



EDWARD M. KENNEDY ORAL HISTORY PROJECT

INTERVIEW WITH PHILIP CAPER

March 20, 2007
Boston, Massachusetts

Interviewers

James Sterling Young
Janet Heininger

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TRANSCRIPT

INTERVIEW WITH PHILIP CAPER

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Heininger: Why don't you tell us when you first met Kennedy?

Caper: I first met him in 1970 at Boston City Hospital. He had recently either joined or assumed the chairmanship of the Health Subcommittee of the Labor and Public Welfare Committee in the Senate. The [J. Lister] Hill-[Harold] Burton legislation, which was a law designed to provide federal grants for hospital construction, was up for its periodic reauthorization the following year I think, and that would be '71. He and Jack [Jacob] Javits, who was the ranking Republican on the committee, in the minority at that time, had always tried to rejigger the formula for the grants to better favor urban areas, because the program had always favored rural hospitals.

He wanted a tour of the Boston City Hospital, which was a municipal hospital in his state, one of them, to gather material for making a case for more money for urban hospitals. So his staff—I think it was Jimmy King—called me and asked if I—I was the president of the House Officers Association at that time, and he asked me if I could show the Senator through the hospital. He wanted the doctors, who really knew what was going on, to show him through rather than the administrators, who he probably thought didn't know as much about what was going on around the wards, which was probably the case. So I met him and took him on a tour of the hospital. It lasted an hour or so. That was the first time I actually met him face-to-face.

Young: So how did the tour go?

Caper: The tour went very well. He toured the wards, and he asked me what I thought was needed, and I said more money for this, more money for that, and better coordination of federal and state funds for healthcare. Because they were all siloed, and they were all in their own programs, and there were a lot of gaps and a lot of duplication.

Evidently his office didn't bother to notify the hospital administration that he was going to be touring the hospital, but they found out. I guess word gets around quickly when Senator Kennedy shows up and starts touring the facility. I was leading him through one of the wards, and all of a sudden we heard the patter of feet behind us. It was the hospital administrator running to catch up with us, wearing his three-piece suit, and he thought he ought to be in on the tour. Kennedy was clearly not terribly interested in having his input, so he tagged along after us for the whole

tour. And that was, I think, typical of the way Kennedy approached things. He wanted to get in at the ground level and talk to the people who were doing the work.

Young: And your position at the hospital was what?

Caper: I was the chief resident on the Harvard Medical Service at the time, and I was President of the House Officers Association at Boston City Hospital.

Young: So you were on the care side of it.

Caper: Yes. I was a resident.

Young: So that's the person he most—

Caper: Yes, I was a resident. At that hospital, it was the residents who provided essentially all of the medical care. Senior staff was in a teaching role.

I had also been involved in a labor action in 1967, when I was an assistant resident at the hospital. So he may have heard of me through that. We held what was called a “heal-in,” where we admitted patients to the hospital more frequently than we otherwise would, in order to demonstrate the shortcomings of the care at the hospital, the supplies and the—it was a typical, underfunded municipal hospital. We got quite a bit of attention for that because what we were looking for was better basic-care conditions and more money for the residents. At the time, residents were making about \$2,500 a year, and we thought we should make a living wage, which was about \$10,000 a year at that time. The “heal-in” got a lot of national attention in the medical-care world.

Heininger: And they still made you chief resident after that?

Caper: *Because* of that, I think. Yes.

Heininger: Too much attention to retaliate.

Caper: Yes. The medical faculty was not necessarily on the side of the hospital administration. They were adversaries. And Boston City was like something out of a Damon Runyon play or novel. It was a patronage organization that was, for Michael Curley, perhaps the greatest source of patronage in votes, and it was still very much so—that was in the mid-'60s. Of course it's a much different place now, primarily because of Medicare and Medicaid, because they gave people the wherewithal to go somewhere else.

Young: This is probably too much detail, but I can't avoid asking. He selected Boston City, not Mass General.

Caper: Right. Mass General is a private hospital, and Boston City was the people's hospital, and it was always where you had these incredible stories happening. Whenever something happened in the city, like the blackout of 1967, the press all headed to the Boston City Hospital; that's

where the stories were, sort of like the Bellevue of Boston. That's where the characters were, and that's where the stories were.

Heininger: How did you go from being a practicing physician, then, to working on his staff?

Caper: Well, I developed an interest, because of my experience at Boston City, in the way medical care was organized and financed. I was an intern in 1965, and that was the year Medicare and Medicaid were passed. I still remember very clearly July 1, 1966, which is when Medicare and Medicaid were actually implemented, and I knew it was going to change the hospital. I mean, this was a hospital that had previously been supported almost entirely by municipal property taxes, and it was a hospital for the indigent sick people of Boston, mostly the elderly. I think the average age on the male ward was about 75, and the average age of the female ward was even higher.

So I became interested in medical-care policy. Why was a hospital like Boston City so much different from the hospital where I had gone to medical school, UCLA [University of California, Los Angeles], which was a very different kind of teaching hospital? You got admitted to UCLA because you had an interesting disease, literally. If your disease wasn't interesting to the faculty, you got sent somewhere else. Boston City took everybody who needed to be admitted. It was the hospital of last resort. So the mix of diseases we saw was a lot different at City: less lupus and weird hairy-cell leukemias and stuff, and more chronic lung disease, liver disease, GI [gastrointestinal] disease, and so on—so, common illnesses.

I was trained as an internist, and the natural career trajectory would have been to go into some specialty: gastroenterology, hematology, pulmonology, nephrology. Instead of that, I took a fellowship at something called the Center for Community Health and Medical Care, which was a Harvard Medical School/School of Public Health joint center. It looked at issues of financing and the organization and delivery of care. I was one of the first physicians who did that. That was a new subspecialty in medicine.

Heininger: What was the name of it again?

Caper: It was called the Harvard Center for Community Health and Medical Care. One of the faculty was Rashi Fein, and that's where I met Rashi. When Kennedy became chairman of the Health Subcommittee, he was able to hire three staff members. They were Lee Goldman, who was the staff director; Stan Jones, whom you've met. And he was looking for a physician, and I think he asked Rashi for a recommendation. Rashi recommended me for the job, which is how I ended up being offered that job. Actually, at the time, I was a candidate for a White House Fellowship, which was another way of getting experience in Government at that time.

Young: You were a White House fellow?

Caper: No, I wasn't. I was a candidate. I withdrew to take the job with Kennedy. So I was going through that track, which was a program that [Lyndon] Johnson established, and you probably know all about it. I took the job with Kennedy in April of 1971. I wasn't due to finish my

fellowship until June, but they excused me from the last couple of months so I could move to Washington. I became the third staff member on this subcommittee at that time.

Heininger: How was work divided?

Caper: By topic. People would be assigned various pieces of legislation to work on. My first assignment was the National Science Foundation reauthorization. These authorities are generally renewed every three years in the healthcare field, the Public Health Service Act. So every three years, we had reauthorizations coming up. I was also assigned to work on the Health Professions Education Act, which was federal assistance to medical and allied health professionals: nurses, dentists, optometrists, osteopaths, allopathic physicians, and so on. I guess the Nurse Training Act was separate, but there were the veterinarians, optometrists, osteopaths, podiatrists.

Then I was assigned the HMO [Health Maintenance Organization] Act. The HMO Act was a proposal actually put forward by [Richard] Nixon, who had what today looks like a very progressive healthcare package, including national health insurance, aid to medical education, the Health Professions Education Act, and then the HMO Act to restructure the delivery system. Stan Jones was actually assigned to work on that national health insurance legislation.

Young: I see. The HMO explained a little bit about that, the concept of it, and Kennedy bought into that.

Caper: Very much. He changed his mind later.

Young: So the context would be important.

Caper: Yes. The context was this: the HMO concept was an idea, I think—well, I won't say dreamed up, but marketed well by a physician from Minnesota named Paul Ellwood. Paul was a physician who was pretty close to Walter Mondale, who was a member of our committee at the time. Ellwood actually succeeded in selling the Nixon administration on the idea of funding HMOs as a way of restructuring the delivery system, which at that time was predominantly a fee for service.

An HMO was an organization that would actually hire physicians and pay them on the basis of capitation—that is, per member of their HMO per year—or salary plus bonuses. It was intended to do away with pure fee-for-service medicine. I had a background in what was then called HMOs. We used to call it prepaid group practice. The Harvard Community Health Plan had been started at Harvard by Bob Ebert, who was the dean of the Medical School at that time, and a group of people who were associated with the Harvard Center for Community Health: such as Bob Weiss and Rashi Fein and Paul Denson, who was the director of the center.

I had been indoctrinated in the virtues of prepaid, multispecialty, group practice, which is one type of HMO. I was very enthusiastic about the prospects for HMO because I saw fee for service being an anachronistic way of paying physicians. I thought that some kind of management structure was going to be necessary to integrate all of the subspecialties that were evolving in medicine.

Young: Was the thought that it would increase coverage or availability?

Caper: No. The thought was it would increase the quality and coordination of care. It was a concept complementary to national health insurance that would provide the financing, and that would increase the availability of coverage. So we tended to think of those two pieces of legislation in lockstep, because in 1971 everyone thought we'd have national health insurance. Nobody was against it except the doctors. The AMA [American Medical Association] was against it, but for everyone else in the debate, it was only a question of what flavor of national health insurance would be enacted, not whether it would happen or not. That turned out to be a miscalculation. But at that time, in 1971, we thought that was what was going to happen.

And of course Kennedy was the lead sponsor of S.3, the Health Security Act, which was the program supported by the unions, primarily the UAW [United Auto Workers] and Walter Reuther, but also the AFL-CIO [American Federation of Labor and Congress of Industrial Organizations]. They were a little less supportive but still supportive of it. And everyone had their own national health insurance plan. The hospitals had theirs, and the business community had theirs, and everyone said, "Gee, this is a done deal. We just have to decide what it's going to look like."

So the HMO plan at that time was designed to be an adjunct and a complement. The HMO Act would essentially take on the question of how you restructure the delivery system. And national health insurance would deal with the financing: How do you pay for it? Who's covered? and that sort of thing. So they were very much complementary.

Heininger: Did Kennedy have any background in HMOs before the idea emerged on a national scene?

Caper: No, I don't think so.

Heininger: Had he had any exposure to the Kaiser Plan in California?

Caper: He may have known what it was, but I doubt that he could really describe it. I don't think so, no.

Heininger: So his was actually a reactive response—

Caper: To Nixon.

Heininger: —to Nixon. Interesting.

Caper: But different. I mean, we had minor differences in terms of the range of benefits. We wanted these HMOs to act as a precursor and as a template for national health insurance. We wanted to make sure that they had open enrollment—that they couldn't cherry pick—and we were willing to provide subsidies for that. We wanted to make sure they had community rating—that is, they couldn't charge different people, different illness classes, different fees. There had to

be cross subsidization. So we were preparing the ground for national health insurance, that was our rationale, and we were willing to provide federal subsidies for that, which, of course, is something the Nixon administration wasn't interested in doing.

Heininger: So where would you say the real differences were between where Kennedy was and where Nixon was?

Caper: Well, I think those were the important ones. We saw the HMO movement as being a way of providing additional access, through federal subsidies, to care. So in that respect, it was about access. But we recognized that HMOs alone weren't going to solve the problem. We needed national health insurance in addition to that. Also we wanted to take on the insurance industry practice of cherry picking and discriminatory pricing, which makes a lot of sense if you're an insurance company, but not as a healthcare financing vehicle. That's still a major issue today. I don't know if you've seen the *Los Angeles Times* series recently on the way insurance companies are cherry picking their cases. It's getting worse. I mean, it has to get worse because it's a structural problem. It's not a question of somebody being evil. It's a question of, well, if you're an insurance company, that's what you do in order to stay profitable.

Heininger: A question of money?

Caper: Yes, definitely.

Young: So Nixon had in mind having this financed through private insurance, basically.

Caper: You're talking about his national health insurance plan now?

Young: No. I'm saying—

Heininger: On the HMOs. The HMOs, you had, at the end of the tunnel, the light you were seeing was, if you did it this way, then the funding would come in from national health insurance.

Caper: Right.

Young: Was that Nixon's anticipation at the same time?

Caper: I think it was. HMOs had been controversial among physicians for many years. I mean, it's not a new concept. The HMO concept goes back to the 1920s, when the first few HMOs were developed.

In some states, they were actually illegal. In Texas, for example, the corporate practice of medicine was illegal. You could lose your license for working for an organization that provided medical care, and that was true until very recently in Texas. Doctors didn't like the corporate practice of medicine. They liked the model of the individual solo practitioner, fee for service, let the doctor deal directly with the patient. Of course they didn't like health insurance particularly either when it was first developed. It was actually initiated in Texas in the 1920s and '30s as a

teachers' medical-care prepayment fund. And the doctors didn't warm up to it until they figured out that through the Blue Shield organization, they could actually control it. Blue Shield was actually medical-society dominated for many years.

