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Folder Title:
Sullivan (HHS)(1990)

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FOR RELEASE
December 18, 1990

Contact: John Bertak
(202) 401-1576

**DEPARTMENT ISSUES POLICY STATEMENT
ON RACE-EXCLUSIVE SCHOLARSHIPS**

The U.S. Department of Education today announced a six-point administrative policy regarding race-exclusive scholarships to prevent disruption to the efforts of colleges and universities to attract minorities to their campuses and to reassure students that no scholarships that have already been awarded, whether in the current year or in a multi-year cycle, will be affected in any way.

The six points are:

1. The Administration fully endorses voluntary affirmative action in higher education, and encourages educational opportunities for minority and disadvantaged students.
2. ED has decided that the Title VI regulations will be enforced in such a way as to permit universities receiving federal funds to administer scholarships established and funded entirely by private persons or entities where the donor restricts eligibility for such scholarships to minority students, although under Title VI private universities receiving federal funds may not fund race-exclusive scholarships with their own funds.

-MORE-

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3. Race-exclusive scholarships funded by state and local governments, however, are covered by the Supreme Court's decisions construing the Constitution and thus cannot be addressed administratively.
4. Given the evident confusion among the universities on this point, ED will provide universities a four-year transition period in order to permit universities to review their programs under Title VI, and to assure that any students under scholarship, or being evaluated for scholarship, do not suffer. ED is eager to provide technical assistance to any institution during this four-year period. Such technical assistance has helped many universities administer their scholarship programs in full compliance with Title VI.
5. During the four-year transition period, the Administration will not pursue a broad compliance review with respect to minority scholarships but will fulfill its statutory obligation to investigate any complaints received.
6. The Administration will encourage state legislatures, local governments, and private universities receiving federal funds to carefully review and analyze the legal restrictions on minority scholarship programs imposed by the courts, so that these entities may continue to the fullest extent possible to provide scholarship assistance to minorities and other persons in need.

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Held

DRAFT

Dear Colleague:

In all likelihood, you are aware of the Department's recent announcement regarding the application of Title VI of the Civil Rights Act of 1964 to the provision of financial aid to students on the basis of race. The purpose of this letter is to discuss with you the genesis of this issue, and to clarify the Department's position on Title VI and how the Department intends to proceed. The Department's position has been widely misconstrued and, in certain cases, exaggerated. America's colleges and universities have made significant efforts in the last few years to enhance the diversity of their student bodies and to expand educational opportunity for minority students. I commend these efforts and encourage all institutions of higher education to continue to do everything possible to increase minority enrollment. It is the policy of the Department of Education, now and always, to provide all students with the broadest possible access to financial aid. To ensure no disruption to current scholarship holders, the Department will provide colleges and institutions an opportunity to review their own programs and to make every attempt to come into Title VI compliance.

In mid-November, the executive director of the Fiesta Bowl announced that the bowl sponsors intended to contribute \$100,000 to each university participant to create scholarships earmarked

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for minority students. In an attempt to intervene in time to prevent a highly-publicized possible violation of Title VI, I offered the executive director technical assistance to establish these new scholarships in such a way that they clearly complied with federal law while achieving the laudable goals of the Bowl's sponsors. My letter to Fiesta Bowl officials was consistent with Title VI of the Civil Rights Act of 1964, the Department's long-standing regulations, applicable Supreme Court decisions and ED's practice over the past several years. The letter was not intended to, and does not, announce any departure in ED's interpretation of Title VI or ED's general enforcement practices. It was not intended to, and does not, announce a new enforcement policy position.

In light of the apparent confusion and anxiety on the part of students, parents and education institutions, we propose that:

- o no systematic review of college and university student financial aid programs be conducted for five years.
- o current scholarship holders will not be impacted in any way by recent announcements regarding Title VI.
- o no college or university will be required to immediately cancel any existing scholarship programs.

