Interview with Dr. Philip Randolph Lee

Date: October 5, 1988
Washington, D.C
Interviewer: Fitzhugh Mullan

Dr. Mullan: We are at the offices of the Physician Payment Review Commission in Washington, D.C Dr. Lee is chairman of the Commission and visiting from his home in San Francisco, where he is Director of the Institute for Health Policy Studies and Professor of Social Medicine, School of Medicine, University of California, San Francisco. Other titles?

Dr. Lee: Outside the University, I'm President of the Health Commission for the City and County of San Francisco, and Chairman of the Physician Payment Review Commission, which was established by Congress to recommend reforms in physician payment in the Medicare program.

Dr. Mullan: I'd like to start with a biographical sketch of where you came from, how you got into medicine, and what brought you to Washington in the early 1960s.

Dr. Lee: I guess I got into medicine because everybody in the family was in medicine. My father was a physician. There were five kids. We were told that we could either be doctors or engineers. All of us, including my sister, who was the youngest member of the family, became physicians.

After graduating from Stanford Medical School, I interned in Boston, came back to Stanford for a year and then volunteered for the Navy in 1949. I spent two years in the Navy, and after that, worked with Howard Rusk in New York for 18 months. Then I went to the Mayo Clinic for a fellowship, came back and worked with Howard Rusk again on the faculty at NYU. Then in 1956, I went to the Palo Alto Clinic, which is pretty much what I intended to do as an internist in the Department of Medicine.

During the earlier periods, one thing I think is important to point out, I had worked for people who really were role models. First was Chester Keefer in Boston. Chester Keefer, while he was the chief of medicine, professor of medicine, and was one of the leading medical professors in his day, was also commuting regularly to Washington during that period of time for the National Academy of Sciences, to run the penicillin trials and then streptomycin trials. Subsequently, he became the special assistant to the Secretary of Health, Education and Welfare, really the first precursor of the Assistant Secretary for Health, during the Eisenhower Administration. Keefer was a very brilliant guy.

Then Howard Rusk. During the time I worked for Howard Rusk, after I got back from Korea, in 1951 to 1953, and then again after the Mayo Clinic (1955-1958), Howard Rusk was commuting to Washington to try to stimulate the development of the field of medical rehabilitation and worked very closely with Mary Switzer, who was then the Administrator of the Vocational Rehabilitation Agency in HEW. Dr. Rusk also chaired a manpower advisory committee for President Truman. Then my dad, who was another mentor, was very actively involved in social issues. While I was still in training, actually when I was in New York with Howard Rusk, my

dad was on the President's Commission on the Health Needs of the Nation. The commission was chaired by Dr. Warren Magnusson, a distinguished orthopedic surgeon. My dad convinced Dr. Magnusson to recruit Lester Breslow, who was then in the Bureau of Chronic Disease in California, to be the executive director of that Commission, because the people who were running it were not moving things effectively. Dr. Breslow was to become a close friend and an important mentor.

Dr. Mullan: What year was that?

Dr. Lee: The Commission did its work in 1952. Its term ended in December of 1952 and the Commission made its report in December of that year. Eisenhower wasn't too eager to act on the recommendations, but a number of them were subsequently adopted. I got to know Lester Breslow, who later became a very influential person in my career. When I was at the Palo Alto Clinic in practice, one of the things Lester did was form an organization, probably in the early 1960s, called the Chowder and Marching Society. Breslow, who is now retired, had served as Dean of the School of Public Health at UCLA, and, earlier as the Director of Public Health in California. He is a world-class epidemiologist. We formed the Chowder and Marching Society, which was a group that met about once a month to discuss broad health policy issues. Members included, John Porterfield, who was the Deputy Surgeon General of the Public Health Service before he retired, then the Special Assistant to the President of the University of California for Health Affairs, coordinating health policies for the nine campuses of the University, and later went on to become President of the Joint Commission on Accreditation of Hospitals; Talcott Bates, who was a pediatrician in Monterey; Dick Wilbur, who was an associate of mine at the Palo Alto Clinic; Bob Alway, who was Dean of Stanford Medical School; and Herb Bauer, the health officer from Yolo County. We really discussed issues. Each one of us had to present a paper once a month on a subject that was non-clinical and usually of a broad nature (e.g., health care financing, medical education, and child health issues). I remember presenting a paper to the group on world population issues, which happened to be something I was interested in. The discussion group served as kind of a postgraduate seminar on health policy.

I then became involved very actively in the debates on the King-Anderson Bill and debated Ed Annis, who was at that time President of AMA. He did not like to debate doctors. He particularly didn't like to debate young practicing doctors; he avoided it whenever he could. One of the high points of that period was when I was on the David Susskind television show. Dr. Annis refused to come on the show, so they invited the President of the California Medical Association. Before I went on, I was terrified, but somebody told me beforehand, "Just make three points and repeat the points, then summarize them at the end. Don't try to do too much on any one of these talk shows." So I did that, plus something I often did in those debates--portray myself as a young practicing doctor up against the heavies of the AMA or organized medicine. It was like David and Goliath, and I was able to evoke a lot of sympathy that way; In addition, most of the audience was in favor of legislation to deal with the health care problems of the elderly.

Dr. Mullan: This would have been what year?

Dr. Lee: This was 1961-62. That was when I became much more interested in learning how the federal government worked.

Dr. Mullan: That was focused on health care of the elderly?

Dr. Lee: Focused on financing the health care of the elderly. King-Anderson was only on hospital care.

During that time, also, I had a trip to the Soviet Union, as part of a U.S. government sponsored medical exchange mission. The trip was organized by Jim Watt. Jim was the Director of the National Heart Institute/National Institutes of Health. He also came out to the Palo Alto Clinic because there was a research foundation there, and he was interested in stimulating the development of clinical research outside university settings, in well-organized group practices. So I got a little insight into at least one part of the Public Health Service from Jim Watt. Of course, he was a very broad-gauged person who was subsequently to play a very important role with respect to my career.

All these experiences increased by interest in the Public Service and national health policy. In 1963, Leona Baumgartner offered me a job somewhat out of the blue, as far as I was concerned. My dad had been a consultant to AID, but I did not expect to be offered a job there.

Dr. Mullan: That job was what?

Dr. Lee: That was as Director of Health Services in the Office of Technical Cooperation and Research for AID. Lester Breslow was present, I think, when Leona made the call to me, as was Howard Rusk, and Bruce Jessup, who had been in practice with me in California. Bruce subsequently put the arm on me in a hotel in Chicago, to urge me to take the job. I was due for a sabbatical at the Palo Alto Clinic, so I had a year that I could take off from my practice. So I decided to go ahead and take the job. It meant moving my wife and five kids to Washington, it meant moving out of a practice which I enjoyed very much, and moving into a world that was quite alien in terms of issues. These included international health, sanitation, environmental health, population growth, family planning, nutrition and other issues that I was not particularly familiar with. Infectious diseases like malaria were important, but--the last time I had done much about malaria was when I was in the Navy as a corpsman on the malaria ward in 1943. Initially, I was a little removed from some of the issues, but after a period of intense learning I managed to deal with the problems reasonably well.

It was also obvious to me--and Leona was very much in favor of this--that we needed a hookup with the Public Health Service. So I discussed this with Jim Watt, who was then the Director of the Office of International Health for the Public Health Service, as to how we could accomplish this.

Dr. Mullan: AID administratively at that point was in the Department of State?

Dr. Lee: In the State Department. They were not disposed to working closely with the Public Health Service. They had their own corps of people. As a matter of fact, I replaced one of those people, Cliff Pease, who went to work for the Population Council. But there was a corps of people who had worked in AID for a number of years, and there was not a lot of interest. I was interested in really having the Public Health Service become the personnel arm of the health

component of AID, if possible. I talked with Luther Terry and asked if we could get a Public Health Service officer assigned to work with me as my deputy. He and Don Price agreed with that, and Jim Watt was certainly most helpful in making that happen. I asked to have Ed O'Rourke assigned to work with me. Ed had had a fair amount of overseas experience, first of all within China at the end of the Second World War in the Navy, and then he had a number of overseas assignments for the Public Health Service, more in Europe than in Third World countries. But he knew the Public Health Service. He was, at that point, working at the National Institutes of Health. I knew his brother very well in California, and that's one of the reasons I asked to have Ed work with me, because Paul O'Rourke worked in the Department of Health for the state of California. He'd been a local health officer, he'd been a family doctor, and was--and still is--a very, very good friend.

So Ed came to work with me. He understood the need to link with the Public Health Service. Of course, there Jim Watt was again a key person. CDC was a key institution within the Public Health Service.

At that time, we were also working with the Association of American Medical Colleges, and Henry Van Zyle Hyde, who had been in the Office of International Health in the Public Health Service, was then at the AAMC. There was a network of people who had been in the Public Health Service, and Leona knew a great many of these people well. As the Health Commissioner of New York City, she knew Luther Terry, Don Price, and Jim Watt very well. They were, in fact, longtime friends. So Leona was very helpful in facilitating linkages.

We ran up against a lot of bureaucratic barriers and difficulties, because there was no authority for the Public Health Service to assign people overseas. But one of the areas where things did work was with CDC, in some very specific instances. One of those was the measles-smallpox control campaign, which was then a demonstration project in West Africa run by D.A. Henderson. That was the model for what became the Smallpox Eradication Program, which D.A. ran for the World Health Organization.

There were a number of helpful people in the Public Health Service, including Alex Langmuir, who ran the Epidemiologic Intelligence Service Program, and Jim Goddard, who was then Director of CDC before he became FDA commissioner, and was very interested in international health. Jim Leiberman, who ran the audio-visual center at CDC, was also very interested and helpful.

However, there were major legal barriers. In addition, there weren't as many positions available to move people into AID, and there were certain large-scale programs, like the Malaria Eradication Program, that didn't require very many people; but mainly required money to buy commodities and jeeps and that sort of thing.

As a result, we were only partially successful in linking the Public Health Service with AID. Following Jim Watt's advice about directions and policies that we should develop proved to be more helpful than the assignment of personnel. There were some areas, such as nutrition and family planning, for example, where the Public Health Service did not have a great deal of

expertise at that time. So in some of those areas, we obviously used a lot of people outside the government, as well.

Dr. Mullan: The Public Health Service didn't have expertise or didn't have authority or didn't have the interest?

Dr. Lee: First of all, they didn't have authority to assign people overseas. Their mission was strictly a domestic mission. So they didn't have the authority to assign people or spend money. We could contract with them on a limited basis, and they could assign people overseas, and that's the way we did that. That was like any other contractor.

Dr. Mullan: As I understand it, population control was an issue of prime interest to you during your AID time.

Dr. Lee: From 1963 to 1965, it definitely was. During that time we developed the first federal policies on family planning. There were no federal policies in HEW and there was nobody in the Public Health Service taking the lead in that area. Celebrezze was the Secretary of HEW and he had little interest. It was felt that it would not get a very sympathetic hearing in Congress. Fogarty was Chairman of the Appropriations Subcommittee in the House and Jim Shannon was the Director of NIH. You had three people who were Catholic. Jim just felt there wasn't good research out there.

Dr. Mullan: Fogarty, Shannon, and . . . ?

Dr. Lee: Celebrezze who was the Secretary. That was in 1963. Leona was very aggressive in moving this area when she felt it should be moved, and was very important in contacts in the White House with people like Doug Cater, who helped to move these policies.

Dr. Mullan: Doug Cater was in the domestic policy household?