Young: So the opponents of the HMOs then were what?

Caper: Mainly the AMA, and that's pretty much it. Elliot Richardson was the Secretary of HEW [Health, Education, and Welfare] in 1971, the first year the HMO legislation was being heard, and he said, "The Nixon administration's goal is to have 80 percent of the population of the country able to access HMOs within ten years"—80 percent. Over time, as the Nixon reelection campaign approached in 1972 and with it Watergate, the weaker he got, the less enthusiasm he had for HMOs. The AMA actually took credit for changing his mind. And at the end, he saw the HMO Act as a demonstration program, very limited funding, and he was really very tepid about it.

We were, of course, still very enthusiastic about it; we thought it was a way of providing Medicare more efficiently and at a higher quality, because of its ability to integrate specialties, and to change the way doctors were paid so they weren't motivated by doing a lot of what we see today, which is doing a lot of stuff of marginal value but very high profit margin.

Heininger: Why did Nixon retreat? Was it simply pressure from the AMA?

Caper: I think that was part of it. It was around the 1972 Presidential campaign, and I think that it was primarily the AMA. They were the only ones really working hard to get him off this idea of HMOs. They were the only ones really strongly opposed to it. Everyone else thought it was a good idea.

Young: This is another form of socialized medicine?

Caper: Well, it's corporate medicine. Corporate medical practice is a way of controlling the doctors. "Here comes the Federal Government in, controlling the doctors." Ironically, while they were spending all that time fighting off the government, the corporations were taking them over. I don't know if you've seen Paul Starr's book, *The Social Transformation of American Medicine*. In 1982, when that book was published, he predicted, "This is what's going to happen: doctors are going to spend all this time, a whole century, fighting off the government, and in the meantime, they'll be taken over by the corporations," which, of course, is precisely what has happened.

There are very few purely solo practitioners anymore, at least around here. They all work for Partners Healthcare or some big medical corporation or the insurance companies. So that was their fear. I mean, that goes back a long time in medicine, this fear of being taken over by somebody else. And I think that was what their concern was.

Heininger: Now, in '73, when the legislation gets enacted, there was an amendment on the floor. Why did the definition of HMO get broadened to include independent practice associations?

Caper: Pete Dominick. Peter Dominick was the ranking Republican member of the subcommittee, from Colorado. The Colorado Medical Association got him to stick that in, at the behest of the AMA.

If we made one mistake in the HMO legislation, that was the one I'd like to take back, because the doctors thought that would open the definition to these independent practice associations, allowing fee for service networks to be defined as federally recognized HMOs. The doctors thought that would give them an opportunity to come in and control them, possibly through the Blue Shield plans, which the medical societies tended to control. Instead it gave the insurance companies the opening. And then, of course, they were better capitalized, better managers, knew how to run organizations, which the doctors really didn't. And so the doctors essentially gave the insurance companies the ability to come in and begin these HMOs, which the insurance companies took advantage of. That is when the backlash to HMOs really developed.

Heininger: Did Kennedy foresee any of this? Did he foresee where this was going to lead? Because this was a real departure from your prepaid health plan.

Caper: Yes, but we thought it was the only way to get the law passed.

Heininger: Okay, so for political expediency, it was necessary to do it.

Caper: We didn't like it, but we caved on a number of issues. One was the open-enrollment, community-rating issue, because without the subsidies, which we couldn't get, we knew it wouldn't work. It does create an unfair burden on HMOs compared to the indemnity insurance companies without subsidies. It is more expensive to enroll sick people than well people, and if you can't differentiate on the premiums, then you have to figure out a way to subsidize the plan. By 1973 we weren't able to do that.

I think one of the reasons we put that stuff in was just to highlight these issues. I mean, these were real problems even then in the health insurance industry. They were not quite as obvious as they are now, but they were still problems that we could see had to be fixed if you were going to have a true national health insurance program. And they're still big problems; they're still big issues. The problems haven't been solved. That's why we have so many uninsured people in this country. That's why so many people are becoming uninsured, so many more people, because of the practices of experience rating and cherry picking.

Heininger: Did he see the HMOs as a mechanism for controlling costs?

Caper: Yes, sure. That was one of the purported advantages of HMOs: first of all, because they were thought to be more efficient than fee for service, and second, because they removed some of the financial incentives operating on the doctors to do tests and procedures that may not be necessary.

Heininger: But they were very expensive to set up—

Caper: High capitalization costs.

Heininger: —because if you're using the Kaiser—yes, high capitalization using the Kaiser model, where they had to build their own hospitals and build out facilities.

Caper: That wasn't the only model. Harvard Community Health Plan never built their own. There are lots of good examples around the country. Kaiser was the biggest one and probably the most prominent, but Group Health Cooperative of Puget Sound is a consumer co-op model. Harvard Community Health Plan was working pretty well at that time. They owned no hospitals. They used the most expensive hospitals in town, and they still were able to be price competitive. So that was one of the advantages we saw in HMOs, the ability to control costs.

Heininger: Was there a debate over which model to follow, or was it left undefined as to whether they would be prepaid development facilities?

Caper: The original HMO Act, which we introduced, allowed for staff models, such as the Harvard Community Health Plan, where the doctors actually worked for the HMO, or a group model, which is the Kaiser model, where the group is a separate entity but contracts exclusively with the insurance plan, the Permanente part of it. Kaiser is the medical group, which I think is still a for-profit group. Permanente is the insurance plan. But they have exclusive relationships with one another, and they own their own hospitals; the Permanente Plan owns their own hospital. Then there was the HIP [Health Insurance Plan] Plan of Greater New York, which is much looser—so we allowed at least those two models. And then Dominick tried to get this IPA [Independent Practice Association] model stuck into the legislation in committee, and I think we were able to fight that off. I think you're right; there was a floor amendment accepted that permitted IPAs.

Heininger: But Kennedy acquiesced on it too.

Caper: Yes, because we thought we needed it to pass the bill, which is not unusual for Kennedy. He does that. He does what he needs to get his legislation passed.

Heininger: Where were the hospitals on this?

Caper: Well, they wanted hospital-based HMOs. I mean, they didn't fight the concept, but they wanted to make sure their flavor was recognized. Actually the federal certification in that bill was the only important element—the money didn't make much difference to the larger organizations. They had their own money. They didn't care about the federal grants and loans.

What was important to them was what was called the mandated dual-choice provision in the HMO bill, which required that employers offer HMOs as an option for their employees if an HMO that was federally certified was operating in their area. So that suddenly gave them enormous market power, and that was the most important provision in the bill in terms of incentives to become an HMO. The grants and loans and all that stuff were nice if you were a nonprofit trying to get started, but I think it was much less important than the mandate, because that guaranteed access to the market.

Heininger: Was that something that Kennedy put in, or was that something that came to you with a concept from—

Caper: I think Kennedy put it in. I can't remember exactly where that concept came from, but we certainly embraced it. At that time, this bill had been going through the legislative process for two years, and I honestly can't remember where that idea originated.

Heininger: Because unless there's mandated choice that they be offered, there isn't a whole lot of incentive for them to—

Caper: Well, no. Nixon was talking about megabucks to finance this bill in 1971, so there was a lot of money in it. By the time we got to 1973, I think it was down to, I forget, \$5 million or something, a demonstration. So we recognized that there had to be something else in it. Of course our concept was, when we got national health insurance passed, we would provide a source of payment for these HMOs. And of course that never happened.

Heininger: Tell us a little bit, from your perspective of working on the HMOs, of what was going on in the national health insurance end.

Caper: Well, there's a lot. Nixon came in and I think he produced his White Paper on healthcare in 1970, which had three elements: national health insurance, which in his bill was an employer mandate, high-risk pool, a blended form of national health insurance. He wanted to increase the healthcare workforce, so he proposed, for the first time, significant federal assistance directly to medical schools, dental schools, osteopathic schools.

Heininger: That was the first time there had been—

Caper: It may not have been the first time, but it was the first significant dedicated legislation intended to vastly increase the number of health professionals. And the third element was restructuring of the delivery system through HMOs, which Paul Ellwood was very prominent in promoting.

Heininger: The health workforce, was there a perceived shortage of health professionals?

Caper: Oh, yes. In fact Rashi had written a book about the doctor shortage. There were periodic shortages of health professionals, depending upon how you define shortage. At that time, there was perceived to be a shortage of physicians, a shortage of nurses, and it was necessary for the Federal Government to come in and pour a lot of money into education for these people.

Heininger: Was this tied to the passage in Medicare?

Caper: Partially, yes, I think, but we're going through another nursing shortage now. What you have a shortage of depends upon how you define shortage and how you envision their roles. Rashi actually made his early reputation through his study of the doctor shortage. I think he wrote the book in the '60s, when he was still at the University of North Carolina, about the doctor shortage. You can ask him about that. He's the expert.

Young: Was the issue of rural versus urban care in the background of any of this HMO stuff?

Caper: Well, not only in the HMO stuff, it was the health professions stuff, too.

Young: Did you give incentives?

Caper: Yes, we provided incentives to medical schools to train primary care physicians, and that was a big deal. I mean, the whole family-practice movement was just beginning to get started as a specialty at that time. Before that, family doctors were basically people who hadn't had a specialty residency. And the specialty of family practice was just beginning to develop in the late '60s, early '70s. There was a doctor I remember. His name was Amos Johnson. He was just an old country doc from South Carolina, and he used to come traipsing up to Capitol Hill and lobby the legislators about the importance of family practice.

So we provided incentives to try to encourage the medical schools to train primary care physicians, because they were going in the opposite direction at that time. They were pushing specialties. Our legislation caused a lot of heartburn within the medical-education community. Suddenly it became an academic-freedom problem. And we said, "Well, no, it's not, it's a manpower-training problem. It's not about academic freedom at all." Of course that irritated them even more because they didn't like to see themselves as training tradesmen. These were academic freedom fighters. So that was a source of friction between us and the medical colleges, which was a true source of a lot of contention, because they didn't want the Federal Government influencing how they taught. In fact my old dean, Sherman Mellinkoff, was one of the chief agitators against federal intervention into what he called the curriculum. "You can't tell us what to teach."

The other thing that happened was that everybody suddenly became a primary care doctor in response to the incentives. Ophthalmologist, primary care. Obstetrician, primary care. Pediatrician, primary care. In order to qualify for the benefits in the federal programs. You know how that works. So it was an education for me and for everybody else.

Young: But the emphasis is on primary care regardless of the people who call themselves that. Less substantial, wasn't it though?

Caper: Oh, yes, very much so, because we said, "What we're going to have is a fragmented delivery system. You're going to have a bunch of specialists but nobody to take care of the whole patient"—

Young: That's right.

Caper: —which, of course, is precisely what's happened despite our efforts. As I myself get into the medical care system, I find myself managing my own care because these guys don't talk to each other—your endocrinologist and your rheumatologist and your cardiologist, et cetera—and they don't share records, and they never talk to one another, and they often don't know what

medicines the other guys are prescribing. So it's a real problem. It has given rise to a little bit of a backlash in medicine but not enough to overcome the economics of the situation.

Heininger: When you looked at it at the time, in the early '70s, was this a problem that had been growing, say, over the '60s, or was this something that was really prompted in large part by Medicare or changes in the academic community, the move toward specialization and away from primary care?

Caper: I think it was a combination of things. It was certainly what was going on in the medical schools. I mean, the specialists were the sexy guys, and the primary care doctors were always looked down upon, at least in my medical school experience. These are people who weren't smart enough to become specialists, weren't well trained, didn't know what they were doing. So they got no respect.

A lot of it was the economics, some tied to Medicare, but I think, more importantly, tied to the spread of health insurance in general in the private, as well as the public, sector. And, of course, tied to fee for service, where this usual customary-and-reasonable-fee model was taking hold, where the higher you could jack your fees up, the higher your payments became, because your actual payments were based upon your historic profile of charges. People figured out also that if you were paid by the procedure rather than by the unit of time, you could make a hell of a lot more money, because procedures don't take all that long and because of the enormous amount of discretion in medical decision-making.

Medicine is not science. I mean, despite the fact that doctors like to dress up as though they're scientists, they're not, really. They're treating one patient at a time, and science is a statistical game, largely. That is still one of the big problems in the explosion of costs in medical care: the number of procedures, both diagnostic and therapeutic procedures, being done. So we saw this probably even at that time, and we made those arguments, but they weren't persuasive because it wasn't a problem for the public, and that's what politicians pay attention to.

Heininger: Now, from the public standpoint, given that everybody thought that national health insurance was inevitable, was there a sense that the public thought that too, and if so, why?