Rather, the Department will work with colleges and universities to develop programs that assist disadvantaged students while complying with the requirements of Title VI. Our early estimates are that most scholarship programs already comply with Title VI.

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- o OCR will respond to existing and future Title VI complaints as it has in the past: by working with institutions to correct features of specific scholarship programs that might be out of compliance with Title VI.

Let me clarify the Office for Civil Rights's (OCR's) interpretation of applicable law. Title VI prohibits discrimination on the basis of race, color or national origin in any program or activity receiving federal financial assistance. Since the Supreme Court's 1978 decision in the Bakke case, it has been clear that under Title VI, postsecondary institutions, in admitting students, may not generally set aside positions exclusively for minority students. We believe the same principle applies equally to the selection of students for scholarships, and that is what we advised the Fiesta Bowl.

However, under Title VI regulations there are appropriate financial aid options to expand opportunities for minorities and provide some flexibility in dealing with the prohibitions of Title VI:

- o A school that has discriminated in the past may use race-exclusive measures to remedy that discrimination;
- o Other schools that are experiencing limited participation by minorities have discretion to use race as a positive factor, among other considerations, in

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selecting applicants for financial aid;

- o Race-neutral criteria such as economic, social, or educational background may be used to benefit disadvantaged students, many of whom are minorities; and
- o Scholarships could be awarded directly to students on a race-exclusive basis by private entities that receive no federal aid, provided that colleges do not assist in that process.

In addition, Title VI does not apply to race-exclusive scholarship programs created by Congress.

I wish to express sincere regret that the motives and purposes of this action have clearly been misunderstood by so many. The Office for Civil Rights, now as always, is prepared to assist you with specific concerns and to work with you to provide broad access by all disadvantaged students to financial assistance.

Sincerely,



Office of the Attorney General
Washington, D. C. 20530

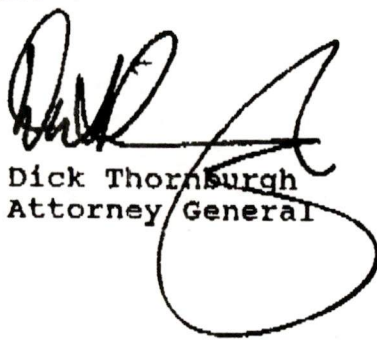
December 14, 1990

MEMORANDUM FOR GOVERNOR SUNUNU
Chief of Staff

Re: Department of Education Scholarship Policy

Pursuant to your request, attached is a statement that the Department of Justice recommends that the President give as he departs the White House this afternoon.

We have not yet been able to reach Michael Williams. However, as you suggested, he should have no problem with the statement. We will continue to try to reach him during the interim before the President departs.


Dick Thornburgh
Attorney General

cc: C. Boyden Gray, Esq.

I've asked the Department of Education to continue to follow the enforcement policy that has been in place over the past several years. There will be no change in that fair and accepted approach to enforcement. Funds that are available to implement legitimate admissions decisions will remain available to students of all races that need help paying for college.

AC - INFO

REVISED

DRAFT STATEMENT ON MINORITY SCHOLARSHIPS

Many questions have been raised in recent days by a Department of Education announcement regarding minority scholarships. The gist of that announcement was that scholarships specifically earmarked for minority students might be in violation of federal law. I think while the intent of that announcement was to increase access of financial aid to all minority students, the process followed was procedurally flawed and caused unnecessary anxiety and frustration on the part of students, parents and education officials.

I have decided that a broader administrative review is needed to determine if this proposal should go forward. In the meantime, scholarships are not in jeopardy, and no student will lose the financial assistance he or she needs to pursue a college education. I also encourage all institutions of higher learning to continue their present efforts to advance opportunities for minority students.

12-14-90
JWC

STATEMENT BY THE PRESIDENT

Throughout my life, I have believed firmly in the principle of racial equality, and also in the overriding importance of education in helping disadvantaged minorities to advance in our society.