Dr. Lee: He was Special Assistant to the President, and it was a point of contact. There were also other contacts in the Bureau of the Budget. Irving Lewis was one of those who was first on the international side, then later on the domestic side. President Johnson, in his State of the Union message in 1964, issued his famous first statement on population. He made many more after that. That really established a policy framework in which we could all move forward. We went ahead then to develop the policies that we'd been working on for some time.

As a matter of fact, within probably the first month I was there, we were asked to help prepare a briefing for President Kennedy in the spring of 1963 on population and family planning. It was thought he would have to respond to a question from the press on a National Academy of Sciences report which Bill McElroy chaired on world population growth. In fact, he did have to respond to a question. In responding to the question, he went beyond what were then existing policies. Earlier President Eisenhower said this was an area the government wouldn't have anything to do with. That policy had been in place from the mid-Fifties. Kennedy first opened the door, then Johnson further opened the door not only to respond to requests, but to move

forward in this area. So we developed the first population and family planning policies and we also worked to develop much stronger nutrition policies in AID.

Again, within the Public Health Service there wasn't a strong resource. We relied mainly on Arnie Schaefer and his staff on the Interdepartmental Committee on Nutrition for National Defense. They were doing nutrition surveys in Third World countries which pointed out the problems of malnutrition and the need, for example, to significantly improve the Food for Peace program. Alan Berg was working in AID at the time, and a person who died very recently named Martin Forman. Both were young, non-medical individuals who were very important in terms of making the Food for Peace program a real instrument for improvements in nutrition and not just a vehicle for getting rid of domestic agricultural products. Various organizations like CARE and a number of the volunteer organizations were involved in that effort.

In public health, the problems that we were most involved in was malaria eradication, which later proved to be impossible, so it became malaria control. The next most important area was environmental sanitation, which meant digging privies and creating safe water supplies in rural areas, and some urban areas. We were not much involved in medical care, but we were involved in programs of medical education, nursing education, and other educational programs.

In 1965, I was offered a job with John Lewis, who was then on the Council of Economic Advisors. He had been asked to go to India to head the AID mission in India, and he had written a book called The Quiet Crisis in India, and was considered to be the leading scholar on economic development in India. I decided at that time, with five kids, that that was a little bit more than I wanted to do. I'd always intended to go back to the Palo Alto Clinic, so at that point, I resigned from the AID and planned to leave there in July of '65 to return to the Palo Alto Clinic. In about May of 1965, Wilbur Cohen called me. He had called on me periodically, even after I was in Washington working for AID, to brief congressional delegations, for example, on the Medicare program or the King-Anderson Bill.

Dr. Mullan: Had you remained involved in either the legislation or the . . . ?

Dr. Lee: No. I was totally into international issues, but nobody in the Public Health Service who was knowledgeable about the issue was willing or able to step forward and speak out. There was little inclination on the part of leadership in the Public Health Service to speak out in the area of medical care until Bill Stewart became Surgeon General. The Public Health Service saw its role as very different: public health developing resources (e.g., hospital construction and research) and providing health services for federal beneficiaries (e.g., native Americans, merchant seamen) but not getting involved in the contentious political issue, which was financing medical care for the elderly or general population.

Dr. Mullan: Was that an explicit policy and thorough process in the leadership of the Public Health Service?

Dr. Lee: I think so, but I never discussed it with Luther Terry or Don Price or others at that time. But I think it was. I think that they felt that they weren't expert in financing medical care, and it was an area that if you didn't know something about, that you shouldn't get involved in. It was

considered to be totally political and, thus, not particularly appropriate for the Public Health Service which was a very well respected professional organization within government.

Dr. Mullan: I think this is a very important point for understanding the Public Health Service. There was a mention in the 1968 Medical World News story on Secretary Gardner about Wilbur Cohen's frustration with the Public Health Service. They said distinctly in the early 1950s at some point Cohen had approached Public Health Service about joining with him or with Social Security Administration in developing legislation or policies or approach to Medicare or medical care issues. He was rebuffed or there was no interest.

Dr. Lee: The person to talk to is Bob Ball. Bob, of course, was around at the time. Another person that might be helpful on that would be Dorothy Rice, who was in Social Security in those days. Dorothy is now at the University of California. Of course, Bob Ball is still in Washington and still very active on Social Security issues. Bob was in the Social Security Administration from 1939 until he retired in the mid 1970's, except for a period of time towards the end of the World War II or right after the Second World War, when he was involved in a non-government program, training people from the states on social welfare issues, Social Security, workers comp[ensation] and that sort of thing. He was very much associated with Wilbur before Wilbur left the Social Security Administration, maybe in the mid-1950s. After Eisenhower came in, Wilbur, who had been head of research and statistics and legislation in Social Security, was not given much to do. As a result, he decided to leave the government and went to the University of Michigan. Wilbur approached the issue of medical care from a social welfare perspective. Social work, you might say, was his background; his natural affinity was with social work and with Social Security. I'm not sure who the Surgeon General would have been in the early 1950s.

Dr. Mullan: Leonard Scheele. Scheele, Burney, then Terry.

Dr. Lee: Yes. It would have been in the polio days.

Dr. Mullan: Did you ever hear from Wilbur tales about this?

Dr. Lee: Oh, yes, the frustrations of the Public Health Service. Sure.

Dr. Mullan: How was that characterized?

Dr. Lee: He just felt that they were not interested. He did express frustration. He was very happy with Bill Stewart and with John Cashman, because as far as he was concerned, they were the first people in the Public Health Service to really be concerned about medical care and really wanted to have the Public Health Service link with Social Security. Another example of that is when Wilbur and John Gardner established the Medicaid program in the Welfare Administration after it was enacted (with Medicare in 1965). That's when I came in the picture, after Medicare and Medicaid were enacted in 1965. A general practitioner from outside the government, an AMA oriented GP, was recruited to run the Medicaid program. But there was relatively little link between the Medicaid program and the Public Health Service. There was much more linkage between Social Security and Art Hess, with John Cashman and Bill Stewart.

An example of what Bill did was in the civil rights area which was, to me, very, very important. In 1965, after Bill was appointed Surgeon General, and, I guess I'd been appointed Assistant Secretary for Health and Scientific Affairs which was a staff position to the Secretary, he organized the effort to desegregate the hospitals.

Dr. Mullan: Why don't you pick that part of your biography up? I interrupted you.

[End Tape I, Side 1. Begin Tape I, Side 2]

Dr. Lee: When Wilbur called me in May of 1965 and asked would I come to work in HEW for a year to help them implement the Medicare program, I was planning to return to the Palo Alto Clinic. Following Wilbur's call, I called the people at the Palo Alto Clinic and said, "Could I have an additional year's leave of absence, because Wilbur has called me and asked me to come over and help with the Medicare program?" They agreed to the extra of the leave of absence. I accepted Wilbur's offer. I said I would come to work after the first of July, 1965. I did want to take some summer vacation, because I had not had much in the previous couple of years.

So we went back to California in the summer of 1965, and that summer I happened to go to the Bohemian Grove as a guest of a friend of mine, Ed Janss. I met John Gardner there. The Bohemian Grove is in northern California, and The Bohemian Club is a club in San Francisco, California but it includes members from throughout the country. There is a Professor Domhoff, at U.C. Santa Cruz, who has written a book, Who Rules America? about The Bohemian Club and its role in American society. The Bohemian Club is one of the places where the power brokers meet every summer. The club is mainly a club in San Francisco of business people, professional people, and entertainers, but it has among its national members people like former President Nixon, former President Hoover, mostly Republicans, and they invite people like Kissinger or various high government officials to their annual summer encampment at the grove. It's three weekends. People can stay up there for a couple of weeks, but there are three weekends in which they have entertainment. People stay in separate camps, so there might be 30 people in a camp, and it's roughing it, but not too rough, but with excellent meals and a lot of social exchange.

I met John up there. He had known my dad from the 1930s. Again, all this old-boy network stuff keeps coming back. Of course, he knew Howard Rusk, because John had been president of the Carnegie Corporation in New York. So we had some long talks and some very interesting discussions which were later to prove to be very important.

When I got to the Department of HEW in August as a Deputy Assistant Secretary for Health, Ed Dempsey was the Special Assistant to the Secretary, and he was the heir apparent for the position of Assistant Secretary for Health. Congress was in the process of upgrading the position of Special Assistant to Assistant Secretary. They called me a Deputy Assistant Secretary because that was sort of a nondescript sort of job. About that same time, Bill was appointed Surgeon General.

The first job I was given was to develop family planning policies for the Department, and the second was to organize on very, very short notice the White House Conference on Health to be held in the fall of 1965. There had been a highly successful White House Conference on

Education which John Gardner had chaired, and the planning for that had taken about a year. We were asked to put together the planning for the White House Conference on Health starting in August. We brought in Peter Bing, who was a special assistant to Jerry Weisner in the White House; Rob Fordham, whom I had known in AID and who was then in the Public Health Service, and very, very good on management issues; and Ed O'Rourke to help us work on the conference. It was the kind of ad hoc tasks that I was assigned, because I had a secretary and a couple of people working for me at that time. It was not a large office and we had to pull groups of people together to move these things forward.

In the fall of 1965--this gets to the Public Health Service and Bill Stewart's role in desegregating the hospitals--the Civil Rights Act of 1964 had to be applied to the Medicare program. The desegregation of the schools, as everybody knew, was an extraordinary contentious issue, had not been particularly successful, John Gardner brought Bill Stewart, myself, Wilbur Cohen, and Bob Ball into his office one day, one of the few times I've ever seen him really angry. He just felt that we were not moving ahead rapidly, that there needed to be a desegregation of the hospitals in order for the Medicare program to be implemented, in order for the elderly to have real access to mainstream medical care, because if a hospital wasn't desegregated, he said they weren't going to be eligible for Medicare.

Dr. Mullan: When would this have been?

Dr. Lee: This was in November of 1965, maybe December.

Dr. Mullan: When was Medicare slotted for operation?

Dr. Lee: July 1, 1966. It was passed in about May, and the organization and mobilization began very, very shortly thereafter. It was signed, actually, in July by President Johnson at the Truman Library, so it was probably enacted in June. The planning for all of it started in August. The meeting with the Secretary might have even been in October, but it was sometime fairly early in the fall.

Bill brought together, out of various parts of the Public Health Service, a team of people that began to inspect hospitals mainly in the South. Bill appointed a director of an office to coordinate the effort. I forget the name of the guy, but you should ask Bill who ran that project. Bill had to do it with no funding. There was no authorization of any money, so he had to bring people from various parts of the Public Health Service, had to borrow people, if you will, and assign them to this task which was basically a Medicare-related task. Bill and his deputy, Leo Gehrig, played an active role.

Dr. Mullan: Just a handful?

Dr. Lee: It was more than a handful of people that he eventually was using, because there were probably 7,000 hospitals in the country, and probably 2,000 of them that would not comply with the Civil Rights Act at that point, including, if I remember correctly, the Latter Day Saints Hospital in Salt Lake City. The President of the American Hospital Association was at that time President of the Latter Day Saints Hospital. There was also, if I remember, either a hospital or a

nursing home in Johnson City, Texas. That was not so much a civil rights issue as it was a staffing issue, but that was another little problem that had to be solved. Bill did an outstanding job in this area. I was involved with some of the site visits, Atlanta particularly. There were key places. If you achieved desegregation in certain cities, like Memphis, New Orleans, and Atlanta, the others, we felt, would come along. But people stonewalled on that, even though we had done all the leg work that had to be done and communicated very clearly to the people what they had to do to achieve compliance with the Medicare regulations; but a lot of hospitals were not moving. So President Johnson convened a conference of hospital and medical leaders. This would have been in June of 1966. Here you've got a Southern President with a Southern special assistant, Cater, and, of course, John Gardner, who had been communicating regularly with the White House during that period, as had Wilbur, obviously. Bob Ball and Art Hess had so many other problems to handle. This was one that was really delegated in a sense to the Public Health Service. When President Johnson met with the state hospital association directors, leaders of the American Hospital Association, and various physician leaders, he made it crystal clear that there was going to be no compromise on the issue of hospital desegregation.

