

Battling for the Right Health Policy, Then and Now

A physician's personal reflections on fighting for better, expanded care for all parties, both under Johnson at HEW, and at UCSF.

When *Generations* Guest Editor John Rother asked me to contribute to this special issue commemorating the 50th anniversary of Medicare's enactment, my first reaction was to wish that this milestone had been reached before my 90th year. Yet, Medicare is about the elderly, and I am grateful for the opportunity to reflect on my experiences. Medicare was my entrée into a long and exciting career in health policy. The efforts I was involved in to advocate for, implement, and refine the program had a profound impact on me. And for the past twenty-five years, since I turned sixty-five, I have been a Medicare beneficiary.

Advocating for the King-Anderson Bill

My involvement with what would ultimately become Medicare began in 1961, several years after returning to California to join the medical staff of the Palo Alto Clinic, a multispecialty group practice that my father had founded in the 1930s. Although becoming a physician seemed to be preordained (it was the path taken by all five of my parents' children), my training was broader than most—residency in internal medicine at Massachusetts Memorial and Stanford hospitals, service as a physician in Korea during the Korean War, fellowships in rheumatology at the Mayo Clinic, and in rehabilitation medicine at the Rusk Institute in New York. So I knew quite a bit about

how medicine was practiced in different settings and specialties around the country.

At the Palo Alto Clinic, many of my patients were older adults, and because they didn't have insurance and had limited financial resources I often had to send them to the county hospital when they required hospitalization. This created serious problems because I couldn't continue taking care of them at the county hospital, and the quality of care was much poorer there than at the private hospital in Palo Alto. My experiences in training and practice had convinced me that continuity and coordination of care was critical for older patients, who frequently suffer from chronic conditions that require a variety of medical services. Wherever these services were provided, their care needed to be under the direction of their own physician who knew them and their families well, and who was familiar with their medical problems.

My concern about this issue spurred my interest in health policy and, in 1961, I became a consultant on aging to the Santa Clara Depart-



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ment of Welfare. Around the same time, Lester Breslow and I established the Chowder and Marching Society, which brought together a group of local doctors from academia and clinical practice who wanted to learn more about state and federal health policy.

Through these activities, I became aware of the King-Anderson bill, a precursor to Medicare that was originally introduced by Representative Cecil King (D-CA) and Senator Clinton Anderson (D-MN) in February 1961. I supported this bill because it would cover my patients' unaffordable private hospital costs, make it possible for them to get needed care earlier, maintain continuity and coordination of care by their personal physician, and make more rehabilitation services available.

Wilbur Cohen wanted me, as a legitimate practicing doctor, to speak out against the AMA and in favor of the King-Anderson bill.

The American Medical Association (AMA) was vigorously opposed to the King-Anderson bill, and spent a lot of money on radio commercials touting it as socialized medicine. Their efforts were effective. As I recall about 80 percent of physicians (with a similar proportion at the Palo Alto Clinic) were against the bill. To counter the AMA's efforts, I worked with Leonard Herzenberg and Robert Mishell at Stanford to organize the Bay Area Committee for Medical Aid to the Aged through Social Security, which soon grew to include sixty physicians and more than 1,000 lay members.

This didn't put me in good standing with the AMA, but I wasn't too concerned about that because my father had successfully dealt with negative pressure from organized medicine when he started his multispecialty group practice in Palo Alto. Wilbur Cohen, who was Assistant Secretary for Legislation at the United States Department of Health, Education, and Welfare (HEW), was interested in having

legitimate practicing doctors speak out against the AMA. Since I was an AMA member, a Republican (at the time), and a practicing physician who knew something about health policy, I was asked to testify in support of the King-Anderson bill before the Ways and Means Committee in Congress and was tapped to advocate for the bill in public debates.

A lot of the material I used in my arguments came from Nelson Cruikshank and Lee Bamberger of the AFL-CIO. I remember portraying myself like David against Goliath—a young practicing doctor up against the AMA heavies. I was repeatedly accused of being a socialist and once (by Malcolm Watts, president of the San Francisco Medical Society) of being a communist. My accusers' rationale was that the King-Anderson bill would interfere with the doctor-patient relationship. I saw it quite differently: it was the lack of insurance that was interfering with that relationship and with continuity of care. No action was taken on the King-Anderson bill. In 1965, the Mills bill (which subsequently became Medicare) was substituted for it and passed.

Implementing Medicare: Hospital Desegregation

In 1963, I moved to Washington for my first full-time policy position in the Agency for International Development (AID). Although that job focused solely on international health policy, I kept in touch with Wilbur Cohen. In March 1965, when it was clear Medicare was going to pass, Cohen called and asked me to come to HEW to work with him. I had just resigned from AID and was planning to go back to the Palo Alto Clinic, but was granted another year's leave of absence to work on the implementation of Medicare.

President Johnson signed Medicare into law in July 1965, in the presence of former President Truman, in Independence, Missouri. I would have gone to that historic event, but John Gardner

had just been appointed Secretary of HEW and he was going to the Bohemian Grove, to which I had been invited by a friend of the family. So I went there instead. John knew my father and we had several long conversations before I started work at the department. In November, he appointed me Assistant Secretary for Health and Scientific Affairs.