Caper: Well, if you can judge by the kind of coverage the issue was receiving in the press, I think people did think it was inevitable, or at least in 1971, '72, '73. I think the first time that we really realized that it wasn't inevitable is when we lost the vote in the House. It was a committee vote, in the Ways and Means Committee, on the Kennedy-[Wilbur] Mills bill. That went down to defeat fairly narrowly in that committee.

I remember Kennedy was there for the committee vote, was there in the House in the committee room. He went over to watch it, and he came back afterwards and said, "You have no idea how powerful these insurance guys are. They've just begun to flex their muscles." And they're the ones, of course, who defeated the bill, because they were opposed to any kind of national health insurance. The insurance industry was much weaker at that time than it is now. There was one point when the big commercial insurance companies weren't sure they wanted to get into the

health insurance business at all, because they weren't sure they were going to make any money at it.

Young: Was it that national health insurance would leave no more room, put them out of business, right? Was that in fact the case?

Caper: It depends upon what kind of program you're talking about. But they were afraid it was going to put them out of business, and it was partially an ideological opposition to any additional government control over the insurance industry. And they've been very successful in putting off any kind of federal control. The insurance companies are still largely regulated by the states, whether it's malpractice insurance or health insurance or any other form of insurance. That's the way they like it, because they're a lot more successful in the state legislatures than they would be with the Congress, particularly with the Democrats in control of the Congress. So I think that it was a combination of things.

Young: But looking ahead a little bit, is it the case that Nixon's proposal for universal coverage of some 80 percent, or whatever it was, would not be a threat as much?

Caper: It wouldn't be as threatening, but it did represent federal regulation of their business.

Young: Regulation or not, but they'd still be in business.

Caper: Yes, but they would be much more highly regulated by the feds than they would otherwise, and they didn't like that.

Young: They didn't like that, so they got to Nixon, or at least the doctors got to Nixon.

Caper: Well, they got to the Congress. I mean, Nixon, at that point, was in big trouble. And he was looking for a win, which is one of the things that motivated us to start talking to him and to try to get this, because the administration was very much a part of the negotiations on the Kennedy-Mills legislation. Stan is the guy to talk to about that. But they got to the Ways and Means Committee members in the various ways these guys get to the members: campaign contributions and whatever else.

Heininger: Kennedy's proposal would not initially have left the private-insurance system in place by going to a single-payer, federally funded—

Caper: Right.

Heininger: —and subsidized. Nixon's original proposal did, because Medicare was still processed through the private insurance companies.

Caper: Well, yes, but there's a big difference between the Federal Government underwriting the risk, which is what they do in Medicare, and the private insurance industry underwriting the risk, which is how they make their money, which is what they would have done in the Nixon proposal. So there was a significant difference. In Medicare, they're just claims processors—

Heininger: Right.

Caper: —which is a good business for them. They make money doing that, but they wouldn't be able to make the megabucks they'd make by selectively gaming the risk pool. That's where the big money is. They're making \$150 billion a year in profits now. That's not chicken feed. And that would be gone under a Medicare for all type of system. But Kennedy, God bless him, is still in favor of Medicare for all; that's his position right now. So he's sticking to his guns.

Heininger: What was Labor's role in this whole process?

Caper: Labor wasn't totally unified. The push behind this was the UAW and Walter Reuther. I don't know if you saw the *New Yorker* article by Malcolm Gladwell—I think it was last August—called “The Risk Pool.” If not, you should read that because it gives a lot of very interesting history about Labor's involvement in the whole health insurance game.

Walter Reuther had the foresight to understand that healthcare costs eventually were going to kill them—the corporations as well as the unions. I mean, they were essentially giving up lots of other benefits in order to just maintain their healthcare coverage, because the cost of it was going up so quickly. He was one of the first people to see that in their own self-interest, their best move would be to offload the whole problem onto the Federal Government. Of course, don't forget that Canada at that time had just recently enacted their own Medicare program, I think, in the early '60s, just before our Medicare program. And theirs was a universal program on that account. So I think the UAW was the real push behind that.

All that politicking happened before I joined the staff. I think Rashi was around for that. The other person you ought to consider talking to, to get additional background, is a man named Max Fine, who lives in Washington. Max was the Executive Director of the Committee for National Health Insurance. Rashi was on their advisory board.

Young: That was not the Committee of One-hundred?

Heininger: It's the same thing.

Caper: The Committee of One-hundred was part of it, yes. The Committee of One-hundred was a hundred experts. They got together, and Rashi was on that committee along with a lot of other people. CNHI [Committee for National Health Insurance] was the lobbying operation set up in Washington, and Max was the Executive Director of that.

Heininger: Is he still in Washington?

Caper: He's in Silver Spring, yes. I still e-mail Max every once in a while. He's in his eighties now. And Max can tell you, I'm sure, some fascinating stories.

The AFL-CIO is a different story. I mean, they were on board, but they weren't as enthusiastic. And the reason they weren't as enthusiastic was, I think, because they really liked their health-

and-welfare trust funds. There were hundreds of millions of dollars that the trustees, the leadership of the AFL-CIO, got to play around with.

In fact I remember a hearing Wilbur Mills held on health insurance—I was there—in the Ways and Means Committee in the House, and George Meany was up there testifying. This was in, maybe, 1972 or '73, and Mills actually asked Meany, “What’s going to happen to these trust funds?” Meany gave testimony in favor of the National Health Insurance bill, S.3 in the Senate. I forget the number in the House. I think it was H.R. 22. Mills actually asked Meany, “What’s going to happen to all these health-and-welfare trust funds when this national health insurance bill takes over and you won’t need them any more?” Meany just said, “Well, you let us worry about that, Mr. Chairman. We’ll figure out a way to make good use of that money.”

They weren’t terribly supportive of the Kennedy-Mills effort at that time because they thought it actually stood a chance of passing, and so they held out for a veto-proof Congress in 1974. “We don’t want this; we want S.3, which is the perfect solution.” I think they would have bolted at the end if it looked as though it actually stood a chance of passing, the leadership of the AFL-CIO.

Heininger: Really?

Caper: Yes. Reuther was an ideologue. I mean, he was a true believer, but I don’t think that was true of the other unions.

Young: Well, that pulled the rug out from under Kennedy-Mills, didn’t it?

Caper: I think they may have very well have done that, yes.

Young: Because then, why would they have to?

Caper: Right. Well, they were left with the UAW, and the Teamsters were never particularly enthusiastic about it. They didn’t care much one way or the other. So yes.

Young: It’s not a strong position to go in bargaining with Nixon.

Caper: Right. Well, Nixon himself was badly in need of a legislative victory. This was months before he ended up resigning. He was being dragged down by Watergate; he was being threatened with impeachment; he was looking for something to boost his own popularity; and that’s why he was willing to deal seriously with us on health insurance. In the end the insurance industry and the lack of dedicated support on the labor side killed it. That’s the closest we’ve come. I think it was 1974 when that vote occurred.

Young: If it hadn’t been for that, Watergate, do you think it had a fair chance of passage?

Caper: I don’t know the answer to that. Nixon and Kennedy were really like that [*gestures*]. They were really at odds. Nixon was quite paranoid about Kennedy because, at that time, he thought Kennedy was going to run against him in 1974, which he had decided not to do. So it was hard for either one of them to do anything and give the other guy credit. Whenever we went

to Kennedy's house in McLean, we were always looking for the stakeout, the FBI [Federal Bureau of Investigations] guy sitting out in front of Kennedy's house watching who was coming and going.

Heininger: And they were there?

Caper: I don't know, but we thought they were [*laughs*].

Young: There is some evidence that at least a suggestion was made by the White House.

Heininger: If they'd burgle a psychiatrist's office, why wouldn't they stake out Kennedy's house?

Caper: And if they killed his two brothers, why wouldn't they? Whoever *they* are.

Heininger: They.

Caper: Jackie [Jacqueline Kennedy Onassis] thought the threat was great enough to move her kids to Greece—the Greek Islands, no less.

Heininger: Well, there are worse places.

Caper: That's right.

Heininger: Let's talk a little bit about Kennedy on health planning. What were his goals for health planning?

Caper: The Health Planning bill really originated in the House. It was really pushed by the staff of the House Interstate and Foreign Commerce Committee—one staffer in particular, named Lee Hyde, who worked for Harley Staggers, chairman of that committee. We didn't really initiate that bill, although we were the chief sponsors in the Senate.

But health planning was another attempt to deal with what we saw to be the lack of coordination in the delivery system. So in a sense, it was like HMOs. It was a way to rationalize the delivery system, because we were worried about too many hospitals in too many different places and not enough planning in the healthcare system. There was no planning prior to that bill. We ran headlong into the people who at that time were beginning to talk about letting the marketplace fix it all.

And that movement really began—the Health Planning bill was passed in 1975. It was implemented in 1976, and it was an attempt to have essentially top-down planning for the entire U.S. healthcare system, which now seems like a hopelessly naive idea, but at that time it seemed like not a bad idea. Built on a system of voluntary health planning at the community level. I think it was a 356-A program or whatever, a public health service program that provided money to these voluntary health planning councils in various parts of the country. And this was an attempt to institutionalize that idea on a national and comprehensive basis. It actually passed, which to

me is still amazing because it just shows you how much different the political culture was at that time than it is now. I mean, nothing like that would ever get out of subcommittee these days.

Heininger: Well, that's socialist.

Caper: Some people would see it that way.

Heininger: It's a whole federal system deciding what can be built in a community.

Caper: Right. But input from localities and states was built into it.

Heininger: It's amazing that it got passed.

Caper: It just shows you what a different environment we were working in then.

Heininger: Well, and '75 was even on the late end too. How did it manage to get through then? Was this under [Gerald] Ford?

Caper: Ford signed it, yes. Ford had just recently taken office. I forget exactly when Nixon left. I think it was '74.

Heininger: Yes, August 11, I think.

Caper: Yes, August. Ford signed it. It was the last bill that passed the House in 1974, just before the Christmas recess. I think Ford actually signed it in 1975, so it was passed within ten days of the end of the year. I don't know how it passed. There just was no real opposition to it. It was amazing.

Young: That is something. Something slipped out of sight. There used to be something called the National Resources Planning Board, which FDR [Franklin Delano Roosevelt] put in. And it had a similarly broad mandate, and it was spotted right away.

Caper: Wasn't [John Kenneth] Galbraith in charge of that at one time?

Heininger: Yes.

Young: Yes, or Executive Director or something. And it was a formula for socialism and for endless reelection for Roosevelt. They tried to convert it to a wartime thing, but it was axed by Congress. It was the only one of the White House organizations that was part of the Executive Office of the President, and then Congress said, "No. No more of this, ever." And here it is, the same thing cropping up again. I wonder if Harley Staggers was around.

Caper: He was around. Lee Hyde worked for Harley, and he was one of the lead sponsors of this thing. So if Harley's in favor of it, it must be okay.

Heininger: Why was he in favor of it?

Caper: I don't know.

Heininger: Was he seeing West Virginia left out?

Caper: I don't know. I think that planning was just not a bad word in those days, and this one staffer, Lee Hyde, was really—he was a physician actually—he was determined to get this thing passed. There was already a planning program in the Federal Government. This was viewed as an augmentation of an existing program. It just slid through.

Young: But it never amounted to much.

Caper: Well, it did, actually. It was around long enough to prove that it didn't work. It was repealed in 1986 under [Ronald] Reagan. I was actually on the National Health Planning Council that was set up to oversee the program on behalf of the Federal Government. Then the Planning Council oversaw state-level organizations in every state. Every zip code in the country was covered by one of these planning organizations, these so-called Health Systems Agencies. There was a federally-required certificate-of-need legislation in every state. It was amazing. I actually sat on that Planning Council for seven years. I was Chairman for three years, during the waning days, under the Reagan administration. Of course the administration ignored everything we recommended.

[Joseph] Califano was Secretary in the first few years, in the [Jimmy] Carter administration. We promulgated guidelines on this, that, and the next thing. Then we figured out that what we'd set up was a franchise system under the certificates of need, and it was a full-employment act for lawyers and lobbyists. "Go out and I'll help you get a CON to build your hospital, buy your CAT [Computed Axial Tomography] scanner, do whatever." All those had to be approved by the state plan, because we thought, if there weren't some constraints in place—I mean, much of that philosophy is the same as the HMO—if there weren't those constraints, we'd develop excess capacity and health care costs would go out of control.

Heininger: Well, and in the wrong places too. Was this an attempt to equalize across urban/rural?