Dr. Mullan: There were hospital leaders and medical leaders, as well as PHS and HEW?

Dr. Lee: The people who came to the meeting were largely hospital directors--state hospital associations, Western Hospital Association, American Hospital Association, plus AMA, and state medical society leaders. President Johnson made it crystal clear to them that there would be no compromise on that issue. Once they finally appreciated that they weren't going to get paid if they didn't desegregate their hospitals, desegregation happened very, very quickly.

I think that Bill deserves a tremendous amount of credit for that. He got a tremendous amount of heat, but there were also people, like Senator Hill who were very restrained. Senator Hill chaired the HEW/Labor Appropriations Committee, as well as the authorizing committee, but he did not really prevent the PHS from its task of desegregating the hospitals. He could have cut off the funds to the Public Health Service. There were various other things he could have done that would have made it extremely difficult. But he was a person of tremendous integrity and he did not run again after that.

Another area where Bill provided very strong leadership for the Public Health Service was working with Social Security on the quality aspects of the Medicare program. There John Cashman was the lead person. Bev Myers, I think, was also involved in that. John later became Health Commissioner of Ohio, and I'm not sure what he's doing now, but he would be a person to talk to about that. Art Hess would be another one to talk to about how the Social Security Administration related to the Public Health Service and how responsive they were in this area.

Bill had to mobilize people again in an area where there had not been a lot of previous leadership in the Public Health Service. One of the knowledgeable people was Carruth Wagner who was Chief of the Bureau of Indian Health Service. Leo Gehrig had headed that up, then Leo became Bill's Deputy Surgeon General. So Bill pulled people into the top ranks of the Public Health Service who were out of the medical care side of the Public Health Service. Many of the leaders in the Public Health Service had, in fact, come out of the Public Health hospital system and gone into various other positions.

Dr. Mullan: Which meant that they were sensitive to medical care or not?

Dr. Lee: Yes, I think so, but prior to Bill's time, they were not anxious to get into issues that related to financing, quality of care, those things that were considered to be private sector responsibilities.

Dr. Mullan: Could the placement and management of Medicare and Medicaid at the federal level have developed differently? Is there a scenario that one could envision where the Public Health Service would have been central, rather than peripheral, to those programs, as opposed to the Social Security Administration, which remains central to them?

Dr. Lee: With Wilbur and Bob Ball being the central people in developing the legislation, shepherding it through the Congress, it's inconceivable to me that they would have turned the administration over to the Public Health Service, which had been not participating at all for a period from the Wagner-Murray-Dingell Bill in 1946 to 1965. For 20 years the Public Health Service had not been involved. Wilbur and Bob had been involved almost for that whole period.

Dr. Mullan: Your comment of the Wagner-Murray-Dingell Bill hits an area that I'm interested in and have had trouble understanding. The Public Health Service's role seems to have been somewhat ambiguous in regard to that. Parran is characterized to me by some as central to the Truman Administration lobbying efforts for it. To others, the PHS and Parran were seen as ambivalent because they were so beholden to organized medicine or to their fellow physicians. As you observed that or heard that described, how would you characterize it?

Dr. Lee: What I would do is talk to a few people like Lester Breslow. Lester was a Public Health type who was very strongly interested in medical care. He was also very much involved, at least by the 1950s, in public health issues at a national level. I was just a young doctor at that time, just getting out of medical school, not paying much attention to that sort of thing. But I would say somebody like Les, who would still have a lot of good recall, from the outside might be able to give good insight. Bob Ball is another person.

Dr. Mullan: The history as you've heard it or inculcated it was the Public Health Service had not been aggressively behind . . . ?

Dr. Lee: Parran was a great Surgeon General. The area where I knew most about him, because my dad was involved in the campaigns in the Thirties, was against venereal disease. It was in that area that he was a towering figure. I understood that he was highly regarded in the Truman period, but I just don't know from any direct knowledge. I know that my conversations with Wilbur would suggest that the Public Health Service really was not involved in medical care issues in a major way, so that I couldn't imagine the PHS being involved in a direct-line administrative way in the Medicare program. By contrast, the Social Security Administration was organized to serve the elderly, it collected the money, it paid beneficiaries checks, so it was relating to every elderly person in the country who was a Social Security beneficiary and who would be eligible for the Medicare program. It was natural for the Social Security Administration to take on that responsibility centrally and through its regional offices. I think one of the things that's been lost with the organization of the Health Care Financing Administration in the Carter

Administration was that network of Social Security offices that served the beneficiaries. They are not, as far as I know, doing it in the same way anymore. So that beneficiaries who had problems with Medicare in the early days had a place they could go. It was the place they went with their Social Security questions.

Dr. Mullan: One thing the Public Health Service did well and did a lot of was relationships with state health departments and with states, certainly following the Social Security Act and the development of programs out of that. There was a rich network of relations. Certainly by the 1960s, those set of relationships had become somewhat less vibrant. As one looks at health policy and health legislation development, the new programs and policies seem to circumvent those relationships. As you came to know the Public Health Service and worked in and around it, did you have observations about that? Was that an antiquated system, or was it still an effective system? What has happened to it over the years?

Dr. Lee: I would say that during the time I was in HEW, there were sort of two phases to that. One was the period from 1965 to 1968, when I served as staff to the Secretary and then the second was from early 1968 until I left the government in February 1969, when I had line authority over the Public Health Service. Bill Stewart became my deputy for operations. This was a very functional relationship and I have a somewhat different notion about how the Public Health Service and the assistant secretary's office should relate to each other than have subsequent assistant secretaries. But there were a couple of things about that. I think it was felt that it was a very different time. As you think about the 1980s, it's almost inconceivable for people now in policy making roles in public health in the federal government, except with respect to the AIDS epidemic, to think of a time when there were, every year, additional resources available for programs.

Every year we had a task force on health legislation which Secretary Gardner chaired in name--but I was, in fact, the chairman. From 1965 to 1969, we were proposing new legislation every year, expanded programs every year. I can remember Ralph Hewitt, who was the Assistant Secretary for Legislation, who worked for the President when he was in the Senate, telling us and the President telling us directly that we should work to get as much legislation passed as we could, because soon Congress was going to turn against the idea of continued expansion of programs. There continued to be new legislation from 1963, when Johnson assumed the Presidency, until 1967.

Dr. Mullan: It was that honeymoon period.

Dr. Lee: The honeymoon was really 1965 to 1967. It was during the two-year term of the 89th Congress, which enacted more health legislation than all the previous Congresses put together. It was an extraordinary Congress. In the 1964 campaign President Johnson made Medicare a major campaign issue, so that when he got elected by a landslide he brought with him over 70 new, mostly liberal, Congressmen. As a result, he was able to get Wilbur Mills, who was chairman of the Ways and Means Committee, who had bottled Medicare up before 1965. Things moved very, very quickly after January 1965, not only on that legislation, but on a number of other areas. Things had been moving, really, since 1963 on public health legislation--health manpower legislation starting in 1963 with major new environmental laws enacted before 1964, as well.

It came to an end in 1967 when the first bill that the President wanted didn't pass Congress. This was not one that was high on his priority list, but it was one that was high on my priority, was the International Health Act. That would have authorized the Public Health Service to assign people overseas. They were able to assign doctors to the Peace Corps as the doctors taking care of Peace Corps volunteers, because they were taking care of Americans overseas. But we wanted them to be assigned to provide technical assistance to Third World countries. The chairman of the Rules Committee was an elderly congressman from Virginia, who said, "If I can't get a doctor in my district, I'm not about to let the U.S. Government send doctors overseas." His language was a little more earthy. That was the period of time when we thought we had a physician shortage in the United States. That was the end. After that, Congress began to not enact these bills that the President was putting forward. We saw increasing resistance.

After the 1968 election, of course, things were dramatically changed, but even after the election of 1966 things began to change. The reason we got the change in Congress in 1967 was that in the 1966 election, there was a swing back. Many of the people who had been elected in 1964 did not get re-elected, many of the freshmen Democrats, the more liberal ones, and as a result, there was this congressional resistance that began in early 1967. We experienced that with the International Health Act.

Dr. Mullan: You were going to make a comment about state relations.

Dr. Lee: The state of state relations. Several things. The climate of Federal-State relations changed significantly in the 1960's because of much more aggressive federal leadership. We were proposing all kinds of solutions to problems that the states were not dealing with effectively. We would have task forces, we would meet with people, get people together on issues like infant mortality and come up with proposals. The Children's Bureau, we felt, was ossified in some ways. There was some good medical leadership under Art Lesser, but there was very little connection between the Children's Bureau and the Public Health Service, which we couldn't understand, dealing with problems like maternal and child health. Why shouldn't all that be in the Public Health Service? One answer was because of the slow movement in the Public Health Service. For example, family planning, when we started out to develop family planning policies in 1965, I was not in favor of a categorical program. I said we should do it with existing authorities. We had plenty of authority within existing laws to provide family planning support through the Public Health Service. Nothing happened, or very, very little happened. By contrast, the Office of Economic Opportunity (OEO) got categorical money for family planning and went charging ahead with funding Planned Parenthood clinics all over the country. OEO was seen as innovative and progressive while the PHS was doing little. OEO also started the neighborhood health centers. Why didn't the Public Health Service start neighborhood health centers? Why didn't the Public Health Service get into family planning? There was a lot of traditional resistance. Family planning was very controversial. Neighborhood health centers--that was medical care that would compete with, you might say, civilian doctors.

When it came to things like VD grants or the traditional things, the Hill-Burton program was very, very successful, but that was federal grants to the states for planning, and then grants to the communities for non-profit hospitals. It did revitalize the hospital system in the United States, with very, very strong support from Congress. In the Hill-Burton Program, the PHS was putting

money into practically every single congressional district eventually. So it was bound to be a very popular program with Congress.

There were some other areas that I think Bill got frustrated about. There were too many categorical programs. So in 1966, in the Comprehensive Health Planning legislation, he proposed a section--I think it was 314--to provide both a block grant and project grants that were not categorical, that would permit the state or local health departments to use the funds to meet needs as they saw appropriate. This was the precursor of what later became known as block grants, but that was basically Bill's idea in 1965. Unfortunately, at the same time, of course, you had the commission . . .

[End Tape I, Side 2. Begin Tape II, Side l]

Dr. Lee: The Commission on Heart Disease, Cancer, and Stroke, chaired by Michael Debakey, with strong outside support from Mary Lasker, which got substantially modified in Congress, to become the Regional Medical Program. Again, the AMA exerted a great deal of influence in changing the character of that program. In 1966, there were two (Comprehensive Health Planning and Regional Medical Programs) conflicting programs enacted at the time. Regional Medical Programs, which was planning, but it was categorical planning, and it was more money than the Comprehensive Health Planning legislation which had been Bill's idea, which proved to be a much more durable concept. Then you had things like the old Hill-Burton program and you had some of the older categorical programs.

The epitome of the categorical programs was reached in the sixties when there was a big furor about rats in the urban areas and a lot of congressional attention around that. As a matter of fact, we had a categorical program for rat control enacted so Congressmen could say they were doing something about this problem. There was a terrible problem in many of the urban areas. One of the things that Mike Gorman told me--this had to do with family planning--he said, "unless you have a categorical program, you're not going to get anywhere." And he was very much in favor of regional medical programs. He thought that was the way to do things. You're not going to get local government to act unless you do it categorically.