Although I worked on many issues during my three-and-a-half-year tenure at HEW, the one that stands out is the use of Medicare to desegregate the nation's hospitals. It brought me together with an incredible group of people, and was one of the most important and moving experiences of my life.

At the time, some form of segregation was the norm for most hospitals in the South, as well as some in the North. Many of these hospitals had received federal funding from the 1946 Hospital Survey and Construction Act (or the Hill-Burton Act), but that program had been following a “separate but equal” policy. In the summer of 1964, the Civil Rights Act passed, and Title VI of the Act stated that federal funds could only be used to support programs and institutions that did not discriminate on the basis of race, creed, or national origin.

With the passage of Medicare, 7,000 hospitals became subject to the civil rights regulations in Title VI in order to receive financial support for medical care to elderly patients. This meant that minority patients could no longer be denied access to any service provided by the hospital, and all parts of the hospital (including patient rooms, cafeterias, rest rooms, and even the blood supply) had to be integrated. Qualified minority physicians could no longer be denied hospital privileges. Minority residents, nurses, and medical technicians could no longer be denied opportunities for training, employment, or promotion to supervisory positions. The time from passage to implementation of Medicare was less than a year.

James Quigley and Sherry Arnstein had already begun developing a hospital civil rights

certification program for Medicare before I came on board at HEW. I had the privilege of working closely with them as well as with other smart, courageous, and committed people at HEW, including my deputy George Silver, Peter Libassi (head of the Office of Civil Rights), Surgeon General Bill Stewart, Wilbur Cohen, Commissioner of Social Security Bob Ball, Deputy Surgeon General Leo Gehrig, and Bob Nash (head of the Office for Equal Health Opportunity). At the outset, President Johnson and HEW Secretary John Gardner made it clear that desegregating hospitals was a top priority, and that hospitals would not receive Medicare funding if they were not compliant. Arnstein was instrumental in the Department's decision that hospitals would have to comply immediately—as a prerequisite for receiving any Medicare funds.

She argued that the slow approach had not been effective in integrating public schools and that Medicare provided hospital administrators with a strong financial incentive to comply. President Johnson and HEW also decided that Medicare would not allow for “freedom of choice” to go to an all-black hospital. Everyone in every hospital receiving Medicare funding would have to be treated the same (Rockafellar, 2010).

It was one thing to be firm in setting the policy, but in March 1966, four months before implementation, fewer than half of the hospitals in the country—and only 15 percent to 25 percent in the South—met Title VI compliance standards. So we ramped up our efforts. George Silver took oversight responsibility for Mississippi, Leo Gehrig for Tennessee, and I had Georgia. I remember during one of my visits, a cardiologist at Georgia Baptist Hospital told me, “Well, you know, Dr. Lee, if I put a nigger in with one of my white patients, it would kill the patient. My patient would die of a heart attack.” So I said, “Well, it's the law; there's going to be no Medicare money if the hospital doesn't desegregate” (Rockafellar, 2010).

To make that happen, HEW worked with the American Hospital Association, arranged

meetings with hospital presidents and boards of trustees, and put pressure on local communities through their elected officials. President Johnson was kept informed of our progress, and on June 15, he met with medical and hospital leaders at the White House, asking them how the federal government could help them prepare for Medicare's implementation.

Johnson told them, "It will be your job to get action . . . to solve the problems which could hamper this program. Now, we know there are going to be problems. One of them arises from compliance with the laws of the land, specifically the Civil Rights Act. In some communities, older people may be deprived of medical care because their hospitals fail to give equal treatment to all citizens, and they have discrimination practices. Well, we believe the answer to that problem is a simple one, and that Congress has given it in the law itself. We ask every citizen to obey the law" (Johnson, 1966).

The President had expressed our biggest concern: if too many hospitals were not compliant in July, elderly patients would be deprived of hospital care. To prevent this from happening, George Silver and I developed a back-up plan that would make Veterans Administration and military facilities available to the public if hospitals didn't meet certification standards. Fortunately, our plan never had to be implemented. When Medicare was launched, most of the hospitals in the country were compliant, even those in the South.

In February 1967, when 95 percent of hospitals were compliant, President Johnson said that these hospitals were "guaranteeing that there will be no second-class patients in our health-care institutions, that all citizens can enter the same door, enjoy the same facilities and the same quality of treatment. We will continue to work for progress in this field until equality of treatment is the rule, not in some but in all our hospitals and other health care facilities" (Johnson, 1967). Working with such a dedicated

group of people to make this happen was a heady experience. We saw firsthand just how much the federal government could accomplish in a very short period of time.

Civil Rights at the University of California, San Francisco

In early 1969, I left HEW to become Chancellor of the University of California, San Francisco (UCSF). Malcolm Watts, the conservative physician who had called me a communist in debates about the King-Anderson bill, was the other finalist for the position. I was much more liberal, of course, and had I known that the vote of the Regents was only 13 to 12 in my favor, I might not have taken the job.