Caper: Yes, that was part of it. There were federal guidelines that the Planning Council was going to promulgate. I remember when we promulgated guidelines for hospital beds: four beds per thousand people was what was thought to be the appropriate level of hospital beds. And we promulgated those guidelines—I think Califano did—and it created an uproar in Congress when they figured out that it applied to their own districts and they started hearing from their hospital people. The House actually passed a resolution opposing the guideline that was promulgated under the bill they'd approved a couple years earlier. So things change.

Heininger: And Kennedy was in favor of this?

Caper: Yes. He was the lead sponsor in the Senate on that bill, and it became Public Law 93-641.

Heininger: Why didn't it work?

Caper: Well, because it's America; it's not Canada. That's why it didn't work. That's the simplest answer [*laughs*]. The American people don't like to be told what to do, and if somebody tells them what to do, their first instinct is not, "Well, maybe we ought to do it for the common good." Their first instinct is, "How do we get around it?" It's America; that's why it didn't work.

Young: I wonder if you might talk a little bit about Kennedy as subcommittee chair, just more broadly, without necessarily relating it, except by illustration, to a particular issue. I had wondered whether that was something he set his sights on early—that is, healthcare issues. But I'm wondering now whether that was the case or not and it was an accident.

Caper: Well, he, I believe, agreed to become the chief sponsor of S.3—

Young: Yes, he did.

Caper: —prior to becoming subcommittee chairman back in '68 or '69. [James] Corman and [Martha] Griffiths in the House, I think, and Kennedy in the Senate. If you talk to Max, he'll tell you that they never expected to get someone as prominent as Kennedy to champion this. They were delighted—ecstatic, I think he'll tell you—when Kennedy agreed to do it. So I think his decision, it was a choice between education and health. I think Claiborne Pell was scheduled/slotted to become chairman of the Health Committee.

Young: Yes.

Caper: He stepped aside. Somebody talked him into stepping aside so Kennedy could assume the chairmanship, I guess, after Kennedy had agreed to be the chief sponsor of S.3. So Max may have been involved in that; Reuther may have been involved in that. I don't know the details on that issue, but at some point in the late '60s—'68 or '69—Kennedy decided to take health on as an issue. I think he'd been involved in healthcare before that, as a member of the committee, with the community health centers.

Young: Yes, that happened.

Caper: And that, I think, is because of Jack Geiger and Count Gibson and the Columbia Point Health Center, which was the first neighborhood health center in the country. It was started by a doc who was actually another Boston City product, Jack Geiger. He is a fascinating character. Just for the fun of it, you ought to look him up if you haven't already. He was a journalist for a number of years, then went back to medical school. He's been quite a real activist and still speaks frequently. So I think Jack had something to do with it. Kennedy toured the Columbia Point Health Center and thought it would be a good idea for the country, so he introduced federal legislation.

Jack started another health center, which was a rural model, in Mound Bayou, Mississippi. So he had these two health centers going: one in the Mississippi Delta, in a very poor, primarily black,

area of the country, and the other up here in Boston. Kennedy had an interest in health prior to S.3 and prior to becoming chairman, but something happened, and he decided to take this on as a major issue. When I first joined the subcommittee, my first day on the job was spent preparing for one of a series of field hearings he conducted across the country in 1971. The first one was in New York City.

Young: Did you go with him on those?

Caper: Yes. The entire staff was involved, and we leapfrogged one another. We divided the country. There were, I think, a dozen hearings in various parts of the country, all of them in states of members of the subcommittee. We had one in Colorado, Pete Dominick, and Jennings Randolph in West Virginia, and Jack Javits in New York. [Charles] Percy was on the committee at that time, so we did one in Chicago. [Alan] Cranston, California; [Robert] Packwood, Oregon. So we went across the country setting up these hearings. I did a bunch of them, and Stan did some of them, Lee did some of them, and a lot of his office staff was involved in advancing the trips. Max Fine helped set them up. He helped get us witnesses, horror stories about people having no health insurance and being driven into bankruptcy.

Young: “Tell us what happened to you.”

Caper: Yes.

Young: I take it that it was excerpts from those hearings that he included in his 1972 book on the crisis of healthcare.

Caper: That’s right.

Young: And it was straight out of those.

Caper: Yes. From his point of view, I think it was a huge success, which means lots of press. Everywhere he went, when Ted Kennedy came to your state in 1971, that was a big deal. He was still a presumptive President someday, and so he got extensive press coverage for these hearings. It was a huge success, and it was part of a push on S.3, on the national health insurance front.

Young: It was also going directly to the beneficiaries of victims—

Caper: That’s right.

Young: —of the healthcare system, getting their testimony into the record, which I don’t know whether this was the first time he did that or not, but it became a repeating—

Caper: I think so. I think this was the first. And as I said, that was my first day on the job, and I was just totally bewildered by everything, coming from universities and academic institutions for the past several years. So this, to me, was just mind blowing.

Young: Well, but you had been at Boston City.

Caper: Well, yes.

Young: So you hadn't been totally blocked out.

Caper: It is a little real world, but Boston City was a unique blend of academic and practical. It was a very unusual program to the extent that—I mean, there were other places, obviously, where medical school—

Young: But I'm sure you could recognize some of the stories from the viewpoint of the patient.

Caper: Oh, yes. But I mean the whole business of a Senate committee coming to town and setting up the hearings and dealing with the press and all. That was new.

Heininger: Do you remember whose idea it was?

Caper: No. They were a done deal by the time I joined the staff, but I suspect Max Fine had a lot to do with it. He was responsible for the lobbying effort for it, to try to get this bill passed. That's what his organization was all about.

Young: None of them televised, I take it.

Caper: There was television coverage. They weren't televised live, but there was television news coverage in every place, yes, sure.

Young: Had he already gone abroad?

Caper: No. He went abroad in the fall of that year, to Israel, to Great Britain, and to Scandinavia to look at their healthcare systems.

Young: How did that come about, do you know?

Caper: I may have suggested it, actually, because of course I knew about these systems in other countries, and I may have suggested that he think about doing that. I can't remember, to be quite honest. Somebody on the staff suggested it. It may not have been me—I can't remember—but I thought it was a good idea.

Young: Did you go with him on any of these?

Caper: Yes. I got to spend a month in Scandinavia advancing that trip, which included Finland, which is not really a Scandinavian country, but certainly the three Scandinavian countries. So I went on the Scandinavian part. I spent a month there preparing for his visit, setting up meetings.

Young: Well, tell us about how that—because this may also be a first for him.

Caper: Maybe, yes. He picked out these three places. He wanted to see how their healthcare systems worked. I'm not sure how those selections were made, as to which places to visit, but I may have proposed Scandinavia because I thought those were the closest to the kind of healthcare program we were proposing, particularly Norway and Sweden, and to a lesser extent Denmark. I was there, based in Stockholm, and I got a chance to fly and meet with the top healthcare people in the governments of each of those countries. We set up a series of hearings in Stockholm, which some of them came to, and they testified about their systems.

Young: These were actual hearings, not just consultations?

Caper: I'd have to go back and check. I can't remember exactly what the format was. But we had a lot of meetings, and we toured health facilities. We toured health centers and hospitals. In fact I still have a picture of us touring a hospital late at night, at midnight one night. He said he wanted to go to see the hospital in Stockholm, and I have a picture of us going through that hospital with the hospital director. It was Joan and Teddy and myself and the hospital director, and someone from the Swedish Government, a physician named Ake Lundgrün, who was a physician and health policy advisor to the government of Sweden.

I can't remember whether it actually involved formal hearings, but there were certainly consultations with various people. In fact one thing that really sticks out in my memory is a visit with Gunnar and Alva Myrdal at their home in Stockholm. We spent the evening, just the four of us, sitting there talking about various things—some of it healthcare, a lot of other topics. He would do that. I mean, he would pick out the people he thought were the best people to talk to about various issues and make sure that he touched base with them and got their input.

Heininger: In '71 they've got two major health—not the legislative end but health fact-finding.

Caper: Fact-finding, right.

Heininger: What effect did you see in him that these made in terms of his thinking? Did you see specific ways that it shaped his thinking?

Caper: Well, he remembers what he hears. He pays attention. He'll come back months or sometimes years later with an anecdote or with a fact he'd picked up and say, "Remember when we were in Sweden and this guy said this about this issue, or in this hearing?" He's able to retain that stuff.

Young: Of those things, he can give you the entire picture.

Caper: And he'll pick out the important points, because he sits through a lot of testimony that's really not interesting, quite frankly, hours of it, and he's able to come back and recall things that he'd heard and put it together. So he listens. At least it educates him. I don't know about the rest of the committee. The attendance for the rest of the committee was spotty. The Senators showed up when we were in their state, obviously, but sometimes they didn't show up at all, because this was all about Kennedy.

Young: Did any other members of the committee go to Sweden?

Caper: I don't remember that they did. I think it was just Kennedy.

Young: And Joan and Teddy.

Caper: Yes, that's right.

Young: Who would have gone with him to Great Britain and to Israel, do you know?

Caper: I think Lee Goldman went to Israel. He was the health staffer. And then, in addition, Jimmy King went everywhere with him at that time. He was his chief advance man. I think Jimmy went to all three countries.

Young: But you did the substantive advance.

Caper: In Scandinavia, in Finland, and the three Scandinavian countries, yes.

Young: Finland, Norway, and Sweden.

Caper: Denmark and Sweden, yes.

Heininger: Did it alter his views in any way? Did he come out of it saying, "We need to pick up this piece of what they're doing and this legislation"?

Caper: Yes. His reaction to me was, "Well, why can't we do that? If they can do this, why can't we?" I guess we found out.

Heininger: In '71 you all thought it could be done.

Young: It's too logical. [Uwe] Reinhardt wasn't in the picture then at all, was he?

Caper: Uwe, no.

Young: He's much later.

Caper: Well, he was in the picture but not as part of the Kennedy operation, no.

Young: Did he ever become part of it?

Caper: I don't think so, no. Uwe runs his own show down at Princeton, and a pretty good one, actually.

Heininger: Let's talk a little bit more about other things that the committee did. Talk to us a little bit about the oversight hearings that are conducted. How did Kennedy run the oversight

function, and was that any different from how previous or subsequent subcommittee chairs have run them?

Caper: Well, by oversight you're talking about, what, the FDA [Food and Drug Administration] oversight?

Heininger: Well, you made some references, in the memo that you gave us, about the hearings he had done on human experimentation in '73; medical malpractice in '75 and '76; pharmaceutical industry, '73, '74; medical ethics; fetal research; right to survival; psychosurgery, '74.

Caper: Right. All of the ethical, the human experimentation hearings, Larry Horowitz was in charge of that. That was Larry's thing. I did the medical malpractice hearings in—I guess it was 1975. The FDA stuff, I think Larry also did most of that, although I was responsible for an effort to gain authority to regulate vitamins, possibly the second-worst idea that we had during that period. That was when Linus Pauling was going around recommending that people take 16 grams of vitamin C every day. We had hearings and we would bring people in saying, "If you had to eat enough cantaloupe to have that much vitamin C, you'd have to eat 748 cantaloupes," something like that, just to try to make the point that these mega doses of vitamins were pharmacologic doses and not natural doses.

So we decided it would be a good idea for the FDA to gain regulatory authority over vitamins in these large doses. Another monumental mistake because we turned loose a tornado. I mean, there are a lot of people in the country who love their natural-food stores and their vitamins, and the idea that the Federal Government could come in and regulate their vitamins is not popular—and I think we received more adverse mail on that one issue than any other single issue. This really hit home. People said, "They're going to go to my corner vitamin store and tell them they can't sell me my vitamin C or D," or whatever it was they were taking. So we were badly beaten. We went all the way to the floor of the Senate with that and tried to get it. And the FDA and the administration were supporting us.

The general counsel of the FDA was a man named Peter Barton Hutt. Peter thought it would be a great idea for the FDA to regulate these quacks and charlatans and so on, and it turned out not to be doable. We held hearings, and we were never able to really demonstrate any harm from taking huge doses of water-soluble vitamins. Lipid-soluble vitamins were something different; vitamin A, vitamin D, vitamin E were different because they got stored in the fat reserves of the body, but water soluble vitamins just got peed out of you. The more you took, the more you peed out, so they never accumulated.

I knew we were done when Phil Hart, who was a Senator from Michigan at that time—still a very highly respected man; (one of the Senate Office Buildings is named after him)—he got up and said, "I just don't understand. There's no harm. Why should we get into the business of telling people what they ought to be doing?" and I thought, *Oh, boy*. So we lost that one badly.

Young: What was Kennedy's reaction?

Caper: He laughed. He said, “Well, I guess I won’t listen to you again,” because I was a physician who’s saying, “There’s no reason to be taking 18 grams of vitamin C. And I know damn well that if you take enough of this stuff, it’s going to end up poisoning you someday.”