Dr. Mullan: Categorical in terms of . . .

Dr. Lee: It would be family planning, tuberculosis, a specific . . .

Dr. Mullan: Specific entities, a condition with specific grants to specific states.

Dr. Lee: Right, or localities or non-profit organizations. Basically, the federal government saying, "If you do these things, you get the money, if you do family planning; if you have a children and youth project; or if you have a program for high-risk mothers and infants," so-called M & I programs in the Children's Bureau. Those programs, many of them, were very effective in achieving their goal, their narrow goal, but they often didn't contribute to the overall solution of the health problems at the local level. You had multiple categorical programs so that a local health director, for example, had to orchestrate a lot of grants coming from the federal government, rather than deciding what was appropriate at that level.

Dr. Mullan: Partnership for Health, which was a 314 program, was both categorical and block?

Dr. Lee: It was the old categorical grants. It was the old Public Health Service grant which was originally not a categorical grant. There was an original grant in the Social Security Act in 1935, which gave grants for general public health for the states and also gave grants for VD. Then later, TB was added, then later a bunch of other categories. Bill consolidated a number of those categories into what we later called block grants, but gave this unrestricted money that they had to come in with a plan, and they had to have some things they were going to do with it.

Dr. Mullan: Categorical in the sense that it was targeted to a locality, but it was not categorical in terms of what it offered.

Dr. Lee: That's right.

Dr. Mullan: It offered a comprehensive package of money for them.

Dr. Lee: To do planning and to have services that met their need, as opposed to a federally designated need.

Dr. Mullan: The Comprehensive Health Planning was part of that 314 legislation.

Dr. Lee: Right. Part of the reason that wasn't popular was because it didn't let Congress decide; it let the communities decide. Congress, at that time, very much wanted to decide, even to the point of rat control programs and various other specific categorical programs. Heart disease, cancer, and stroke (the Regional Medical Program) was an example of the categorical approach.

Several other areas during that time that were important in the Public Health Service, obviously Jim Shannon's leadership at NIH, which at the end of that period, Jim retired and Bob Marston was selected as the Director. That was in 1968. Bob had directed the Regional Medical Programs. That marked the end of the Shannon era, which was the period of the most rapid growth of NIH, the consolidation of NIH leadership as the preeminent biomedical research institution in the world, including the intramural programs. People at NIH, as well as NIH grantees, were beginning to get Nobel Prizes. The extramural programs had clearly made a major contribution in building a research infrastructure around the country.

The National Institute of Mental Health, which was a very different kind of organization, combining services with research, was much weaker on the research side, although the intramural program at NIMH was quite a good program. The extramural program was not nearly as strong. NIMH was, of all the units within the Public Health Service, I would say the most overtly political, related more to the external community than it did within the Public Health Service. NIH, of course, did that very well, also, I think more effectively than NIMH. Stan Yallis was the Director of NIMH during that period.

Dr. Mullan: He was effective in relating?

Dr. Lee: I would say Jim did it more effectively. He was really brilliant at the political end. He was working with Fogarty and Senator Hill, both of whom were great supporters of NIH. He had Mary Lasker and Florence Mahoney lobby, helping him and mobilizing scientists and public opinion.

Dr. Mullan: But NIMH was more overtly political?

Dr. Lee: I would say that NIH was more effective politically. NIMH was more overtly, in some ways, political, working with their outside constituencies. But it wasn't as popular with Congress partly because services weren't as popular, they cost more money, they were more difficult, you couldn't talk about breakthroughs every year, and there weren't as many breakthroughs in the mental health research as there were in other areas of biomedical research.

Environmental health was another area. As a matter of fact, when I got to HEW, they had just moved water pollution to the Interior Department. I believe his name was James Quigley. He was in the Department and negotiated with the Interior Department and Congress.

Dr. Mullan: It was established as a separate administration within HEW and then a clean move to Interior.

Dr. Lee: Air pollution and water pollution control was moved to Interior, while solid waste and radiation safety remained in HEW. In my period, I would say one of the biggest failures of the Public Health Service in what should have been their responsibility was in auto and highway safety, what was then called accident prevention. We really should have called in injury prevention. Ralph Nader's book, Unsafe at Any Speed, resulted in a major legislative initiative which was done largely with a task force not from the Public Health Service, so when that legislation was enacted, it didn't include the Public Health Service. We did not play a major role in injury prevention, which became highway safety and auto safety, and it was in the Department of Transportation.

Dr. Mullan: Why was that? Was that failure of vision on the part of people in the Public Health Service?

Dr. Lee: There were some very inadequate people in the Public Health Service. The most embarrassing testimony I ever had was when I had to testify with people from the Public Health Service on accident prevention.

Dr. Mullan: This was auto accident we're talking about?

Dr. Lee: We're talking about injury prevention in general--burns, auto, various other things. There was just not strong leadership. Bill was doing a number of things, but that was just one area that in the time that was available, this thing came along while he was being appointed Surgeon General, Ralph Nader's book was out, this legislation was in the works, and there wasn't any opportunity for him to exert leadership. The thing had been moved. The Department of Transportation was a newly created department. I think the President wanted to give the new department some things that they had to do. Bill Haddon was the person who was put in charge

of auto and highway safety in DOT. He was at that point, one of a handful of M.D. experts in the area of injury prevention. At a conceptual level he made major contributions. He was not impressed with the people in the Public Health Service, so that in a sense, he was using his own people, as well. We attempted to make some relationships with them. We did, but that was something that belonged in the Public Health Service. It was lost because there had not been strong leadership in the PHS. I think the leadership in the Public Health Service had been more on infectious disease, CDC type of things. The Hill-Burton program was non-controversial.

Dr. Mullan: The engineers were prominent in what became environmental health because of their relationship to water pollution.

Dr. Lee: Absolutely. The M.D.'s played a very, very limited role.

Dr. Mullan: There was, I think, great bitterness within the Public Health Service about the departure of water pollution and efforts to maintain activities in the Public Health Service. Was that anything that you were involved in?

Dr. Lee: Of course, we were involved mainly in getting legislation enacted. Bill's job was to organize it. He had the management job because until 1968, he was reporting directly to the secretary and had the managerial tasks of taking this tremendous amount of legislation and translating it into organization, in an organization that was working. Bill made another very important contribution and one that was tragic that it was not sustained. That was the establishment of the Global Community Health Fellowship Program. I don't know if you were one of those fellows at any time, Fitz, but you would be qualified. Some of the major leaders in public health today, people like Steve Joseph, for example, the Health Commissioner of New York City, Merv Silverman, who was Health Director in San Francisco, who is one of the world's authorities on AIDS in public health, people like that were selected by a very good review process. Bill wanted to duplicate in community health what the Epidemiologic Intelligence Service had done in epidemiology, and recruit good people. There were a tremendous number of really talented people interested in community health and health services. People like Steve Joseph, Steve was recruited from the Peace Corps, was then sent to school to get an M.P.H. in International Health at [Johns] Hopkins, then actually came to work in my office in 1968, then went to the poverty program, later AID, and later he ended up as Health Commissioner of New York City. Again, there were a number of those people. It would be interesting to get a list of those former fellows and see where they are today. I think if there's one thing that ought to be reinstituted in the Public Health Service, if I could do one thing, I would probably do that.

Bill reorganized the Public Health Service in order to handle a tremendous amount of legislative change and a lot of new authority for the Public Health Service during that period of time. Whenever you reorganize, you don't make any friends; you simply create enemies, I think. There was a lot of resistance to those changes. It was in 1967 that John Gardner decided that he would put the assistant secretary over the Public Health Service. In other words, you'd have a direct-line relationship. That, in fact, happened in early 1968, if I remember correctly.

Dr. Mullan: What went into that thinking?

Dr. Lee: I think that John felt that the Public Health Service was not sufficiently responsive. Because I wasn't encumbered with a lot of organizational and management responsibilities, he could turn to my office and we did a lot of things and produced things for him. I was able to recruit some very, very good people from the Public Health Service, some of them like Leon Jacobs, who was Deputy for Science, and Leon handled some very, very tough issues for us. As a matter of fact, I think Jim Shannon got a lot of respect for me when I told him that the person he'd originally assigned in response to my request wasn't strong enough in science to deal with the issues effectively. He was, however, a very, very good guy, David Levitt. We put Dave in charge of population, where he did a very good job. But on science issues, where it really meant understanding basic research, I was able to get Leon Jacobs. Again, a very good friend of mine from the Palo Alto Clinic who had worked with me, suggested that I should try to get Leon because he was so smart and so tough, and he was. Milton Silverman, who had come to work for me from California, handled the task force on prescription drugs, which most of the recommendations we made in 1968, with the catastrophic health insurance legislation just enacted by Congress, the final recommendations had now been implemented. George Silver was my deputy in the medical care area and a very, very brilliant guy and very energetic, so John Gardner saw this energy and innovation coming out of the assistant secretary's office, and he didn't see that coming out of the Public Health Service. He saw a lot of inertia. I've ticked off for you several areas where Bill has made major contributions.

Dr. Mullan: There have been suggestions by Bill and others, Rufus Miles' book being another, that it was Secretary Gardner's sense that HEW had never really come together as a department, that it was a series of fiefdoms, a derivative of the antecedent organizations, and that in order to really capture it from a management and political perspective, he had to break those up. The Public Health Service was perhaps the most . . .

Dr. Lee: Oh, yes.

Dr. Mullan: Share with me what the feeling was on that. Was it words like "old guard" or "unresponsive?"

Dr. Lee: Absolutely. And "fiefdom." Those were all words that I've heard used. John Gardner was very impatient to get things. He was a great believer in self-renewal at the individual level and at the institutional level. I think he believed that reorganization was one way you achieved that. I think he didn't see that coming out of the reorganization that Bill had created. He saw the same old people, in a sense, still in charge, except with Bill at the top. He also saw Jim Goddard moving from CDC to FDA, creating very dynamic organization out of a dead organization. Of course, Jim made a few mistakes later, but he really turned the FDA around in terms of the public's perception of it as a consumer oriented organization.

Dr. Mullan: Had he been a PHS-er?

Dr. Lee: He had been head of CDC.

Dr. Mullan: Coming up through the ranks?

Dr. Lee: Coming up through the ranks. He took a public health approach to drug regulation. He brought in epidemiologists, people like Herb Ley, who really understood some of the problems that they were up against. He organized the National Academy of Sciences review of the pre 1963 drugs that had to be done as a result of the Food, Drug, and Cosmetic Act amendment of 1962 and he did some very innovative things. John saw that kind of dynamic leadership in FDA. Bill was not an extrovert in that sense. Jim Goddard liked to wear his uniform, liked to get publicity, was very outspoken, but at the same time, I've been with Jim when he was laid out flat on my couch in my office with a migraine headache before he had to go up and testify. So there were a lot of inner tensions there, as well.

Dr. Mullan: In moving to reorganize and reconstitute the Public Health Service, the commissioned corps, obviously, was in for some changes potentially. What were the feelings about the benefits or detriments that it represented as a personnel system? I've read that there was thinking about establishing a health service corps different than the National Health Service Corps, but a different personnel system for a newly reconstituted Public Health Service. What thinking went into that?

Dr. Lee: Don Simpson developed that. Don had been in the Public Health Service, but was then the Assistant Secretary for Administration, which handled personnel at the department level. He must have spent a year or more developing this new personnel system, which did not see the light of day. It never was accepted. I forget whether it was at the OMB level, the Bureau of the Budget level, or the Civil Service Commission level, where John Macy was the director, a very outstanding leader of Civil Service, or in Congress. Don could give you the details on that. I was not as involved in any of that. Bill certainly was involved in that.