I understand that the Department of Education felt it necessary to take their recent action regarding minority scholarships in order to comply with current law and court rulings. However, I feel strongly that the outcome of this decision is wrong, and that its egregious impact on the cause of minority education cannot be justified. The Federal government has long supported higher education for the disadvantaged as a means of overcoming poverty and enhancing equality of opportunity in our society. It should be possible to comply with current law and court rulings in a way that does not do harm to a practice which has manifestly benefited not only minorities, but our Nation as a whole.

Accordingly, I have asked the Attorney General to review the issue carefully, and to work with the Education Department to see that federal funds are administered consistent with legal requirements and court rulings. I have also asked the Attorney General, insofar as possible, to see that this is done in a way that does not disturb the current system and practice of minority scholarships.

I've asked the Department of Education to continue to follow the enforcement policy that has been in place over the past several years. There will be no change in that fair and accepted approach to enforcement. Funds that are available to implement legitimate admissions decisions will remain available to students of all races that need help paying for college.

Withdrawal/Redaction Sheet

(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
01. Memo	From Ede Holiday to John Sununu Re: Health Care Reform Update w/Secretary Sullivan (1 pp.)	12/13/90	P5	

Collection:

Record Group: Bush Presidential Records
Office: Chief of Staff, White House Office of
Series: Sununu, John, Files
Subseries: Cabinet Agencies Files
WHORM Cat.:
File Location: Sullivan (HHS)(1990)

Open on Expiration of PRA
(Document Follows)
By JP (NLGB) on 5/12/05

Date Closed:	12/14/2004	OA/ID Number:	29190-006
FOIA/SYS Case #:	1998-0004-F[1]	Appeal Case #:	
Re-review Case #:	2005-0426-S	Appeal Disposition:	
P-2/P-5 Review Case #:		Disposition Date:	
AR Case #:		MR Case #:	
AR Disposition:		MR Disposition:	
AR Disposition Date:		MR Disposition Date:	

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P-1 National Security Classified Information [(a)(1) of the PRA]
P-2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P-3 Release would violate a Federal statute [(a)(3) of the PRA]
P-4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P-5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
P-6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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Freedom of Information Act - [5 U.S.C. 552(b)]

(b)(1) National security classified information [(b)(1) of the FOIA]
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(b)(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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(b)(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
(b)(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
(b)(9) Release would disclose geological or geophysical information

THE WHITE HOUSE

WASHINGTON

December 13, 1990

THE CHIEF of STAFF
has seen

MEMORANDUM FOR GOVERNOR SUNUNU

FROM:

EDE HOLIDAY *EH*

SUBJECT:

Health Care Reform Update with Secretary
Sullivan

J
Friday at 12:00 (noon) Secretary Sullivan, Deputy Secretary Horner, Attorney General Thornburgh, Director Darman, Michael Boskin and Roger Porter are meeting with you to discuss the status of health care reform. You had asked him six weeks ago to schedule another meeting "after the dust settles" to confirm the timetable for developing health care reform proposals. Since your first meeting, Secretary Sullivan has completed two speeches in his public outreach effort, one on cost control and one on personal responsibility and the need for fostering a "culture of character." Both have been well received.

In addition to an update on the public outreach effort, Secretary Sullivan will discuss some ideas for encouraging states to undertake experiments with some fundamental reforms, along the lines suggested by Director Darman at the last meeting. He may also raise some ideas for consideration as we develop the President's State of the Union address.

The Department has a good handle on the likely Congressional activity in this area, should you wish to discuss that as well.