The other stupid thing was the chiropractors and Medicare issue, which came up every year. Chiropractors were always trying to get themselves included as providers under Medicare. And of course the docs hated that. Physicians are taught in medical school to hate chiropractors. So every year, the amendment would come up to include chiropractors, and I always advised Kennedy, “Don’t do it. These guys are quacks. They’re dangerous,” and so on. Every year the chiropractors would actually be successful in the House and usually fail in the Senate, and then the House would recede on it in the conference committee.

This one year, the same scenario was being played out, and somehow I talked Teddy into demanding a floor vote on the chiropractor issue in the Senate. When the Senate was asked to vote on the floor, most of the Senators, who knew that a lot of their constituents liked their chiropractors and would love to have them under Medicare, voted against us, I think, by a huge majority. I remember Russell Long coming to Kennedy just before the vote, saying, “Teddy, don’t push this to a vote. Let’s have a voice vote.” Teddy said, “No, I want a floor vote.” So we got clobbered and he said, “Well, it’s going to be very difficult for me to recede to the House with this kind of a mandate from the Senate on record.” So I think that may be when the chiropractors got into Medicare. It’s probably not a bad thing.

Young: Here were two situations where he got talked into a position.

Caper: Yes. Bad advice from me.

Young: By you.

Caper: Right.

Young: I can imagine some Senators, what their reaction might be, but I don’t know what his reaction was.

Caper: Well, he wasn’t happy, but on the other hand, I think he understood that my job was to give technical advice, not political advice, and that if he chose to take my technical advice and try to translate it into politics, that was his problem, not mine. So I think he understood the difference. He was the guy voting, not me.

Young: Yes. I mean, I’ve heard stories too about his brother and about Bobby, something like that happening. We’re not quite sure it would be that kind of outcome. “You put me in a spot and made me look—”

Caper: Yes, well, I’ve never—

Young: He’s not that kind of person, then?

Caper: I've seen him get very nervous and upset if he thinks he's not well-enough prepared for a hearing or a conference or a markup session. He'll turn to you and expect you to have the answer, and if you don't have the answer, you're in trouble. But I think he understands the difference between the politics and the substance and the technical aspects of the issue. I never knew Bobby, but from what I've heard about him, they were quite different. I mean, I think Teddy's a lot of more forgiving and not quite as caustic as his brother could be.

Heininger: Younger child.

Caper: Maybe, whatever, yes, by a long shot.

Heininger: The older ones were the more intolerable ones. I speak as an oldest child.

Caper: Yes, that could be, but for whatever reason, he doesn't like to be left unprepared. If you fall down and don't prepare him properly, you're toast.

In fact there was a funny story he told at a funeral recently of Eddie Martin, who was his administrative assistant when I first went to work for him. Eddie let him down on something. There was some issue, and Eddie had a copy of a speech he was supposed to give on the Senate floor. He was in Boston at the time. Eddie was to meet him at the airport and give him the speech so he could look at it on the plane ride down so he'd be prepared for the Senate speech that afternoon. Eddie got confused about the time the flight departed and didn't show up in time to get the speech to him. Teddy gave his eulogy at Eddie's funeral and said, "I was just fuming, and Eddie avoided me for a day or so. So he knew he was in deep doo-doo for missing this flight. When Eddie finally came in, he said, 'Look, Ted, what do you want me to do, set myself on fire?' So that just broke the ice, and I said, 'Okay, you got me. We all make mistakes.'"

Heininger: Your function on the subcommittee was to be the physician and to provide the technical advice. Was there a division of labor between you and the other subcommittee staff members?

Caper: No. I had input into other topics. We'd have staff conferences about various issues, so that was my chance to have whatever special input I could provide on the technical side. But other than that, I was just another staff member.

Heininger: Who handled the politics? Was there anybody on the subcommittee staff who was really thinking politically all the time?

Caper: No. That was handled by Paul Kirk, who was actually, at the time, on the Administrative Practices subcommittee of Judiciary. I'm sure you've run into Paul. He handled most of the politics.

Heininger: What was Lee Goldman's function?

Caper: He was the staff director, that was his title, but he was a very egalitarian staff director. If anyone on the subcommittee staff was concerned with the politics, it was Lee. There were only

three of us on the permanent staff at the time, and Lee was always into the musing. He loved to muse about the politics of the committee and what this guy's constituents, Jennings Randolph's constituents in West Virginia for example, think about all this. He was fascinated by the politics, but I don't think his input on politics went beyond the subcommittee staff. In terms of the political impact of what he was doing, I think Kennedy relied on Paul and maybe a couple of others on the staff to worry about that.

Heininger: How did you interact with his personal staff? Was there a division, or were you all one being?

Caper: There was a division. We were physically separated from them. Our office was in the Dirksen Building until it was moved to the Carroll Arms, a hotel across the street from the Russell Building. The personal staff did his personal Senate work. We interacted with them—the top legislative assistant was Carey Parker, and Carey essentially had final approval on everything: legislation, positions he would take. Speeches went through Carey. In fact his office is probably still located right next to the Senator's office in Washington. We would interact with other staff members as needed by the issue at hand.

I actually ended up going on a couple of international field trips with people from the Refugee Committee, which was the way we got into Vietnam and Cambodia. We sent a group of academics and physicians to Southeast Asia in March of 1973—it was a health and refugee study mission. I was the only representative of the health side, and the other people were the refugee people: Jerry Tinker, who is no longer alive, and Dale deHaan, who was the staff director at that time. Have you run into Dale? Have you caught up with Dale?

Young: Yes.

Caper: So he's still around?

Heininger: He's in Florida.

Caper: He's in Florida, retired?

Young: Yes.

Caper: Give him my regards if you see him. I haven't seen him for years. We had two of these study missions, and one really had to do with the Vietnam War. This was in March of 1973. We sent a group of experts in medicine, in population, and nutrition. There were two teams. One of us went to Cambodia and South Vietnam, and the other went to Laos and North Vietnam.

Heininger: In '73 you got into North Vietnam?

Caper: Yes. We were perhaps the first American government officials to get into North Vietnam. One of the people we sent was a doc named Michael Halberstam, who is David Halberstam's brother. Michael was a cardiologist in Washington at the time and politically active. He and, I think, Nevin Scrimshaw, who is a professor at MIT [Massachusetts Institute of

Technology], a nutritionist, went to Laos and North Vietnam, and I believe actually met with Ho [Chi Minh] at that time. I think that's correct.

We went to South Vietnam, and it was a time when the U.S. was just beginning to withdraw our troops from South Vietnam. We were ferried all over the country by not only the Embassy but by Air America, which was the CIA [Central Intelligence Agency] contractor in Vietnam. We went to the central highlands. We went to Quang Tri. We went to the delta region, just to assess how the war effort was going. The official reason we were going was to see the impact on refugee status in both North Vietnam and South Vietnam, and Cambodia in my case.

Young: And Kennedy was on this trip?

Caper: Kennedy was not on the trip. It was a staff trip. He had been there before, but he wasn't on this trip.

Young: Again, on refugees earlier.

Caper: Yes. We did another trip in '75, which was a refugee trip that had to do with the sub-Saharan African famine and the Southeast Asian famine at that time, and also to assess what was going on in Bangladesh and Pakistan. We visited a number of countries then. We went to Senegal and Mauritania in sub-Saharan Africa. We went to Egypt, Pakistan, India, Bangladesh, and to the Philippines on a six-week staff trip. And then we wrote a report, and had hearings after we returned.

Young: And he wasn't on these trips?

Caper: He wasn't on those trips. The purpose of the trip was to try to provide support for his efforts to increase humanitarian assistance versus military assistance, which is always the fight that goes on in these foreign-assistance programs. So that was another creative use of his committee chairmanships, to get into issues that some other Senators wouldn't think was their turf. One thing I learned is that in the Senate, your turf is whatever you make it.

Heininger: Would you agree, if you work for Kennedy?

Caper: Well, if you're a Senator and you're aggressive enough. The same is true but to a lesser extent with House Members. The House is much more rule bound than the Senate is. Look at what Henry Waxman is doing with his Oversight Investigations Committee now. And Kennedy's hearings on national health insurance, we never had jurisdiction over national health insurance.

Heininger: It depends on how you define it.

Caper: In fact we couldn't work on national health insurance legislation in the Health Subcommittee, it was referred to the Finance Committee. We never had it in our committee. We could hold hearings around the edges and say, "This is going to impact the Public Health Service programs. It's going to impact NIH [National Institutes of Health], a legitimate reason to be

concerned about it,” which is true. People who were less secure politically than Kennedy would probably shy away from stepping on somebody else’s turf.

Heininger: What was his relationship with Russell Long?

Caper: Tense. Remember, he had been defeated for the whip position in the late ’60s. He was the Senate whip at one time.

Young: Yes. He was defeated in ’71.

Caper: Seventy-one? He defeated Long.

Young: That was in ’69.

Caper: Right, okay. He defeated Long. And I think even he realized at that time that he wasn’t cut out to be the whip. Too much detail, too much administration, too much work that he thought wasn’t all that interesting. He defeated Long.

Young: And then [Robert] Byrd defeated him in ’71.

Caper: And then Byrd defeated him. That’s right. He and Long weren’t the best of friends. I think Long was still mad at him for running against him for the whip position. We had cordial working relationships with the staff of the Finance Committee. Our work intersected with theirs enough.

Young: But on Kennedy-Mills, I had understood that one of the reasons that Kennedy looked to Mills to try to do something was because of the Finance Committee. There’s no chance of getting anything on the Senate side by going through the Finance Committee.

Caper: I think that’s true, but I’m not sure it had all that much to do with Kennedy’s personal relationship with Long as it did with the composition of the Finance Committee. It was more conservative. And I believe that tax bills have to originate in the House.

Young: It was a strategic or a tactical move.

Caper: Yes, that’s right. In fact, at every hearing—

Young: And then [Daniel Patrick] Moynihan.

Caper: Of course Moynihan came in after I left. I don’t think he was even in the Senate.

Young: He had another agenda.

Caper: That’s right. I remember that at almost every hearing we held having to do with national health insurance, and there were quite a few in Washington in addition to the field hearings,

Peter Dominick would get up and say, “This committee has no jurisdiction over national health insurance,” and Kennedy would say, “Thank you, Senator Dominick. First witness, please.”

Having said that, I think one thing that’s changed dramatically is that at least when I was there, we always tried to gain consensus, even with the minority. In the case of Javits, it wasn’t very hard to do, because he was politically and philosophically closer to Kennedy than he probably was to a lot of his Republican colleagues. There wasn’t this, “To hell with you. I’ll vote you down” mentality that seems to exist so much today, at least under the Republican Congress. Now it is, “We don’t care what you think.”

Young: You try to get the minority on the committee aboard—and outside the committee as well.

Caper: Yes. Try to gain as much consensus—and recognize that you could never accomplish what you wanted to and gain complete consensus. If we thought it didn’t really defeat our principles of what we were trying to do, we would always try to get as many votes as possible.

Young: The soundings were taken pretty early, were they typically?

Caper: Yes.

Young: When Kennedy was going to move on something, he’d be in touch or staff would be in touch?

Caper: Javits’s staff office was actually right next door to ours in the Dirksen Building. So we’d just have to walk through a door and we’d deal with Jay Cutler, who was Javits’s top health staff guy. Jay had a lot of authority to do things. In those days, usually if Javits came aboard, most of the other Republicans would also.

Young: On healthcare.

Caper: On healthcare, yes. So it wasn’t all that difficult to do. We didn’t have this kind of loggerheaded politics that we see so much today.

Heininger: Now, where did the War on Cancer fit into any of these issues?

Caper: Lee actually handled that issue, but it was something that Kennedy signed on to very enthusiastically. And it originated, I think, with Mary Lasker and Jim Shannon, who was the head of the NIH at that time. And Benno Schmidt, who was a Wall Street investment banker, signed on early. Dear Abby [Abigail Van Buren] got involved somehow, pushing this thing in her column, which created a lot of popular support for it. Kennedy agreed to champion this idea in the Senate and actually ended up passing the cancer authority legislation over the opposition of a lot of the biomedical community and the people at NIH who didn’t want to see the NIH split up and were afraid that cancer would get a disproportionate share of the money relative to the other institutes.

Heininger: I've got two other things I'd like to go through: the War on Cancer and then the issue of moving to disease-specific funding. Wasn't there a lot of opposition to disease-specific funding?

Caper: I'm not sure Kennedy did that. I mean, the disease-specific funding came out of the way the NIH is structured. It's just easier to give money for specific diseases than it is for general research. The NIH, early on, was structured along disease lines—the Arthritis Institute, the Cancer Institute, the Gastroenterological Diseases Institute, infectious diseases. And I think that's just the character of the Congress. People understand fighting diseases. They don't understand genome research or some more general scientific effort. There are constituency groups, organized constituents for diseases, and that's still true today. So I think it's just a reflection of the nature of the political process and what you can sell to politicians and what you can't sell to them.