There are some people in the Public Health Service, commissioned officers, who felt that George Silver and I "destroyed" the Public Health Service because of the reorganization and in other changes we initiated. They felt that we were the enemy. We were both medical care types, very strongly oriented to an activist role for the government in medical care. While I don't feel that we "destroyed" the PHS, or anything approaching that, nonetheless, that was the perception of some of the well-established people in the Public Health Service, some of them senior people, some of them younger people. So there was a lot of resistance when that realignment took place and my office was put in charge of the Public Health Service. We then had some further reorganization. In doing that, I appointed two blacks as assistant surgeon generals, and that was something that was unheard of in the Public Health Service prior to that time.

Dr. Mullan: Who were they?

Dr. Lee: Ed Cross was one of them. He was Assistant Surgeon General, and he was directly in my office. He basically took George Silver's place when George went to the Urban Coalition with John Gardner. The other was C.C. Johnson, who was an engineer. C.C. we put in charge of Consumer Protection and Environmental Protection Health Organization. We put FDA within that, and I think, in retrospect, that was a mistake. We should have had FDA still as a separate entity because it really needed to report directly to the assistant secretary, not through somebody, because the issues were such that even when we did that, I still was seeing the commissioner. So there were some mistakes we made and that was one of them.

Dr. Mullan: With the reorganization, on one hand, the decision to downgrade the role of the personnel system with the Surgeon General at the head of it, but at the same time there was a decision to keep at least the name and, to some degree, the tradition of the Public Health Service. What went into that?

Dr. Lee: My feeling was that the Surgeon General should be always the senior professional person in the Department and Public Health, and that should be a person from within the Public Health Service.

Dr. Mullan: A career person.

Dr. Lee: A career person. The assistant secretary should be a political appointment. The Assistant Secretary could be a physician, or a non-physician. The Surgeon General should always be a physician. Maybe some people now would say it could be a nurse or it could be a dentist, but my view was that it had to be a physician, and I still feel that way. That office has gone through a series of subsequent changes, and I think each assistant secretary had a different view of the role of the Public Health Service. Nobody quite had the same notion that I had when we did the reorganization. So you obviously have to speak to each of the assistant secretaries to get what was their view about the role of the Public Health Service. Certainly when Julius Richmond came in and combined the two jobs, he did that for particular reasons. I don't myself feel that's the way to do it, because I think that makes, in a sense, a more political appointment, although the Surgeon General is always a political appointment because it's a presidential appointment. I think that something that's happened, particularly with Nixon and then subsequently, with Nixon and more with Reagan, was the politicization of senior-level positions within the Public Health Service. When they made the Cancer Institute director, for example, with the war on cancer, independent, really, of the Director of NIH, I was one of the few people against the war on cancer. I can remember that Senator Nelson was the only person in the Senate to vote against it. When I went to see Senator Cranston to say that he should oppose it, he said he had 6,000 letters from constituents in California telling him he should support it. But to me, it was a mistaken piece of legislation. It created an anomalous organization. Then every subsequent institute director wanted that kind of autonomy. It didn't mean anything in some ways, I mean, a report to the President through this council or advisory committee. I think that we should have strengthened the role of the director of NIH, and we should still give more authority to the Director of NIH, rather than having kind of the chairman of the board, which is what the NIH director is now. As the Institute has gotten larger and more powerful and bigger constituencies, it's become more difficult to have coherent planning at the NIH level.

Dr. Mullan: You were talking about the political appointments at the top and then down into ranks.

Dr. Lee: You had Nixon and this guy Fred Malek. I think during that period of time they looked for positions where they could put people who were ideologically sympathetic and made political appointments, in my view, of the Director of NIH, and in other fairly senior-level positions. When DHHS was created, the senior appointments in the PHS should have all been professional appointments, they should have all been within the departments strictly, they should have been made by the assistant secretary with the approval of the secretary. In fact, the assistant secretary

should be an under secretary of HHS. He/she should be a political appointment, a presidential appointment. The Surgeon General should be a presidential appointment.

Dr. Mullan: You think the Surgeon General today should be a presidential appointment?

Dr. Lee: I do.

Dr. Mullan: But of a career officer?

Dr. Lee: And a term appointment. In other words, it shouldn't necessarily coincide with the President and it should not relate to partisan politics. In a sense, Julie Richmond politicized the job, although I happen to agree with his politics, and for him it worked to do both jobs.

Dr. Mullan: In bringing in and being a politically appointed leader of the Public Health Service, there are those who argue that politicized the Public Health, so that opened the door so that other political appointments on lower levels followed naturally from it. I don't think that's necessarily the case, but on the one hand, that argument is made. On the other hand, it is said that by politicizing the upper ranks, you make the Public Health Service more a part of the administration, whatever the administration, and therefore more liable to be effective. That, of course, is an argument on the state level and city level everywhere you go, the management of public health. What do you feel about how it has developed? Do you feel that making political of the chief health officer is a beneficial outcome?

Dr. Lee: I see a difference between the assistant secretary, political. I see the Surgeon General presidential appointment, but picked for professional reasons. When I was picked as assistant secretary, I wasn't asked whether I was a Democrat or Republican. I wasn't asked what my politics were when I was interviewed at the White House, when I was interviewed by John Macy of the Civil Service Commission. So even then, even though you had people in the White House who were extremely political in Johnson's period, they didn't perceive this job as that type of political job. They wanted a professional person who was competent, intelligent, energetic, and could do the job, and who had the full support of the secretary.

[End Tape II, Side 1. Begin Tape II, Side 2]

Dr. Lee: I think when you have a Surgeon General appointed by the President, for example, when Luther Terry was appointed, Senator Hill was the one who recommended him to President Kennedy. That's got to be a political appointment. He was the Clinical Director of the Heart Institute at the time. I don't think he was even Director of the Heart Institute when he was picked as Surgeon General. When John Gardner picked Bill Stewart, Bill was Director, I think, of the Heart Institute, but was highly regarded professionally. I don't know whether he's a Democrat or Republican; I still don't know. He was never asked, as far as I know, what his politics were. He was picked as a professional person, but he was appointed by the President. Same thing when Jim Goddard was appointed as FDA commissioner; ideology was not considered. I think it's been that that has concerned me, and I think that's been more true in the Reagan years. It was certainly true in the Nixon years, as well. I think when Julie Richmond was the Surgeon General, he was looking for professional people; he was not looking for political people. I think with Joe Califano

as secretary, I think one of the reasons that Chris Fordham didn't take the job as assistant secretary was that he felt it was going to be too political, and I think Joe was more partisan politically. Part of that depends on the secretary's style, as well. The evolution of the Public Health Service, the major things, one of those events was the war on cancer with the Nixon Administration. I think that was a negative. People say it created all this money for basic research and we wouldn't have gotten the money. It's the same categorical people who say you've got to get categorical programs or you're not going to get money. Look how much benefit we got in basic research. Nobody said it's really done a whole lot for cancer, but it's helped basic research. That's not being very honest with the public, it seems to me, if that's the way we're going to approach it. Another major event has been the AIDS epidemic since 1981. Despite Reagan Administration policies, the leadership of Surgeon General Koop has been outstanding. I think that the constraints that have been placed upon the Public Health Service by OMB, first on personnel, then on budget, where you had to use people who were in other programs to deal with the AIDS epidemic has really precluded the kind of response that we should have had. I think Admiral [James] Watkins, in his report, particularly that section of the President's Commission's Report that was not adopted by the full commission, hits the nail on the head. Admiral Watkins described the problem in quite a bit of detail and recommended that the epidemic be designated as a public health emergency by the President, and that the Surgeon General be given very explicit government wide powers as a separate office, and that the Deputy Surgeon General assume the operating responsibilities of the Surgeon General. That the Surgeon General have this special policy coordinating role is, I think, a very appropriate recommendation. I would strongly urge that that be done, whether it's Koop, or whoever, is the Surgeon General. We should have somebody capable of providing that kind of national leadership. Then Admiral Watkins called for the appointment of an advisory committee within 30 days, and within 60 days the development of a national plan--which we don't have. I think the other question currently, the big unanswered question which was the one unanswered question in 1963 to 1965, even after Medicare, is the question of national health insurance. What should be the role of the assistant secretary, or should it be an under secretary in health care financing. Should the Health Care Financing Administration report to an under secretary for health?

Dr. Mullan: You actually had a plan in the works which you would have been under secretary.

Dr. Lee: That's correct. That was blocked by the mental health establishment. That's my understanding.

Dr. Mullan: Blocked at the legislative level?

Dr. Lee: Yes.

Dr. Mullan: It was part of a piece of legislation. In order to reorganize the department at that level, you needed . . . ?

Dr. Lee: No. We could reorganize. We had the authority to reorganize, but Wilbur felt there should be an Under Secretary for Health, and was going to get a position added to the appropriations bill, without any hearings, without any debates. He had talked to Senator Hill, and the thing was going to move through. Then the mental health people, who felt that I wasn't as

sympathetic as I should be to NIMH, mobilized their lobbying operations, I think including Mary Lasker, although I don't know that for a fact. The thing just got killed. It was raised behind the scenes and it was killed behind the scenes. I was never directly involved in any of those negotiations.

Dr. Mullan: In that conceptualization, would Medicare- Medicaid have been brought in?

Dr. Lee: Not at that point.

Dr. Mullan: It would have remained in Social Security?

Dr. Lee: Right. But now with the Health Care Financing Administration, you basically have two choices. One is to move Medicare back to Social Security so you can get the kind of services for the beneficiaries that they ought to be receiving, which they're not, or you bring it under an Under Secretary for Health, where a health perspective is included, or a public health perspective gets included in the policy deliberations of HCFA. Also, when you can then link more effectively things like the National Center for Health Services Research with the Health Care Financing Administration, where you can link the NIH consensus conferences, which are very important, with the Health Care Financing Administration, where you can have an integrated research program where Health Care Financing is doing certain things, where Public Health is doing certain other things. But it's an integrated policy.

Dr. Mullan: So you would be an advocate of establishing that under secretaryship.

Dr. Lee: Absolutely. I would have a Deputy Secretary, I'd have the Commissioner of Social Security equal, certainly, to an under secretary level position. I would still have the Surgeon General as the principal operating officer for the Public Health Service, as the chief professional person in the Public Health Service.

Dr. Mullan: And you would have a deputy or assistant secretary for HCFA?

Dr. Lee: You'd have, at the equivalent level, the administrator of HCFA and the Surgeon General reporting to the under secretary. That's the way I, off the cuff, think of it now. I think you could also then move the EPA into that department. The Environmental Protection activities, they're not principally for aesthetics; they're principally for public health reasons. I mean, even if acid rain kills trees, you've got to think of those issues, I think, within a public health context. You could have a Department of Health if you did that.

Dr. Mullan: That obviously moves from history and policy into where we're headed.

Dr. Lee: Yes.

Dr. Mullan: I'd be interested in your thoughts on the realignment under a new administration. Would you envision that being a political possibility that you could aggregate health authorities? One theory is that health has become so powerful, people don't want to see it in a single unit, and that keeping it displayed as it is makes it less of a threat to other interests or less of a cohesive

force in American life. Everybody in the world has Ministries of Health, but we don't have a Department of Health.

Dr. Lee: Right.

Dr. Mullan: I wonder what your thoughts are on why that hasn't happened and what the impediments to the future are.