Withdrawal/Redaction Sheet

(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
02. Memo	From Ede Holiday to John Sununu Re: Secretary Sullivan's Speech Tomorrow (1 pp.)	11/27/90	P5	

Collection:

Record Group: Bush Presidential Records
Office: Chief of Staff, White House Office of
Series: Sununu, John, Files
Subseries: Cabinet Agencies Files
WHORM Cat.:
File Location: Sullivan (HHS)(1990)

Open on Expiration of PRA
 (Document Follows)
 By JF (NLGB) on 1/9/09

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FOIA/SYS Case #:	1998-0004-F[1]	Appeal Case #:	
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AR Disposition Date:		MR Disposition Date:	

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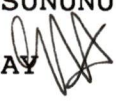
THE WHITE HOUSE

WASHINGTON

November 27, 1990

THE CHIEF of STAFF
has seen

MEMORANDUM FOR GOVERNOR SUNUNU

FROM: EDE HOLIDAY 

SUBJECT: Secretary Sullivan's speech tomorrow

Secretary Sullivan has prepared an extraordinarily thoughtful and eloquent speech that he will deliver at Yale University on Wednesday. A draft is attached. This speech is his second in a series of talks on health policy reform. The topic for this speech is personal responsibility and health care: how unwise or irresponsible behavior can result in poor health for individuals and enormous health care costs for the nation.

Sullivan presents an impressive array of statistics on the costs of bad behavior choices. Examples include:

- o illnesses caused by smoking produce a health care bill of \$23 billion a year.
- o unhealthy diet and sedentary habits contribute to 300,000 to 400,000 deaths each year; one-quarter of the U.S. population is overweight.
- o many of the 60,000 deaths occurring each year among minorities are associated with preventable disease and injuries.

Sullivan then argues that we should look not just to the medical profession or the federal government for health improvement, but rather to the "culture of character." We instill character in individuals, he argues, by "reinvigorating and shoring up those institutions that teach and nurture values and principles of acceptable behavior."

As currently written, the conclusion of the speech is likely to attract undue media attention. On page 17, Sullivan praises Jesse Jackson as a leader in the black community who has managed both to fight for social and economic change and call for the improvement of individual character.

I am calling Sullivan with the suggestion that the reference to Jackson be removed; it will only serve to detract attention from the rest of this speech with its very powerful message.

Attachment

REMARKS BY
LOUIS W. SULLIVAN, M.D.
SECRETARY OF HEALTH AND HUMAN SERVICES
AT THE
TETELMAN LECTURE/YALE UNIVERSITY
NOVEMBER 28, 1990
NEW HAVEN, CONNECTICUT

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[The Secretary will be introduced by Dr. Bernard Lytton, Master of Jonathan Edwards College].

Thanks very much, Dr. Lytton, and thank you all for that warm welcome. It's a great honor to have been invited by Jonathan Edwards College and Yale University to join you as a Tetelman Fellow, following in the footsteps of so many distinguished scientists and physicians upon whom you have previously bestowed this singular honor.

This historic university is, of course, not only a center of learning and research in science and medicine, but one of the nation's truly distinguished centers of liberal education, with interests and expertise ranging across many intellectual and academic boundaries. My lecture this morning, likewise, will range far beyond what we normally consider science and medicine, and even health care policy. Indeed, we will venture into some territory that this college's namesake, Jonathan Edwards, would have found familiar. For I propose to talk about the role of individual responsibility in health care today, and our need to cultivate a new "culture of character" within this nation.

But first, a word of context. This lecture today is part of a much larger dialogue that I am conducting with the American people, about the present problems afflicting our nation's health care system, and some possible solutions.

This dialogue is critical. Recent events in Washington have reminded us once again that, before we attempt to make significant change and reform in our health care system, we must first explore thoroughly with the American people the problems we face, and the difficult and painful choices we must make. Upon the firm foundation of mutual understanding and trust, we can build the widespread and durable consensus that must undergird any proposed changes in our system of health.

Undertaking this consensus-building dialogue has, therefore, been my first step in meeting President Bush's charge to examine thoroughly issues of health care quality, access, and cost containment. Last month, at Stanford, I discussed the factors that have driven the dramatic rate of increase in health care costs. In future lectures, I will talk about providing essential health care to those who are currently underserved; the structure of public and private insurance; and the effectiveness of our medical practices.