Heininger: Was there a real departure in that? When you get the War on Cancer, was that the first big, "Okay, we're going to separate out one really important disease and devote a huge number of resources to it"? Did that open a floodgate, or was this really part of a progression that had begun before that?

Caper: I think it was a question of emphasis on cancer. The NIH, from its very founding, has been set up along disease-specific lines. If you think about it, medicine is organized along disease-specific lines. The question of whether to single cancer out is particularly important, and I think that it reflects popular opinion and popular support. A lot of people are affected by cancer. A lot of people are scared to death of cancer.

Heininger: What's been the effect of the War on Cancer? Did it alter—

Caper: It was hope. I think the accomplishments have been less than what was hoped. I don't know if it's altered the trajectory or not. The funny thing about medical science is that progress in the war against any disease requires an understanding of the fundamental mechanisms of that disease, which may go across disease categories. So I think we've made progress in a lot of fields other than cancer because of the War on Cancer efforts, because the people who are writing the grants are smart enough to present them as cancer-related efforts, when in fact they are much more fundamental, and they're research on things that would never generate public support because nobody understands them except the scientists themselves.

So what effect has the War on Cancer had on cancer itself? The answer is probably not as much as was hoped 35 years ago when the Cancer Authority was created. If you had asked me, what have been the spin-off effects and the other effects on related fields, that's a more difficult question to answer. The answer would probably be more than we had expected in related fields.

Heininger: Do you think that it has brought more money to basic science research than would have been appropriated otherwise had there not been the cancer, disease-specific approach?

Caper: Oh, no question.

Heininger: So it actually turned out to be a backdoor to increasing federal health resources.

Caper: Yes, absolutely.

Heininger: And in that sense, a very successful one? I'm not trying to put words in your mouth.

Caper: Well, in that sense, in terms of the amount of money it's generated, yes. I think it has been very successful.

Heininger: But as soon as you single out a disease, aren't you starving other ones?

Caper: That was the fear, of course. That's why there was opposition within NIH to singling out cancer. Whether you're starving them or not depends upon how much money you think they would have gotten without the cancer effort. Congress has been very generous, I think, to the NIH over the years. I mean, you always hear people complaining that they're not getting enough money, but the NIH budget has certainly increased exponentially since the early '70s. So I think it's hard to make the case that the cancer effort starved anything else out, particularly since the cancer funds were obviously used for lots of things in addition to cancer.

Heininger: As the AIDS [Acquired Immune Deficiency Syndrome] funds haven't.

Caper: AIDS is a different problem. AIDS has a stigma that cancer doesn't have.

Heininger: But haven't the funds for AIDS research gone into a lot of research into basic science as a result?

Caper: Oh, I think so, yes.

Heininger: I mean, it's a similar process that took place with cancer.

Caper: Yes. Part of the AIDS syndrome is Kaposi's sarcoma, which is cancer.

Heininger: Right. Nice fit.

Caper: Yes. How do you separate these? These are artificial boundaries that make political sense, but they don't particularly make scientific sense.

Heininger: Were some of the ones that you had listed in the memo that you gave us in December—lead-based-paint poisoning, sickle cell anemia, hemophilia, sudden infant death syndrome, diabetes, arthritis—were there any of these that were a specific, high-priority interest for Kennedy?

Caper: I tend to think the reason for singling out something like sickle cell or lead-based paint is because of the disproportionate effect it has on a minority population. The lead-based paint was an issue of low-income housing, although not exclusively, but that's where the greatest impact tended to be. And sickle cell, almost exclusively an African American disease, or an African

disease actually. There's lots of it in Africa, but in Africa it actually probably has a protective effect against malaria. So sickle cell anemia is a plus in Africa, and that's not the case in the United States, where we don't have malaria. Again, in politics, you can generate support, press interest, and Senate votes for specific diseases. The Institute of—it may not even exist any more; it's called the National Institute of General Medical Sciences. It has chronic funding problems.

Heininger: I was like, what's that?

Caper: Yes. I support general medical sciences. No, I support—there are organized pressure groups, constituents, for these specific diseases. Autism, you're going to watch to see what's going to happen there.

Heininger: It's skyrocketing.

Caper: Right, and that's the nature of politics. It may not make a lot of technical or medical sense, but it does make a lot of political sense to approach things that way if you're looking for votes.

Heininger: The last thing I want to just go over briefly is, you have also cited that he made a lot of efforts for a more effective regulation of food, drugs, medical devices, and other substances for safety and efficacy. And you cited, in particular, Food Amendments Act, Food Inspection Act, medical devices, lead-based paint. What were some of the triggers for these?

Caper: Well, the trigger is, these authorities expire every three years, so you have to renew them, and the question is whether you renew them without modifying them or renew them with improvements. His inclination was always to renew them with improvements. So that was basically the genesis for that. Plus the fact that the FDA people—the American people like to think they're being protected from danger, as George W. Bush understands very well. And whether it's from terrorists or from faulty medical devices or dangerous drugs, that's a political plus to be at least looking as though you're doing that.

Heininger: Was the Dalkon Shield one of the prompters for medical devices?

Caper: I don't remember that being specifically one of the—it was certainly an issue, and it could have been. I just don't know. Again, I wasn't handling that issue. I think Larry was doing that. And that actually all may have occurred after I was there.

Young: Ready for a break?

[BREAK]

Young: This is the second session, the afternoon session. Did you finish with the things you were talking about earlier?

Heininger: Yes, and I've just got a couple other quick ones. Tell us a little bit about what Kennedy's relationship was with the AMA, and the hospital and insurance industries.

Caper: I would say, probably adversarial. The AMA was not happy about almost anything we were doing. They didn't like national health insurance; they didn't like HMOs; they don't like federal involvement in just about anything having to do with medical care. The hospitals were also—one of the selling points of HMOs is they reduce the rates of hospitalization. The claim was you could cut it in half, given adequate outpatient care. It's probably not far from the truth, but reducing hospitalization rates was one of the ways they saved money. So the hospitals weren't all that enthusiastic about it. They were less totally opposed to health insurance if it were the right kind.

Of course we were proposing to basically abolish the health insurance industry, so the industry was not too happy with what we were trying to do. They'd send people up to testify against whatever it was we were proposing. I think it's safe to say that they were adversaries legislatively.

Young: Did that continue throughout?

Caper: Throughout my tenure it did. I'm not sure exactly what happened after that, but yes. Certainly Kennedy's been pounding on health insurance for 40 years now, and he's always advocated expansion of the public-sector role in health insurance, and generally more regulation of the healthcare industry, although that may have changed in the late '70s when they were all into deregulation. That was when Steve Breyer was on his staff, I think, with the Judiciary Committee.

Young: And he was for that deregulation.

Caper: Yes, he was leading the charge for deregulation of the airlines, of the trucking industry. I'm not sure he'd be quite as enthusiastic today, but he was leading the charge at that time. It was an interesting thing, because you wouldn't expect that position out of a liberal Democrat, but he's changed positions over the years.

Heininger: When you look at the health universe, were there any aspects of it with whom he had reasonable relations or better relations than others? More like the academic health centers and the medical schools?

Caper: One thing that changed in the early '70s, as a result of the changes in the Congress more than anything else, is that the size of the Congressional staff began to mushroom. People who were subcommittee chairs began to have a little bit of power, meaning they could hold their own hearings; they could hire their own staff; they began to bring more and more subject-matter experts onto the staff. I was an example of the leading edge of that movement, and what that meant was that more and more legislation was developed in-house. So in the mid-'60s, if you

wanted a bill dealing with medical schools, you'd send it over to the Association of Medical Colleges, and they'd draft a bill, and you'd introduce it, and everything would be fine.

When we began to get a little independence, we began straying from the party line, whatever the interest group was, and that was a change. The relationship with the various lobbying groups and advocacy groups began to change as Congressional staff became more and more professionalized. In the past the staff were experts in the legislative process but not necessarily in the substance of the topic they were dealing with, so they relied much more heavily on outside experts.

Young: Well, what about the experts in the executive, if there were any?

Caper: We certainly relied heavily on executive branch experts, but again, when you were the party out of power in terms of the executive branch, and particularly when you had an adversarial relationship with a President, as we certainly did, because Kennedy was viewed as a political threat to Nixon, it was dicey to rely on the executive branch, and we weren't always as confident as perhaps would have been the case in an earlier era when we were getting more objective help from the executive branch.

Young: But didn't Cap [Caspar] Weinberger play a constructive—or was it a constructive role? Well, that was when he was his budget head.

Caper: He was the budget director before he was HEW [Health, Education & Welfare] Secretary, and he had a reputation of coming in and cutting federal programs.

Young: That is correct, but when Labor—this is my understanding, and please correct me if I'm wrong; I haven't done a deep study of it at all—or UAW or whatever said, "No, let's go for the gold. Nixon's on his way out, and we can get a veto-proof—"

Caper: In terms of health insurance?

Young: In terms of health insurance. This is what I was talking about. And at that point, I mean, it didn't entirely work out, but Weinberger was not making an issue of the money. Stu Altman and Stan Jones started carrying on what looked like a serious negotiation.

Caper: Yes. I think that's true.

Young: And those were both executive—

Caper: Yes. My interaction with Weinberger was mainly around the Public Health Service programs, where he was always in favor of less federal intrusion, less money, and so on. By the time we got around to dealing with Nixon on health insurance, the politics had changed, and Nixon was anxious to get something done. That's what provided us with that opening. I think Lee Goldman was actually the first one to see that possibility, which led us to initiate those talks with both Mills' people and with the administration, Stu Altman, and the others. I don't know

how much—I mean Weinberger had to give the green light. I don't know how, beyond that, how supportive he really was.

Heininger: But he was not on Public Health Service. He was the—

Caper: It was a Republican versus a Democrat. Democrats were in favor of big federal programs, lots of money, such sums as may be necessary, and Republicans wanted small government, balance the budget, cut taxes.

Young: Did you say that was a Republican? *[laughs]*

Caper: He was, believe it or not.

Heininger: Those were the days.

Young: I rather thought the Republicans had changed on that subject.

Caper: I think they have, some of them. There are Republicans who still believe that, though. They're looking for a new home, I think.

Heininger: Who handled the debate over capitation payments to medical students and medical schools?

Caper: That was my province. I was assigned to the Health Professions Education Act, but I don't remember much of a debate. I mean, the medical schools were certainly in favor of it. We were in favor of it because we wanted it. Nixon was in favor of it because he wanted to expand the health workforce. So I don't remember that that was a contentious issue. What was contentious was how many strings to attach to that money, and we really annoyed the medical school deans when we started saying you had to train so many primary care docs. So that's when it became an academic-freedom issue, which I still to this day argue it is not, but hey. It's a good argument, a good flag to raise, I guess.

Heininger: Well, it did become very contentious between the medical schools and Congress on that, didn't it?

Caper: Whether there should be capitation payments or not?

Heininger: And what the strings would be that would be attached to it.

Caper: Oh yes, the strings were contentious. The question of whether the Federal Government was actually paying medical schools by the head for medical students, I don't believe that was controversial. I don't remember any controversy about that. It was what strings you attached to it. Their position was, "Give us the money, and leave us alone," and our position was, "It's in the public interest to try to train more primary care docs." Everyone agreed with that, but the question was, how do you do it? And was it appropriate for the Federal Government to be doing that?

I remember attending an alumni dinner at UCLA, where I went to college and medical school, and one of the leaders of the “give us the money and leave us alone” camp in the medical school world was Sherm Mellinkoff, who was dean at UCLA Medical School. I remember hearing a speech given by Chuck Young, who was the chancellor at UCLA at that time. I was in the audience. I was on Kennedy’s staff at that time. It was the middle of this fight about how much control the feds should have over how many and what kinds of doctors are trained. Chuck Young gave a speech just reaming out those elements within the Federal Government who believed that the feds should influence the curricula of medical schools. I know damn well it was aimed right at me. I’m sitting among 300 people in the audience, and they felt very strongly about it. People in the medical schools felt that the government shouldn’t be designing curricula for the medical schools. “That’s our business. We ought to be doing that.” So that was contentious.

Heininger: Have the capitation payments continued?

Caper: I think they have. I mean, they certainly did through the ’80s, when I was still involved in the medical education.

Heininger: It would be nice if they were higher, to reduce the cost of my daughter going to medical school.

Caper: Well, when I went to medical school, my tuition and fees were \$112 a semester at UCLA, up from \$56 dollars, what it was in college. So things have changed. That was the University of California, and it wasn’t the model in the Northeast, certainly, or among the eastern seaboard private schools. That was the model on the West Coast.