Dr. Lee: In England, they've gone from a Ministry of Health, then they had a Ministry of Health and Social Security, and now [Prime Minister Margaret] Thatcher has recently taken the Ministry and made it a Ministry of Health again. Canada has, I think, a Ministry of Health. It's interesting, in some countries like France, the financing of health care, as I understand it, is basically more Social Security related than public health related. In other words, the national health insurance program is a separately administered activity. So that different countries do it somewhat differently. My own view is that from a policy point of view, from the standpoint of a President, to look coherently, you'd have to have people in the White House doing it, or you'd have to have a department that puts those pieces together and gets some coherent policies. I think that a Department of Health makes sense, or, let's say, like the Department of the Navy and the Army and the Air Force, within a larger department.

Certainly Social Security, in my view, needs to be somewhat protected from some of the kinds of things that have gone on in the Eighties, in terms of the political decisions affecting beneficiaries. It's so important for the fabric of American society and for the future that you don't want novices mucking around with it, and that's why I think it has maintained so far, although I would be very worried myself about somebody like [George] Bush because of what he's done in the past, what he would do with Social Security.

Dr. Mullan: In the sense of . . . ?

Dr. Lee: And I don't know that [Michael] Dukakis knows as much about Social Security as he needs to, but I think he would be getting good advice. I think people see the surpluses of Social Security, for example: "Let's use those for some political purposes." That I would be very worried about, because they're for the future of the beneficiaries. Those surpluses are accumulating because beneficiaries have to be paid down the road and you've got to have that money to pay them. That's why they're accumulating those.

Dr. Mullan: Implicit in your discussion about the Public Health Service and HCFA today, or Medicare- Medicaid in earlier days, is an absence of, or a failure of, coordination or an insufficiency of coordination. Is that, in fact, your feeling in terms of how things developed and how they function today? Could there be better integration of activity between HCFA and the Public Health Service?

Dr. Lee: I would say probably yes, and I would say certainly there could be at the level of health services research and policy relevant health services research. In terms of quality assurance, the development of clinical guidelines, I think the Public Health Service has somewhat gotten out of the medical care business. They're no longer providing care for the merchant marine. They still

have the Indian Health Service, but they're not a major actor and they haven't really maintained a strong base of people involved in what are very important issues. The quality, access, utilization issues is the other side of the payment, the price issue.

Dr. Mullan: Has HCFA developed that?

Dr. Lee: Not sufficiently. I think it's more difficult for them to recruit medical physicians. Bill Roper is a physician, obviously. But to be in a non-public health organization, let's say, health insurance, basically, it's a health insurance company, I think it's more difficult for them. Yet this is an extremely important area, and I think it's an area that needs to be strengthened within the Public Health Service. NIH has done some of it. The National Center for Health Services Research is certainly funding some of the very important research, but at a higher level of the Public Health Service that needs to be some leadership.

Dr. Mullan: There's a certain amount of squeamishness about technology assessment. It's one thing to run a consensus conference, but who is going to then translate that into reimbursement policy?

Dr. Lee: But we have to. We cannot go on the way we've gone on and simply have the Treasury an open-ended spigot for every new operation that somebody wants to perform, or every new technology that comes along that's safe and functions the way it's said to function, whether it does any good or not. We need to do much more with devices and with procedures as we've done with drugs.

Dr. Mullan: There was a comment, I think attributed to you--or perhaps not--in the 1968 article on Gardner, about trying to get the NIH or keep the NIH more involved in service delivery system or closer to issues relating to services or the delivery of medical care. Do you recall discussions about that? Was that ever a conscious effort?

Dr. Lee: The Regional Medical Programs was part of NIH. It's like the academic medical center; it's linked to medical care as a tertiary care provider, very directly linked to medical care. The NIH was, in a sense, the academic medical center of the Public Health Service. It did have a tertiary care clinical space. Mainly it was supporting research in these universities, but their perception of the linkage was only at the bedside clinical, not into the delivery system. Regional Medical Programs was an effort to link the academic medical center into the delivery system. It was an effort to get people at NIH to be thinking that way. But increasingly, NIH has become biomedically a paradigm dominated, as have the academic medical centers, instead of what I consider to be a more appropriate paradigm, which is really the Engle notion of a biopsycho-social paradigm for health. But if you look at how atrophied the behavioral and social sciences research has become, particularly in the last eight years, and the lack of support for that, that paradigm is not very influential in NIH or in the academic medical centers. Yet, we see with the AIDS epidemic the absolute necessity of linking the cutting edge information out of biomedical, behavioral, and social science research and translating it into policy as quickly as we can. Research in epidemiology, in HIV testing, as well as what we've learned about behavior and behavior change--those are things that must be linked to policies and service. Of course, NIH has never been connected with the Public Health system. While NIH is somewhat connected with the

medical care system in terms of public health, they've really shied away from that. They've really wanted to be insulated even from the rest of the Public Health Service.

Whether you should put NIMH back into NIH, as well as NIDA and NIAAA back into NIH and have the research enterprise under that broader research umbrella, I think is something that ought to be looked at. I would say myself, at the present time, I would favor that because I think the service linkages can be achieved by other mechanisms.

Dr. Mullan: You'd put the services in another agency and put the research back into NIH?

Dr. Lee: Right. Of course, the intramural programs are still within NIH.

Dr. Mullan: The 1960s were a watershed period for community health. The legislation and the programs born of that are with us yet today-- community health centers, the National Health Service Corps, the changes in the maternal and child health program, migrant health, etc. How do you feel about that "quiet revolution" and did it succeed? Did it stay on track? Did it fall short of its goals?

Dr. Lee: Again, if you go back to Bill Stewart and Bill's idea about community health and community health centers, although neighborhood health centers were first funded out of the OEO, this was certainly an area that Bill was thinking about very, very actively. Had we done what we promised to do in the Sixties, namely, fund 800 community health centers around the country and sustain that funding, we would now be able to combat the AIDS epidemic, the heroin epidemic, and the crack-cocaine epidemic far more effectively.

For example, with the heroin epidemic, which is now getting a resurgence, to deal with that and the HIV epidemic, you have to have an organized setting in the low income areas which are most affected by both of these epidemics. The community health centers, as well as the hospital and their out patients must be involved, but, it's more the community health centers which are in those neighborhoods that could do this if they were adequately funded. They could take heroin addicts, they could run methadone maintenance programs, and at the same time provide primary care. We ought to medicalize drug addiction as a public health and medical care problem, instead of stigmatizing it and separating it. The place to integrate that would certainly be the community health centers. The private practitioner isn't going to do it; they can't do it. A private practitioner cannot really handle a drug addict. They don't have the social services, they don't have the counseling services in their office, and in many cases, they don't speak the same language.

Dr. Mullan: Your feeling is that the infrastructure that was built through the community health center/neighborhood community health center movement, etc., is insufficient to the task?

Dr. Lee: Absolutely insufficient and it's grossly underfunded. Every one of those centers is now underfunded. Every year the federal government is cutting back on their funding, saying, "You have to compete. You have to get more fee-for-service income." You have to compete with people who can't pay. So it means shrinking their services, being less accessible, less available. There were some problems with the neighborhood health centers. There was a lot of politics often at the local level. Sometimes the local board saw them more as employment agencies than

as health care delivery, but many of those problems have been resolved. We went through a lot. Sometimes the practitioners in the neighborhood health centers also had a private practice and they referred the paying patients to their own private practices. There were lots of things that were part of the growing pains. In fact, we are facing the most serious epidemics, both the crack-cocaine epidemic and the HIV epidemic. This institution is one of the key institutions for dealing with that from the standpoint of both caring for people who are afflicted, but also in prevention. As you think about the development of prevention treatment programs for people who have got HIV disease, but don't have AIDS, and the early treatment with AZT in organized settings to do that, again, that kind of community health center is a very appropriate setting to do that. You're going to have more private practitioners involved in that, as well, but again, the bulk of the patients as the epidemic in the gay community is both controlled and then practically eliminated, it's now down to transmission rates of less than 1% in San Francisco and Chicago, probably Los Angeles, at least the white gay community in New York. You're going to have more and more HIV-infected people or IV drug users or sexual partners of IV drug users, and they are coming from low income areas that have large minority populations. South Bronx is an example. We need to augment these resources, and there needs to be a national plan to do that. There was in the late 1960s.

Dr. Mullan: What is your surmise on the Public Health Service's role in the AIDS epidemic? Do you feel it's been adequate to the challenge?

Dr. Lee: No. It's taken seven years to develop a national education program. Just distributing the Surgeon General's brochure to households, they did that in England more than two years ago. We don't have yet national surveillance data. I don't attribute it to necessarily internal problems within the Public Health Service, but rather external constraints from OMB and perhaps from the secretary's office. I think if the CDC had been given the authority that it sought, we would be farther ahead.

I think there was a lot of internal squabbling between CDC and NIH and between Cancer Institute and Institute of Allergy and Infectious Diseases. We now do have an executive task force. There are representations from all the agencies that are involved. We do have mechanisms, but it took us too long to create them. I think when Ed Brandt was there, we had very strong leadership, yet he wasn't given the resources that they wanted or they needed. There were particularly these constraints on personnel and personnel ceilings, so you could not hire the people to move forward. That, of course, was consistent with the ideology of the Reagan Administration. It's a local problem. The President didn't mention it until 1987. I mean, here we've got the worst public health epidemic in the world in our lifetimes, and it will probably be worse than the flu epidemic before it's over in terms of numbers of people who die. Certainly the social consequences of it have been devastating for some communities. If you look at New York and the problems of the hospital systems, those are things that really haven't been dealt with by the Public Health Service. "That's a HCFA responsibility."

[End Tape II, Side 2. Begin Tape III, Side l]

Dr. Lee: If you look at the AIDS epidemic, the health services area is the one with demonstration projects, public and private funding, but no clearly defined federal role. We need

to define more clearly the federal-state-local government responsibility, and we need to define and work much more actively with the private sector. We're seeing increasingly private insurance companies uninsuring people who are HIV-infected or at risk of HIV infection. So we're seeing a big shift from private insurance to Medicaid. Again, that's happening in a vacuum of inadequate federal leadership. I think Koop has done an outstanding job on the education side, but that hasn't been backed up with sufficient funding for the kind of statewide and local efforts that we should have. We've known what to do since the early 1980s in terms of education. We said, "We haven't proof, but we've seen the prevalence rates in San Francisco," and the incidence rates dropped dramatically since 1982. Are we going to have to wait until other communities experience this same kind of high mortality that New York, San Francisco, and Los Angeles had before other communities are responding?

Dr. Mullan: That raises a question I'd like to ask, again going back to your reflections from the Sixties on. The role of state and local health departments, in the assessment of many, probably reached a high-water mark in the infectious disease control programs of the first part of the century, and through mid-century have maintained a fairly traditional and by many standards not very proactive or exciting place in health policy and health care delivery, albeit an important one. As you have observed the latter part of the century on into the current decade, dominated as it is by AIDS, but not only in regard to AIDS, I wonder what your reflections are on the state of state health departments and the relationship, or lack thereof, of the federal public health establishment to state and local public health?

Dr. Lee: They still have the relationship with CDC and the EIS officers being assigned to the states and local governments. It seemed to me that the state health departments were still playing in some states-- California, New York--a very, very active leadership role-- Herman Hilleboe of New York, Malcolm Merrill in California, Les Breslow in California, in the Sixties. When Bill and I were in Washington, we had very outstanding people at the state level that we could work with. I think that we saw in California, for example, Ronald Reagan really dismantled the state health department in California, politicized it. And people like Lester Breslow, who were world-class public health leaders, left the department because they were not given the authority and responsibility to do what they felt they should do. California had the best epidemiological training program in the United States, even better than the EIS training program in the Sixties. They were training people from all over the country in migrant health. You had Herman Hilleboe, New York, again a very outstanding leader. There were other very strong state health department leaders in the Sixties.

