Deuschle’s contacts at the Commonwealth Fund were impressed by the proposal. Dr. Heffron, who was in charge of evaluating the program for the CF, wrote, “So far as I can recall, I do not believe that the Fund has ever had the opportunity of aiding a program that offers so much promise from so many points of view relating to community health and postgraduate education as well as medical education.” Seeing that Deuschle’s program had the potential to become a model for medical schools across the country, the CF funded the program, and thus began its support of community medicine.

Over the next decade, the CF funded many more community medicine programs across the U.S., including departments at the University of Pennsylvania, Mt. Sinai, and Johns Hopkins. Although each program differed, they were all loosely based on the Kentucky model established by Deuschle in the early 1960s. All, for example, combined an interdisciplinary curriculum with a “field” element that reached out into the community. As the idea of community medicine spread, quickly becoming a buzzword among medical educators, its rise to prominence was consistently fueled by the financial support of the Commonwealth Fund.

Thus, a combined partnership of medical schools and private foundations drove the community medicine movement in the 1960s. The Commonwealth Fund’s support allowed medical schools to give the movement an institutional home, ensuring that community medicine would be considered a legitimate field of medicine. Meanwhile, the work of the Rockefeller Foundation connected American physicians to the global movement, enabling the transnational diffusion of ideas. This active—though often “behind-the-scenes”—assistance of private foundations allowed medical schools to explore and experiment with new
methods of healthcare delivery. Ultimately, by highlighting the linkage between poverty and health, these programs reflected and helped to solidify a more expansive notion of social welfare in the 1960s.

8 “A Statement of the Teaching, Research, and Service Aims of the Department of Community Medicine, University of Kentucky College of Medicine,” Folder 1659, Box 178, Commonwealth Fund Records, Grants, SG 1, Series 18, Rockefeller Archive Center.
9 “A Statement of the Teaching, Research, and Service Aims of the Department of Community Medicine, University of Kentucky College of Medicine,” page 4. Folder 1659, Box 178, Commonwealth Fund Records, Grants, SG 1, Series 18, Rockefeller Archive Center.
10 “Progress Report to the Commonwealth Fund on the Community Medicine Clerkship Project,” January 1, 1964, page 3, Folder 1663, Box 178, Commonwealth Fund Records, Grants, SG 1, Series 18, Rockefeller Archive Center.
11 “Department of Community Medicine, University of Kentucky, Discussion with Dr. Kurt W. Deuschle, Chairman, Comments by Dr. Heffron.” October 19, 1961, page 20. Folder 1661, Box 178, Commonwealth Fund Records, Grants, SG 1, Series 18. The Rockefeller Archive Center.