Heininger: She’ll be at \$55,000 to \$58,000.

Young: Back in the ’50s—this may not be the analogy—but the Federal Government, and subsequently foundations, were pouring money into language training and area training. This is a result of World War II and the UN [United Nations] to train people in Arabic, people to learn the local cultures. And I don’t believe they did that by capitation, which didn’t raise the issue for the graduate schools. They did it by, “This money is available if you want to do it.”

Caper: Block grants for the colleges.

Young: Block grants or—

Heininger: No strings.

Young: Right, and it left people like me, who weren’t interested in Arabic at that time—I should have been—completely out in the cold, because they got very good funding for training of various specialties in terms of a national need, and the National Science Foundation backsliding on that. So it’s interesting that when they want to train more specialists in what’s called primary care, it’s done by capitation, and you immediately get into the academic-freedom issue.

Caper: Well, capitation, of course, is an incentive to increase the class size, for one thing, as well as to try to influence the mix among specialties. But there were so many other things. The Federal Government doesn't have a single coherent policy, because a lot of the specialization was driven by NIH funding, and the NIH funding was always much more important to the medical schools than the manpower funding was. NIH funding absolutely encouraged specialization because of the way the institutes were set up. You could argue that that may be the leading drive toward specialization. Specialty wards were set up, and the institutes were set up along disease-specific system lines, basically. So the feds were encouraging specialization with one hand and general practice with the other. But that's a function of the Congress. I mean, ironically in our case, they were both coming out of the same committee at the same time. So go figure.

Heininger: Go figure. Do you have a sense as to how Kennedy—and you'd watched him over many years—how he's asserted himself behind the scenes in dealing with the White Houses that he's served under? Is he a political factor that they feel they need to take into consideration? Do you have a sense that he's actively consulted? Is he somebody they have to work around?

Caper: I think he does whatever he thinks is necessary to get things done. I obviously don't know a lot of what he does behind the scenes, because it's behind the scenes. He will make phone calls to people on staff's recommendation if he thinks that's necessary.

I'll give you one tangible example. There's a neighborhood health center in East Boston that may be the best neighborhood health center in the country, one of the largest. They had 900 employees at one time in the '90s. It serves a large lower-income population, mostly Latino. It was Italian when it was started a few decades ago. They got into some financial trouble a few years ago because of changes in federal law that lowered payments for home healthcare and a bunch of other services. It was the BBA [Balanced Budget Act of 1997] Act of, I think it was 1997. And they went into bankruptcy because they were essentially patching together a lot of sources of funding to try to put a comprehensive health system together. Medicare will only pay for certain types of services and Medicaid and the free care pool in Massachusetts and so forth. BBA reduced funding suddenly for some of these components, and it put that center into bankruptcy.

A friend of mine, another ex-Boston City Hospital resident, has been the medical director there for the last 40 years. He started the center. So when he got into trouble, I sent a note to Kennedy saying, "Ted, this is something that really deserves to be saved. Can you give them a hand? They need some immediate relief, or they're going to go belly-up. It serves a large population right in the middle of Boston," and so on. He went to work on that. He did what he had to legislatively, and he talked to the people at the top of HEW, and it was during the [William J.] Clinton administration, so he talked to Clinton about helping out.

I remember hearing a story of some guy four or five levels down in the HEW bureaucracy, in the Bureau of Community Health, who was sitting in his office. And all of a sudden, Ted Kennedy's on the phone, from an airport someplace, calling him to see if he could facilitate this grant getting through. I've heard other stories like that about him. He'll do that. He's not afraid to get

his hands dirty and roll his sleeves up and work at that level if he thinks it will be useful. That's the best response I can give to answer that question.

Heininger: Boy, you've given us so much time, and you really covered my questions.

Caper: Good.

Heininger: Does this mean I need to come up with some more questions for you? Do you have any?

Young: I'd like to ask a couple. I find it interesting that nobody has mentioned—and I'm thinking of his personal life and his political life together—nobody has mentioned his losses and the tragedies as anything that would have affected his energy or his availability to do things. And yet I do think there were times when he just couldn't be there.

After Bobby, there was a period of time within one year, or about one year after that, more or less, over Chappaquiddick, where what's going to happen to his career has got to be a question in his mind. He comes back—maybe it wasn't a great loss, but it was another kind of setback: he loses the whip. Maybe he didn't care too much, but these are all questions that have got to affect, in some degree, the perception of his effectiveness—the perception or the reality. But it also strikes me that he always comes back. I mean, the 1960s, that first decade, was a rough time for him, but it was also the new time in the Senate. I'm trying to understand how he copes with all these dreadful things that are happening.

Caper: Well, of course I didn't join his staff until '71, so I never knew Bobby. I wasn't there during Chappaquiddick.

Heininger: You were there during Teddy's [Edward Kennedy, Jr.] cancer surgery, weren't you?

Caper: I was, yes.

Heininger: How did that affect him?

Caper: I guess the best way to answer that question is the way he copes is through his ability to compartmentalize. When Teddy's leg tumor was discovered, he focused on that almost 100 percent of the time, through the surgery and the following decision as to what kind of follow-up treatment he'd get. As you know, Teddy was hospitalized up here at Children's for his chemotherapy, every other weekend. And Ted would just move in with him. He'd fly up here on Friday, come with him to the hospital, sit there in his room over the weekend when he had his chemotherapy, and he would go back to work the following week.

There was never any question about competing priorities. During that period, his devotion to his son was the only thing he was thinking about. He put as much energy and focus into that as he does into his legislative work. But there was never any question in my mind about his priorities. Senate work had to wait, just got put on the back burner. He'd do it; he'd do what he could. But if it came to a conflict in terms of his time, there was no question that he would be there for his

son. He tried to assemble the best people in the country to focus on the problem, and I think he did that. He was tremendously supportive of Teddy.

Young: You hear a lot of stories—I have, interviewing people on the Presidential staff over many years. And of course you hear a lot about burnout or about what people—for many of them, there’s just an inherent conflict between your family and your work. There have been divorces; there have been breakups. People have seen, some of the people on the staff, this is a clear choice: that they’ve got to do this; they’ve got to give up their family and their marriage. And I’m not seeing that in Ted over the years, and I’m wondering, what might be the resources that he has to allow him to do that? Now, one is, he has a lot of staff resources, or he had a fair amount.

Caper: Yes, he had a lot of staff.

Young: So he had people to keep working for him, as do very few people in the White House—they don’t have big staffs to carry on the work. If they’re not there, they get their throat cut. So that’s one thing, but I still think it’s something about the person who won’t, whose dedication to family—I think about Bobby’s children and all that, and Jack’s [Kennedy] children—who won’t give that up but will integrate it somehow into his own work. It’s remarkable.

Caper: It is remarkable, yes. It is, I agree. He was very devoted within the human constraints to Bobby’s kids. I think there were 11 or 12 of them?

Young: Twelve.

Caper: Uncle Teddy was always there. I spent quite a bit of time at one point in my career at Hickory Hill, when I was working for him. I got to know Ethel [Kennedy] and the kids pretty well. They were a handful. I mean, I’ll tell you [*laughs*]. But he was always there, he took that on, which is what makes me chuckle when somebody like Newt Gingrich starts screaming at him about family values. You have to wonder how those guys look themselves in the mirror in the morning sometimes. His family, his children, and his nieces and nephews have always been extremely important to him. He loves kids. He loves being around kids and family.

Heininger: Do you have a sense that he did this at the expense of his relationship with Joan?

Caper: How do you tell?

Heininger: I don’t know, but I can barely cope with two kids. I don’t know how you cope with three plus twelve plus two. That’s an awful lot of kids.

Caper: Yes, it is.

Heininger: It’s the division of time that—

Caper: I’m sure that was a factor. I don’t know how important a factor it was. Joan has her own set of issues, and I think she found it very difficult to keep up. It was a rough family to keep up

with. They were extraordinarily competitive. I saw it as a guest in that house, because there was always something going on. And I can understand where she would have trouble coping with that, plus all the Kennedy—being that famous, world famous, and recognizable is not always great. You really have to be on the defensive a lot of times, particularly in politics, because somebody's always out to get you for political reasons, particularly if you're as outspoken as Kennedy is on issues that are controversial. You're going to make a lot of enemies. So I think you have to be very tough to put up with it, and I think you have to compartmentalize your life to some extent, and he did.

He had his small circle of friends who have always been his friends: the Claude Hootens and the John Tunneys and the Lee Fentresses. Dave Burke, a little unusual along with Paul Kirk, because they were both staffers and more recently have become very close friends, intimate friends of his. One way you deal with things is, "This is my professional life, this is staff, and these are friends." The two don't mix very much.

Young: But he didn't depend on the Senate for a living.

Caper: Quite true, he didn't, and he had a very safe seat. He didn't have to worry much about what people outside of Massachusetts thought of him, except of course, when he was still thinking about running for President. I think he was always really ambivalent about that. That came out in his later campaigns, in his 1980 campaign, that Roger Mudd interview, not being able to answer a question like, "Why do you want to be President?" I think he was never quite sure he wanted to do that. You have to have a burning in the gut to do what you have to do to become President. I remember having a conversation with Bob Coles once, who was a child psychiatrist here at Harvard, about what kind of personality disorder it took to really want to be President of the United States [*laughs*] and to go through what you have to go through to get there. I'm not sure he really—

Young: Well, here again, I would imagine family pulled both ways. In a sense he was the last brother, and there were fallen standards. Pick out the fallen standard.

Caper: Joe [Kennedy], then Jack. There was Bobby and Teddy.

Young: Right, and you've got to carry on their work.

Caper: The expectations. I mean, the father always lurking in the background, or at least the image of the father—I mean, he must have been a tough guy, Joe Kennedy.

Young: Yes, the father inside as well as the father actually fallen, and probably the mother as well. And yet he just seems so fitted to the Senate in many ways.

Caper: Yes, which neither of his brothers probably was—certainly not as well fitted. Jack didn't do all that much in the Senate. He wasn't there that long.

Young: Well, it was to get someplace else.

Caper: Yes, and Bobby never—

Young: To get someplace else.

Caper: Maybe. In Bobby's case, I think, when he first was elected to the Senate—when was it, '64? Yes, I guess it must have been '66, maybe. I don't think he understood how ill-suited he was to be a Senator until he actually had to do it.

Young: Well, he'd been there as a staffer.

Caper: He'd been there as a staffer, yes. It's very different. Ted's stamina and his focus have always amazed me and his ability to stick to his guns. I mean, he just doesn't blow in the wind the way so many politicians swing—and have to. You have less secure seats and less of an image and less of a legacy to fall back on. I may have told you this story once before, but I remember 1980, after the Reagan win, and the Congress changed hands, or at least the House did. I don't remember the Senate.

Heininger: The Senate did too.

Caper: I was working at UMass [University of Massachusetts] at that time and I was down in Washington. I had to talk to Ted about some issue, and the only time I could get to see him was driving to the airport with him on his way somewhere. I remember walking through National Airport in the old north terminal. I was talking to him about something when a black cabbie came up to him and tapped him on the shoulder and said, "Are you Senator Kennedy?" Ted replied, "Yes, I'm Senator Kennedy." The cabbie said, "You're my favorite Senator." Kennedy looks at this black guy and says, "Right now I think I'm your only Senator." *[laughs]*

But he has stuck with what he thinks over the years. The Iraq war, national health insurance. I was down there in December talking to some of his staff: David Bowen, who is now his top health staffer, and Mike Myers, the HELP [Health, Education, Labor and Pensions Committee] chief counsel now. I was really encouraging Teddy to stick with Medicare for everyone. I said, "It's something you don't have to explain to anybody. It's one of the most popular federal programs. As the next few years go by, there are going to be more and more people who are going to benefit from it. Stick with it. I think it's a winner." Bowen said, "We only have two co-sponsors on this bill. We've introduced it, but nobody wants to support it." So I said, "Well, have a little patience." That's this year. It could change. And he's been willing to do that, even though it's not the popular thing to do at the moment. But he'll do what he thinks is the right thing to do. In a way, that's a luxury, because most politicians don't have that kind of grip on their seat that he always has.

Young: You have to have the grip on the seat. So he has longevity. He also has a lot of memory, and there must be things you learn as you go along. So he's a walking encyclopedia of the Senate.

Caper: He is. Yes, that's right. There's too little of that. I mean, I think if we had a little more appreciation of history, there wouldn't be as many blunders in public policy. Bobby Byrd is

great. I mean, he's been terrific in his floor speeches on the Iraq war. He's just been right on target. But there aren't a lot of people like that. I probably wouldn't recognize two-thirds of the Senate if I walked into the chamber today.

Young: And there's no institutional memory, so to speak. There's no memory of what—there is on the staff, I guess.