Some of those people had come in during the Thirties, during the war, like the people in the Public Health Service. One of the reasons there were so many outstanding people in the Sixties still, is that many of them, like the people in Social Security, had come in during the late Thirties when jobs were not so easy to come by, and during the war, when that was highly regarded service, and they stayed on after the war. So you had, I think, very outstanding leadership.

Look what Luther Terry did on smoking and health. Luther Terry began the whole turnaround on that, not only in the United States, but in the world, so far in the industrialized world. That's been maintained by every Surgeon General since then. Koop has gotten more credit because he's operated in a climate that was less supported, but certainly Bill Stewart was as strong as Koop on

those issues. But because Bill was in an administration that was supportive of that, and he wasn't an anomaly, Koop tends to get more credit because "Isn't it wonderful what he's done about smoking?" He has been outspoken and, of course, he's got a particular capacity for working with the media, and he's done a very, very good job.

I think he's made another contribution which may be very important, but again, Julie Richmond started this. Julie's prevention objectives and his approach to areas such as nutrition, the approach which is now the Surgeon General's Report on Nutrition, the ideas that have come to light now so strongly in that report really began when Carol Foreman was in the Agriculture Department and Julie was in HEW, and they got a joint agreement about policies. To do that in the Agriculture Department was a miracle, to get them to think about lower fat and more vegetables and more fiber. But that began ten years ago when Julie was assistant secretary. So we had, in some of the areas, this kind of leadership we haven't seen at the state level.

We don't have the same kind of leadership, and I think we've seen many people who are not public health people, not physicians, running health departments. In California, we have Ken Kizer, a young emergency medical doctor with no previous public health experience, put in charge of this enormous department. It's a huge responsibility. Part of the problem, I think, relates to the schools of public health. They have not been working with the state health departments the way they used to. There was a close link between the California Health Department and the School of Public Health for many years. That tie was really broken by Reagan in the Sixties and hasn't really been returned. So I think we've lost leadership in the state level, we've lost leadership at the local level. You have some outstanding local public health leaders. I think Dave Werdegar in San Francisco has done an outstanding job; Merv Silverman certainly did when he was Director of Public Health, in dealing with the AIDS epidemic, dealing with what was the big, important issue. Steve Joseph has done an outstanding job on AIDS, on smoking, and on child health. That's just in two and a half years in a very, very tough political climate. You have some other good state and local health officers. In the old days, some of the leaders in the schools of public health, like Myron Wegman at Michigan, of course, June Osborne now at Michigan is another emerging leader in terms of AIDS and a world leader in that regard. Certainly D.A. Henderson at Hopkins on smallpox. So there's maybe some hope that we'll see the schools of public health provide leadership. Bill Foege now down at the Carter Center, some of the people who have been outstanding leaders, maybe we'll see more rejuvenation of public health training and things like the Global Community Health fellows program.

I think the need for the Public Health Service to provide the leadership, to strengthen state and local health departments, to have that as their major objective, some of the authority gets pulled away by CDC. When they go in to do a study, it's their study. It isn't the local health department's study. They're not strengthening that local health department. They're doing the study, they're getting the information, and then sometimes they're even publishing the articles only with their names on it. Some of that stuff is not right.

Dr. Mullan: Back in the Sixties, my sense is--and I'd be interested in your recollection--a feeling that local health departments and state health departments were the problem, not the solution. So

that when neighborhood health centers were designed, they circumvented local health departments and went directly from the federal government to the communities.

Dr. Lee: During the Sixties, the legislation that was enacted permitted grants not just to the state health departments, but to local health departments, to non-profit organizations of all kinds, and some of them were directly in opposition to the local health department. In family planning, that was certainly true. The local health department wasn't going to do it, but even opposed it being done in some communities. The neighborhood health centers often were a foci for community action against local entrenched political organizations. I think we went a little bit overboard on some of that. Instead of looking at the institutions and how you could strengthen them and improve them, it was more an impatience to move ahead. In a sense, what Johnson called "creative federalism" was more federal control, more federal categorical programs, more federal dollar dictation, and not sufficient recognition, although I think there was within the Public Health Service, and this is something that Bill certainly tried to do, but tried to do in a modern way and not in just an entrenched old-fashioned way, to strengthen state and local health departments. But there was resistance. When you saw high infant mortality rates in communities all around the South, then how do you get at that problem? Certainly in some cases, George Silver worked for months with state health officers and local health people. In Mississippi, for example, we developed very good state programs, but it was felt that universities or other groups were more innovative, more ready to move, more ready to get the job done.

Let me discuss the driving forces now. When NIH was created in 1930 out of the Public Health Service laboratory, that sowed the seeds for what is really the driving force now in terms of the technological change that's affecting so much of medical care and public health and environmental health. So the Public Health Service is still, through NIH, very much in a leadership position internationally, but there hasn't been enough connection between that kind of research and public health. Certainly epidemiology is a very key way to do that, I think. We are beginning to see more epidemiology at NIH, and I think we need to see much more inter-linkage of NIH with the other elements of the Public Health Service, to take advantage of that leadership.

Dr. Mullan: To fight off the centrifugal tendencies.

Dr. Lee: Yes, that's right, and also to focus NIH's focus on the academic medical center, if you will, the research institute.

Dr. Mullan: Were there instances during your tenure in Washington when NIH, Dr. Shannon or others, made a serious run on schism, on breaking off from the Public Health Service?

Dr. Lee: Jim wanted to keep his distance. He was loyal to NIH, not to the Public Health Service. He was such a good manager, he ran such a good organization, and it was such a high quality operation, NIH and Social Security really stood out as two of the jewels of the federal government in terms of outstanding people. Jim wanted to protect that and keep enough autonomy. He did not want to be identified with the old-line public health types, particularly with state and local health departments. He saw that wasn't the place to go politically. He was a very astute politician and he really created the modern NIH.

Dr. Mullan: I wanted to get your reflections on certain several people since you worked closely with them. It would be of interest to me and others in the future. Lyndon Johnson, the time that you observed him or met with him, what sort of style of leadership and appreciation of health did he have?

Dr. Lee: Going back even to when I was in AID, and after President Kennedy died, this was a tremendous shock to all of us who had gone into the government, in part because of Kennedy. Many of us thought about leaving. My perceptions of Johnson were very erroneous at that point. Two things happened fairly early after that. Jim Cain, who was Johnson's personal physician from the Mayo Clinic, had been a guy that I knew when I was a fellow at the clinic helped to change my view. We got a copy of a report which Jim wrote for the Vice President when we were in AID after Johnson was elected. It was very clear that the President had a much stronger interest in international health than did President Kennedy. Kennedy was much more interested in economic development and in what I'll call the economists' view of international development. Johnson was much more interested in the personal side, the kid who needed to get an education, the person who needed health care. I think his own growing up in poverty, his own experiences in terms of what education could do for you made him see those things in a very personal way. This was also true when we went to HEW. I can't imagine a President more supportive of what we were trying to do. He was very tough, he was extremely intelligent. John Gardner said he never knew anybody who knew more how the government worked than Lyndon Johnson.

I felt that a lot of what's been written about him takes the very political side and doesn't look at the extraordinary accomplishments in civil rights, in Medicare, as two examples, but in the poverty program, in areas of highway safety, beginning the environmental health activities in a major way. Of course, Nixon really coordinated those through the EPA and made a major contribution.

The thing that I saw from Johnson, we didn't meet with him too often, but those times when I did, when we were talking about the NIH budget or talking about the department budget, or, for example, there was a task force on nursing homes, we met with the President. He described in very personal terms why he wanted this task force to come up with recommendations for model nursing homes and then policies that would translate those into services for elderly people. I can still see him at the head of this table. There was an Englishman there who was an expert on gerontology that Wilbur Cohen had invited to come to this meeting. This guy was in Oxford and he'd set up one of the first day treatment and geriatric treatment hospitals in England, was a real pioneer. Johnson was sitting at the end of this table and said, "I don't understand why in a nursing home bathroom they've got the toilet paper back here. I've got a bad shoulder." He goes through this in about a five-minute mimicking of sitting on the can in a nursing home. He says, "Why can't they just have the toilet paper out here in front of you so you can reach out there?" So you had this earthy description, but very personal. He cared about the old person in that nursing home, and that came across very strongly.

On the civil rights question, about Medicare, he was absolutely firm on that issue. The Civil Rights Act was going to be enforced, even if it meant denying Medicare benefits to these elderly people. When Medicare was going in effect, we organized every Army, Navy, and Air Force hospital, every Public Health Service hospital. We had a hotline at NIH out of the Surgeon

General's office that people could contact this number if they couldn't get medical care anywhere in the country. That's the kind of thing he did, because he cared about every one of those people. It was extraordinary that somebody who was so engaged in very, very tough issues and very hardball politics would have that kind of personal concern. He could also be very critical. He could also be very tough. He certainly listened to his budget people. He had extremely competent people working for him-- Doug Cater, Jim Gaither, Harry McPherson, Joe Califano on the domestic side, Peter Bing-- extremely competent people working in the White House. That was the other thing. The level of competence and commitment said to me something about his qualities. When he chose people like that, who were very independent minded, who weren't just yes-men, who could also deal with the bureaucracies with agencies like ours very effectively, I thought.

Dr. Mullan: The Vietnam War, since Johnson was at the apex of that, was a burden to his domestic programs, both economically and morally. How did you experience that?

Dr. Lee: I would say we experienced that mainly by 1967 and 1968, and much more in '68 than '67. I think John Gardner's decision to leave was related to that. He's never said so, but that decision he made in late '67. It was very clear by that time that the resources that were available for new initiatives weren't going to be available to the same extent, even though there was still a lot of effort to move forward and get things done and not slow down.

The biggest effect it had, I think, was having to deal with the poverty issues, civil rights related issues. The poverty encampment in Washington. Had it not been for the Vietnam War, that probably never would have occurred because we would have been able to be much more responsive. There would have been more funds for OEO programs, more funds for the anti-poverty programs. Some of those were things that the growth got really curbed. The establishment of community mental health centers, instead of moving very rapidly forward, got slowed down dramatically. The funding at NIH even by 1969 leveled off, after a very long period of steady growth. So we saw that in budgetary terms, and then we saw that translated subsequently into programmatic dollars.

Dr. Mullan: What was John Gardner like to work with and for?

Dr. Lee: John was almost, in a way, a non-politician. He and Wilbur were, I think, a great partnership. I went to see John one day and I said, "John, do you realize that Wilbur is going over to the White House and talking with the President and meeting on these issues?"

He said, "Of course I know that. We're working very closely together." He wasn't the least bit concerned. He was thinking a lot about organization issues, about renewal. He wasn't thinking about some of the nitty-gritty politics which really Wilbur handled as the under secretary. Those things were delegated to Wilbur. I think in some ways John was a little bit removed from some of the things that maybe he should have been somewhat more involved in. He certainly was outstanding in recruiting and picking people, people like Bill Gorham, Alice Rivlin, Lyle Carter, Bill Stewart, Jim Goddard, he picked people that did outstanding work, and in his own personal staff, people that he had working with him, his relationship with Wilbur.

It was interesting. When he was ready to end a meeting, he would always tighten up on his tie, and you knew you'd better finish up in about a minute, or it was all over, because he could get very impatient. He pretty much would leave the office at 6:00 o'clock so he could go home and think about things. He wasn't going to be swallowed up by the day-to-day minutia, because he was thinking more broadly. He was a tremendous inspiration to many of us to try to think about problems in different ways, to try to not go through the old channels if those weren't working. He was also very open to people and their ideas. For example, George Silver was one of the smartest people around and, George went to work with John at the Urban Coalition. But he would be very open if George wanted to go see him. Here's George, the deputy assistant secretary, wants to talk to John Gardner about something, kick around an idea. He was very open to that. He was impatient when things didn't move as quickly as he thought they should. The notion of these fiefdoms and how to make this department function as a department, at that level he was thinking about those kind of things. He wasn't thinking so much about a particular appropriation level or going to see a particular congressman about some constituent.