Returning to California, I hadn't expected civil rights to be a major issue. After all, San Francisco is not the South. But my work to desegregate hospitals under Medicare had sensitized me to discrimination, so I was receptive, if initially surprised, when Cecil Williams, the minister at Glide Memorial Church, told me that in his circles, UCSF was known as "the plantation."

With Medicare, minority patients could no longer be denied access to any service provided by the hospital, and all parts of the hospital had to be integrated.

The Black Caucus, a group of UCSF staff concerned about discrimination and segregation on campus, was founded in 1968 after the assassination of Martin Luther King, Jr. At UCSF, it was the first group to hold a reception for me and my family, and through Black Caucus members Wendell Adams, Joanne Lewis, Pop Nelson, and others I learned what they and other minority workers were experiencing on campus. Black people with college degrees or valuable military training were relegated to being janitors—and, as "janitors," they were paid less than the White "custodians" at U.C. Berkeley. Black

workers had to eat their meals in the basement, and those who worked on the top floors were not permitted to use the restrooms there; they had to go to the first floor.

Work on affirmative action in the medical and other health professions schools at UCSF had begun in 1966, with the objective of having 25 percent minority students in each entering class. But my discussions with the Black Caucus made me realize that achieving a more diverse student body would solve only part of the problem. We had a big job to do—recruiting black men and women in the campus workforce and administration. As a first step, I appointed Joanne Lewis as affirmative action coordinator for the campus. We also instituted a series of “racial confrontation groups,” organized by Price Cobbs, which brought black staff and white faculty together. For many, I think it was the first time they had ever spoken to one another. UCSF had almost no black faculty at the time.

I was Chancellor for only three years, but by the time I left that position (to start what would become the Health Policy Institute at UCSF), significant progress had been made in terms of job opportunities, pay disparities, access to services and facilities, and student enrollment. The emphasis on issues facing the black community created resentment among Hispanics, however, and one day in 1971 the campus police informed me about a bullet hole in the window of my office.

Reforming Medicare and Expanding Access to Care

As head of the Health Policy Institute, I had little involvement with Medicare policy until 1986 when members of Congressman Henry Waxman’s (D-CA) staff asked me to chair the newly established Physician Payment Review Commission. Waxman chaired the House Energy and Commerce Subcommittee on Health and Environment, which oversaw Medicare. The Commission’s purpose was to advise Congress on reforms in policies for paying physicians—

specifically, to institute a fee schedule for physician services and to slow the growth in spending for those services. Tapping me for the job was somewhat ironic because in meetings with medical societies in 1965, I had assured doctors that their usual and customary fees would apply to Medicare. And that had been the policy up to this point. Yet I felt I could bring something valuable to the Commission because, from the time I had been Assistant Secretary, I had been committed to listening to diverse ideas and to doing things with doctors rather than to them or for them.

At UCSF in 1969, black workers had to eat their meals in the basement, and top-floor bathrooms were off limits.


In many ways, I think the Commission fulfilled its task. We gave voice to people and organizations with very different points of view, and actively involved practicing physicians in designing, and participating in, studies to inform payment policy. But the Commission did not succeed in accomplishing one critically important objective: rationalizing the payments physicians receive for talking with patients and evaluating and managing their problems, as compared to performing procedures on them. I believe this failure contributed to the current shortage of primary care physicians.

During my tenure at the Commission I turned sixty-five and I vividly remember the celebration that the staff arranged for me, with a cake decorated as a Medicare beneficiary card. In the twenty-five years since, I have been grateful to have that card in my wallet. Medicare has given me access to outstanding medical care in Washington, D.C., California, and New York, and has protected me from what would otherwise have been unaffordable medical bills. I haven’t been involved in Medicare policy since I left the Commission, even when I was Assistant Secretary for Health a second time, under

President Clinton. But with his Administration's attempts at reform (in which I was involved) and with the passage of the Affordable Care Act under President Obama, I have thought a lot about the role of Medicare in our health system.

As I testified in 1961 to the Ways and Means Committee, what matters to me a great deal—both as a physician and a patient—are continuity and coordination of care. Physicians are not interchangeable. It takes time for patients to find the right physician for them, for a physician to get to know a patient and his or her problems, and for the two to develop a trusting relationship. When patients have multiple problems, which is often the case, a number of physicians are involved in their care. But the potential for error and harm is substantial if that care is not overseen by a physician who knows the whole patient.

Continuity and coordination of care are not possible without access to health insurance, and the Affordable Care Act has made insurance available to millions who otherwise would not

have it. But I am concerned that narrow physician and hospital networks are becoming the norm in affordable insurance products and when insurance rates go up and patients switch to less expensive plans, some are no longer able to receive care from their primary physician. Or, alternatively, their physician may leave the plan the patients can afford. As a Medicare beneficiary, my relationship with my primary physician is not at risk and I am able to receive care from physicians who work together in an integrated group practice. In 1967, President Johnson said we would continue to work until equality of treatment is the rule. By making Medicare an option for all Americans, the kind of care I receive could be available to everyone. 

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