Caper: Yes, the staff has been the institutional memory, particularly in the Senate, but also in the House. There were guys there when I was working there who have been there for 30 years.

Young: Still there.

Caper: Still there. This guy knows more than any living human being about railroad retirement or something, some other issue like that. The staff has been the institutional memory. I just wonder if that hasn't turned over a lot. I think, particularly with the Republicans in control—my bias is going to show—but I think the Republicans tend to view public service as something to prepare them for a better life in the private sector when they get done with it. I think the Democrats tend to view it more as a career, as just an end in itself rather than a stepping stone to something else.

Young: I'm thinking about Bob Dole and people like that in the past. It may have been a stepping stone to the Presidency. I don't know, but it seems to me they were very much dedicated to—

Caper: I'm not talking as much about the elected officials as I am about the staff. I think a lot of these guys who come in and out of the Federal Government, the revolving door—the Billy [Wilbert] Tauzins of the world and their staff, looking for a fat lobbying job. Even Jim Greenwood, who I really admired, a Republican from Pennsylvania, from Philadelphia, ended up taking a job as a lobbyist a few years ago, and that's just, people don't see it as a career in public service anymore so much as a stepping stone to make contacts and generate a résumé to get you something better in the private sector.

Heininger: What happens to staff when they leave Kennedy?

Caper: They fade away. *[laughs]*

Heininger: Do they fade away, or are they drawn on as the years go by as well?

Caper: You mean in terms of their relationship to him?

Heininger: Their relationship to him and their relationship to—is their expertise drawn on subsequently by him?

Caper: I can only talk about my own experience. I've made myself available to him. I've not been shy about sending him memos. I see him maybe several times a year now, and he's always been very open to that. I don't know about other staff. He's had some staff who have been there

forever. You've certainly met Carey Parker. He's an institution in his own right. Have you met Barbara Souliotis?

Young: Oh, yes.

Caper: Barbara's another one. She was his first hire in 1962. Jimmy Flug has been in and out of public service for a long time. There was a staff reunion at his 75th birthday celebration down in the Senate Office Building a few months ago. There were several hundred people there. It was quite amazing. And I think people do keep in touch with him. Mark Schneider was head of the Peace Corps. Marc Ginsberg has been an Ambassador. There are people who go into the executive branch and have important jobs there.

I intentionally didn't do that. I didn't want it. I wanted to get into something that was closer to medicine when I left the staff, so I came back and took a job at UMass Medical Center. I'm not sure that was the brightest thing that I've ever done in terms of making my own life easy, because there was a lot of hostility toward Kennedy among physicians because of the positions he's taken that people disagree with. When you go off the staff, you lose some of the protection from that hostility. All the power you had is delegated power, and I think you lose some of the protection, and people do to you what they wish they could do to Kennedy sometimes.

Young: This is observations from the outside. You weren't there. I'm thinking about the times that he's tried to get national health insurance, to get everybody covered, and it's not come off. There was the time of Kennedy-Mills or of Nixon. He didn't succeed with Carter. Apparently he made a strong effort, but then he was going to run against Carter, so I don't know how that figured. And then the big moment comes, apparently, with Clinton, and that doesn't work either. So I'm wondering, why doesn't he give up? Or why is he back with Medicare for All now? Did he have a really strong role in the Clinton health project, do you know?

Caper: I don't know. You probably should talk to—and I'm sure you have—to David Nexon.

Young: We will. We haven't yet.

Caper: David was the staff director. I don't know the answer to that question. I think he's in favor of Medicare for All because he believes in it. I think there's a strong strain, wherever it originates, of egalitarianism in him. I think it makes him angry when he hears these stories about people basically being screwed because they get sick, and they lose their house and they lose—the stuff that Betsy Warren is doing, basically, on bankruptcy and medical care, for example—I think just infuriates him. I just think he feels it's wrong, and he'd like to correct it. He hasn't given up, because he's always done incremental stuff when he can't get the whole piece. He did CHIP [Children's Health Insurance Program] with Nancy Kassebaum whenever it was, in the mid-'90s.

He said something that really surprised me a little. I was down there. I think it was the day we had our session in Washington, and I had to leave a little early. The reason I had to leave early was because I had an appointment to meet with him to talk about healthcare. Now that the Democrats are in control of the Senate, what's going to happen? What should the strategy be? So

I wrote him a memo a few weeks before and said, “I’m going to be down in Washington. Can we set up a meeting?” He said, “Yes, come on by.” So I was in there with Mike Myers and David Bowen and Teddy, the four of us in his office, and I had written him a memo outlining my take on the political situation and the policy needs. I ended up making a strong pitch for Medicare for All, for reasons that I’ll outline.

I think one of the biggest mistakes that Clinton made was to come up with something that was so damn complicated nobody could explain it, and nobody could understand it. I mean, that’s a recipe for legislative gridlock automatically. And the fact that they didn’t understand that was astounding to me. Then the process they went through with all the secrecy and all the—it heightens everybody’s paranoia. It was just mishandled.

So my advice to him was to keep it simple. “Medicare for All,” that’s all you have to say, and people understand what that means. You don’t have to go to your Rube Goldberg organizational chart to show how it’s all going to work. I think that appeals to him, and I think he sees the political sense that makes, because he saw what happened to the Clinton proposal. That was just an invitation for anybody who wanted to block it. The easiest thing in the world to do legislatively is to stop something from happening. It’s much harder to actually get something passed.

Young: Carter wanted this series of decide this now and then that the next time.

Caper: It was too complicated. Also, you have to wait for the level of pain to get high enough so that you get the public’s attention.

Young: That’s right, but Carter didn’t do this on energy.

Heininger: Carter or Clinton?

Young: Carter.

Caper: He’s talking about Carter. I was talking about the Clinton plan.

So we finished the meeting, and I stayed after the rest of the staff had left because I wanted to talk to him about—he needed some advice about his boat. So we came out into his office, and he introduced me to his very young staff. He said, “This is Dr. Caper. Dr. Caper is an absolute bulldog on national health insurance. He’s been at it for 35 years, and he doesn’t give up. I can’t tell you how much I admire that.” *[laughs]* I said, “Me? You’re talking about me?” So I think he admires that perseverance.

Young: I just wondered why Clinton would not have made an arrangement with Kennedy and said, “Look, we want to get healthcare. Let’s give him the lead on it, whether up front or behind the scenes.”

Caper: I have no idea. Maybe there was a rivalry there. But he also had this whole cockamamie task-force structure, this thing Ira Magaziner set up. I mean, I still get angry when I think about it. In a way, it was a real blown opportunity. They should have moved faster on it. It should have

been simpler. Clinton was right to go around the Congress. I think he was correct in trying to build public pressure on the Congress to get this done, because the special interests are much stronger now than they were in the mid-'70s when I was there. Now they're going to do everything they can to block it, the insurance industry in particular, because they don't want to lose this golden goose they've created. I think the only way to overcome that, really, is to build enough public pressure on the Congress that it becomes an election issue. And they'll vote with you. But if it goes beneath the radar, then they're going to be controlled by the special interests. I don't know how you would deal with that problem.

Young: What's Bush up to now?

Caper: I think he's trying to survive for the next—

Young: Yes. When he's out talking about—

Caper: On healthcare?

Young: Yes.

Caper: Oh, nothing.

Young: Nothing, but why is he talking this way?

Caper: Well, because I think he thinks he has to look like he's doing something. So how do you look like you're doing something and still do nothing? You come up with tax credits.

Young: That really helps the—

Caper: You probably don't spend a lot of time watching Comedy Central, but I watch Stephen Colbert every once in awhile. And he came up with a beautiful riff on the Bush health plan, about how you're giving tax breaks to people who don't pay taxes because they don't make enough money. They're going to take the tax breaks that they don't get to buy the health insurance they won't get, and then everybody's happy. It's nothing.

I mean, tax breaks are a wonderful conservative answer to almost everything, because there's no leverage in them. You can't use the funding as you—I mean, Medicare sets the payment rates. When you give tax credits to buy private insurance, you don't even touch the delivery system or control costs or anything else. Plus the fact that it doesn't cost much money; plus the fact that it benefits mostly the wealthier people. It doesn't benefit poor people who don't pay taxes and don't have any income. So it's a great solution to looking like you're doing something and not doing anything.

I mean, this is classic. This goes back to Reagan. This is always the conservatives' answer to health insurance—taxes: tax breaks, more tax deductions. It won't solve the problem. The problem is much bigger than that. The problem has to do with income and wealth transfer and redistribution—which is, of course, anathema to conservatives—and controlling the capacity of

the system so it doesn't bankrupt the country, which it easily could if it's not controlled. I agree with the conservatives there. I think we have to couple the two. But the American people don't want to hear about limits.

One of the riffs about national health insurance is, "Well, we're going to have rationing in this country, rationed medical care, people dying on the streets." No, that's not the case, because first of all, people are already experiencing rationing, on the basis of ability to pay instead of medical necessity. Second, the medical care system is enormously wasteful. The administrative costs are unnecessarily high. We're doing a lot of stuff that, while it may have some benefit, nobody would do if they understood the cost-benefit relationships, which, of course, patients don't usually and the public doesn't.

I was talking to a friend of mine who runs a boatyard up in Brooklin, and his wife is very concerned about getting breast cancer, so she goes in for mammograms regularly. He said, "Well, they have a new mammogram machine. They have something like an MRI [Magnetic Resonance Imaging] scanner that does mammograms." I said, "Gee, that's pretty fancy. So what happened?" "Well," he said, "the test was non-conclusive, so they ended up doing a needle biopsy anyway." I said, "Gee, what did that cost?" He said, "Well, it cost me \$9,000." I said, "What do you mean it cost you \$9,000?" He said, "That was after the insurance got through paying, and I still owed \$9,000 for this test."

I mean, I don't know if it was \$9,000, but I know it could be done a hell of a lot less expensively with an equivalent result. The system is just full of that sort of thing, absolutely full of it, because it's a goldmine. There's a lot of money to be made on this stuff. We have these machines that do a dozen, two dozen tests at the same time, and we end up charging for each one, as though we were back in the 1930s still doing each one by hand in a lab somewhere. It's a goldmine.

But the American public doesn't believe that. They think that if we control costs or control capacity—they think we have Canadians streaming over the border to get treated. That's just a myth; it's not true. The Canadian government buys capacity here if they choose to, or they do their own cost-benefit analysis. But there's a lot of mythology, and I don't know how you overcome that, because the people with the money are the people creating the myths. They have control of the message, usually, to the public. It's a tough political problem.

Young: According to the polls, people would like to see sick people get cared for, and they're willing to pay more money for it. I think there have been polls to that effect earlier.

Caper: A friend of mine over at the School of Public Health, Bob Blendon, does a lot of public polling on the healthcare issues. He does these Harvard/Kaiser polls that you hear on NPR [National Public Radio] all the time. And it depends on how you ask the question. We know that. If you say, "Would you be willing to pay more to have everybody covered?" they say yes. If you say, "Would you be willing to wait twice as long to have your hip replaced or your mammogram?" the answer is no. If my kid's sick, I want the best. It doesn't matter what it costs.

Young: So what does it take to get it done?

Caper: It takes enough pain being felt by the right people, meaning the middle class or the upper-middle class has to be—

Young: And that's a question of what, pocketbook?

Caper: Yes. I think what's happening now with people losing their health insurance, with what's happening in the individual market, that's becoming very painful. Healthcare is becoming very painful to the corporations who are at a competitive disadvantage. If you read the piece by Malcolm Gladwell in the *New Yorker* called "The Risk Pool", that I mentioned earlier, he points out that, in his view, corporate America is basically not acting in their own self interest when they oppose national health insurance, because why shouldn't they unload this problem onto the Federal Government the way most other countries have? But he says that's an ideological problem. It's just opposition to more federal control over what's now one-sixth of the economy. We have \$2.5 trillion worth of healthcare spending in this country a year, something like that. It's ideological. I don't know. It's very tough.

When I teach about this, I often like to say, "Let's do some international comparisons." I used to teach about the systems in Japan, Britain, France, Italy. Now I just use Canada as the example. They're fascinating because they're the country probably the most like us in the world, with the possible exception of Australia, and yet they're very different. How are they able to build a national health insurance system when we haven't been able to do that? I mean, what's different about the Canadians? I think the answer is in their national motto. Our national motto is, "Life, liberty, and the pursuit of happiness." Right? And their national motto is, "Peace, order, and good government." So think about the difference in values that implies. They're willing to say, "We're all in it together, more or less. We're willing to wait in line a little bit longer in order to make it affordable for everybody." I don't see that happening here. We're all about individual rights and freedom.

Heininger: We should probably draw this to a close. Thank you very much.

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