Dr. Mullan: How did he handle politicians? There are political pressures in a job like that.

Dr. Lee: Wilbur handled some of it. Obviously John handled some of it. Certain things he didn't like to do and certain hearings he didn't like to go to. It wasn't his favorite occupation getting up there. These were basically publicity generators for the people who were chairing the committees, and he didn't like to waste his time because there was an awful lot to do. Often those were of marginal benefit. It was interesting. This nursing home task force I mentioned, this meeting must have been in 1967. We waited for the President maybe 20 or 30 minutes. We were supposed to meet with him, let's say, at 10:00 in the morning, and at 10:30 he still wasn't there. So John Gardner gets up and leaves. He had something else to do. John wasn't too engaged in the work of this task force. Wilbur, of course, was very much involved in that meeting, but basically I ran the task force and came up with the recommendations. John had some other things to do. Here he is at a meeting with the President, and none of us would have had the guts to do that. Nobody would do that. I guess he was comfortable enough in that relationship. The President comes in and says, "Where's John?" Wilbur said, "Well, he had to be somewhere else. There was something else he had to do, some other urgent matter he had to attend to." Or "He had to go up on the Hill," or something. The President dismissed it in a minute and was off at the meeting. I think John's capacity to come in from the Carnegie Corporation, a private foundation, an organization that must have had 30 people in it on a staff, and take on this enormous bureaucracy, it was because he thought so much about these questions of leadership and organizational change and self-renewal. Those were the kind of broad ideas he brought to the department. I think it was a tremendous morale builder in the department. I doubt that it had better morale anytime.

Dr. Mullan: People did not take umbrage at his reorganizations?

Dr. Lee: I think they did. I think a lot of people down the line did, but, of course, those of us who worked for him were very enthusiastic and very supportive. I think somebody like Bob Ball could also give you insights into John because Bob was such an extraordinary manager, but he basically let Bob manage Social Security. It was a well-running machine. NIH was a well-running machine. He wasn't going to screw around with it. He was going to protect NIH. Other

parts of the Public Health Service he wasn't satisfied with, so he was going to stir the pot. Those parts of the Public Health Service clearly were resistant to his ideas.

[End Tape III, Side 1. Begin Tape III, Side 2]

Dr. Mullan: Wilbur Cohen.

Dr. Lee: Wilbur, of course, I first met in the early Sixties when I was doing this campaigning for Medicare. He was, to me, an incredible guy. I continued to work with him until he died. He was coming out to California and we were going down to Texas to see him.

Dr. Mullan: Where was he from?

Dr. Lee: Wilbur was from Wisconsin. He graduated from the University of Wisconsin. Before he went to graduate school, he came to Washington to work with a guy who had been one of his professors, who was on what was the planning board for Social Security. So Wilbur was involved in Social Security from the planning of the report that went to the President, to the establishment of Social Security, to being one of the first employees of Social Security.

Dr. Mullan: This would have been 1936-38?

Dr. Lee: This would have been 1935 when they did this report to the President. It was '34 when he went to Washington.

Dr. Mullan: Before the law was enacted.

Dr. Lee: Right. Eloise, his wife, was from Texas. Wilbur had a great sense of humor, tremendous energy, was very political. We got along very well. He liked me. He was very frustrated by the Public Health Service. I think people in the Public Health Service felt he was very biased toward Social Security and welfare. He had a tremendous grasp at a very micro-level of the legislation and the issues, and yet he was always open to seeing people. If you really wanted to see Wilbur to talk business, you basically had to wait until about 7:00 when the routines of the day were over, and then you could go in and talk with him. You could spend a half-hour or an hour on some issues that we were concerned about, either reorganization or FDA, or you would have lunch with him and talk about those issues. After that, he would often go out to a reception. Eloise would come down and they'd go out to a reception or some dinner or some event. So he sort of represented the department on a political level. I think John also went to some of those, but not as many. So he was an individual of tremendous intelligence.

Dr. Mullan: So rarely does someone come out of the ranks all the way to the secretaryship.

Dr. Lee: Right. He's the only person who's ever done it.

Dr. Mullan: What enabled him to do that? You think of somebody that's basically a green-eyeshade Social Security bean counter.

Dr. Lee: Bob Ball, also, has been a towering figure, politically as well as managerially. Those two people were two of the most important public servants of the last 50 years, and both of them out of the Social Security Administration. Of course, Wilbur went to Michigan in the mid-Fifties when his job was made nothing, because he was very active politically in the Truman years, working for things like the Murray-Wagner-Dingell Bill. Wilbur was identified as a person in favor of national health insurance, and for that reason was perceived very negatively by the doctors. I think partly that had a ripple effect into the Public Health Service.

I think it was a combination of imagination, energy, tremendous political skill. Bob Ball has that. Bob had more managerial ability than Wilbur. Wilbur wasn't the most tidy manager, but you had good people running most of the agencies. Wilbur also had very good budget people like Jim Kelly, and very experienced people like Rufus Miles, at least initially, who were also very outstanding.

One other thing that John Gardner did was have John Corson come in and work with him as a consultant on the reorganization. He was one of the old Social Security hands and had long experience in government. He used consultants like that very, very well. When the thing wasn't going to move internally, he had these people come in from the outside to work on the reorganization.

Dr. Mullan: As a secretary, was Wilbur Cohen different in any manner? How was he as a secretary?

Dr. Lee: It was just like working with him as under secretary, practically, because in some ways John had delegated a lot of functions to Wilbur. But as secretary, of course, then he was the bottom line: he was the final authority. But it didn't change him in any way in terms of personality or his openness or his energy or enthusiasm for the work.

Dr. Mullan: Secretary Finch and the transition. What did you see coming in his person?

Dr. Lee: Bob Finch had been an outstanding lieutenant governor in California. As a matter of fact, he had been on the Board of Regents and had been one of the people who recommended me for the chancellor job at UC- San Francisco. He came in with an extremely good team-- Jack Venneman, Lewis Butler, Tom Joe. He brought in a very, very good team of people with him. But as lieutenant governor, Bob did not have large managerial responsibilities. One thing that we were very worried about and was something that hurt him early on, Wilbur told him not to get involved in decisions relating to the FDA, because those should be the commissioner's decisions, and the secretary shouldn't second-guess the commissioner. Bob Finch did get involved in the decision--I forget about what particular drug. But it really weakened the authority of the commissioner and it weakened the perception of Finch as secretary. But he still had a very, very good team of people working for him. I don't know what the stress factors were that eventually led to his decision to resign, but I know it was a very stressful period, and I think it was a very stressful job for him.

Dr. Mullan: The whole reorganization that you crafted really began to come apart.

Dr. Lee: Sure, when new people came in with the Nixon administration they wanted to change it. First, Roger Egeberg, I don't think paid as much attention to the organization. Roger functioned more not as a line manager, but more as an advisor to the secretary on policy. I think some of the mistakes we made, like having the FDA under another agency appropriately was dismantled and put back in a line relationship. I think that organizations have to suit the people who are there, in a sense. I don't think they're there forever. Yet I do think that the FDA and the NIH ought to be quite autonomous within the structure, particularly the FDA as a regulatory agency. I don't think that the assistant secretary should be second-guessing the commissioner, ever. If you don't like the commissioner's decisions, then you get rid of them, but that person has got to have the authority to make those decisions.

Dr. Mullan: Jesse Steinfeld. Did you work with him at all?

Dr. Lee: I knew Jesse and I worked with him after he was Surgeon General. I knew him because he was in the Department of Pathology at USC, and he was at the Cancer Institute. He was on his way back to L.A. when Roger Egeberg recruited him. I got to know Jesse more after he was Surgeon General.

Dr. Mullan: Had he been a commissioned officer?

Dr. Lee: He was a commissioned officer when he was at the Cancer Institute.

Dr. Mullan: And he had left before?

Dr. Lee: He had left before Roger got there. Then Roger, in a sense, called him back. I think Jesse, particularly in the smoking area, was another very aggressive, very active Surgeon General. But other than those workings with him around that issue, I didn't have much close relationship with him.

Dr. Mullan: Howard Rusk.

Dr. Lee: Howard Rusk is one of my mentors, one of the people I respect the most. He has been one of the most influential people in my life in terms of my own orientation to public service, and a continuing commitment to that, even after returning to the university, to stay involved, as I still am involved. As I reach age 65 next year, I am probably as actively involved as I've ever been in activities concerned with, for example, the AIDS epidemic. I have served as President of the Health Commission in San Francisco. It would have been nice to have had that experience before I got to Washington, to really understand local government, but sometimes you learn these things a little bit late. Then as Chairman of the Physician Payment Review Commission I have a further opportunity to serve. Those things I attribute more to Howard and my dad. Although my dad was much more rooted in private practice, he was still a person who was very committed to the public welfare. Howard translated that into being active politically, which I have continued to be, working with mainly the Congress, but also, interestingly enough, in the last four years, working a lot with various parts of the Public Health Service during the Reagan Administration on AIDS and various other issues. I serve on an NIMH Advisory Committee. I have been asked to serve on a CDC Advisory Committee, but I couldn't because I was doing too

many other things. I serve on the Secretary's Advisory Committee on Health Promotion and Disease Prevention. I've worked with Mike McGinniss all the time he's been in that job as deputy assistant secretary from the time he worked with Julie on prevention activities. When he recruited Mariam Nestle from UCSF, we were very instrumental in recommending her for the job. I think she did a very good job in editing the Surgeon General's Report on Nutrition. So there's been a continuous involvement which he was really the role model for me more than any other person.

Dr. Mullan: I ask with particular interest. My father was a flight surgeon in World War II and flew with Dr. Rusk. I got to know him. I grew up in New York City. When I was about 15 or 16, the first job I had was compliments of Dr. Rusk. I went to work as a nurse's aide at the Institute for Physical Medicine Rehabilitation.

Dr. Lee: What year was that, Fitz?

Dr. Mullan: That would have been 1955, probably.

Dr. Lee: That's when I was there, actually, working on a project. I went back there from Mayo Clinic and worked on a project on cardiac rehabilitation, then went to the Palo Alto Clinic in '56.

Dr. Mullan: We were probably there at the same time. I was changing beds and dumping bedpans literally.

Dr. Lee: He was a great guy.

Dr. Mullan: He was a mentor to me, but much more distantly.

Dr. Lee: He was very, very important to me, both personally and professionally. My oldest daughter is named after him. I was introduced to my first wife by his daughter. We've just been a very close family. He was a very good friend of my dad's.

Dr. Mullan: Is he still alive?

Dr. Lee: Yes.

Dr. Mullan: How is he doing?

Dr. Lee: He's had a very hard time with his back. Of course, he's getting very old now and getting more frail.

Dr. Mullan: He must be 90?

Dr. Lee: He's about 88.

Dr. Mullan: His book, The World as I See It, he sent me a copy and inscribed it.

Dr. Lee: Yes. It's almost like one world, but it was that kind of idea.

Dr. Mullan: I know there are many things you have down there that we didn't touch on. Is there anything that I've missed that you particularly would like to add or reference or comment on?

Dr. Lee: I don't think so. I think we've covered as much as my brain is capable of communicating at the moment.

Dr. Mullan: Thank you.

[End of interview]