But today, I wish to discuss the critical role that a renewed sense of personal responsibility must play, as we seek to forge a more effective, economical, and humane system of health care in America. For the harsh truth is that a shockingly high percentage of the disease and disability afflicting the American people is a consequence of unwise -- indeed, often irresponsible -- choices of behavior and lifestyle.

Those poor choices result in lives that are blighted, stunted, less fulfilling, and less meaningful, and they cause an unnecessary, costly drain on the resources available for health care.

The decision to smoke, for instance, is responsible for one of every six deaths in America each year. The cumulative toll is 390,000 deaths per year, including 21% of heart disease deaths, 87% of lung cancer deaths, and 30% of all cancer deaths. In addition, smoking is responsible for 20 to 30% of low birth weight babies. The illnesses caused by smoking produce a health care bill of \$23 billion annually, with over \$52 billion in total associated costs.

Abuse of alcohol was responsible for one half of the 30,000 motor vehicle deaths in 1988, and 40% of the drownings. Drinking is a major cause of cirrhosis, the ninth leading cause of death in the United States; it has been linked to violence, homicide and suicide; and its costs to society amounted to some \$70 billion in 1989.

Improper diet and inadequate exercise are other major contributors to poor health outcomes. Poor diet is related to five of the ten leading causes of death in the U.S., including coronary heart disease, some types of cancer, stroke, noninsulin-dependent diabetes, and atherosclerosis.

Physical inactivity is related to osteoporosis, osteoarthritis, and obesity. Together, unhealthy diet and sedentary habits contribute to 300,000 to 400,000 deaths each year, and leave one quarter of the U.S. population overweight.

Inadequate safety precautions and injury prevention measures take an enormous toll on America's health: nonfatal injuries account for one of every six hospital days; motor vehicle accidents are responsible for one-third of all injury deaths each year; while homicide and suicide make up another one-third of injury deaths. For children and youth, injuries are the leading cause of death. The lifetime costs of injuries were estimated to be \$158 billion in 1985.

These and other problems of behavior and lifestyle contribute critically to some of the leading health problems facing this nation, including infant mortality and low birth weight, which is associated with smoking, alcohol and drug use, and lack of early prenatal care; heart disease, associated with smoking, high blood pressure, a diet high in calories and saturated fats, and lack of physical activity; and cancer, with its ties to smoking and high fat diets. It is particularly tragic that so many of the 60,000 excess deaths occurring each year among our nation's minority citizens are associated with preventable diseases and injuries.

If we are to bring better lives to all Americans -- and if we are to cope with the dramatic increases in health care costs in America -- it will be necessary for us to address frankly and directly the problem of ill-advised choice of behavior and lifestyle. But, as I noted, this carries us well beyond the range of traditional medicine, into questions of appropriate standards of human behavior -- indeed, into the heart of the realms of ethics and culture.

Now, this is not a comfortable passage for physicians and health care professionals to make -- nor for Americans in general. By our actions, it is apparent that we would rather avoid the issue of appropriate, healthy behavior altogether -- to live however we wish, to eat and drink and smoke whatever we wish without regard to physical, psychological and social consequences, and to permit those around us to do likewise. And then, when the day of reckoning comes, as it inevitably does, we present ourselves to that all-purpose "fix-it" shop, the health care system, for some quick repairs -- so that we can return to our old, comfortable, and unhealthy habits. Clearly, this is ill-advised behavior, from the standpoints of both healthy, fulfilling lives, and financial costs.

Why do we approach health this way?

In part, I believe, because we have seen such astonishing, almost miraculous achievements in the realm of medical science over this century that we believe that we can, indeed, fix virtually any ailment imaginable. Our faith in science and medicine grows ever stronger, as we push the frontiers of research steadily outward, unveiling more and more of the secrets of life on this earth. Consequently, we have come to think of medicine as a capacious safety net, strong and wide enough to catch all who fall from the high wire of an unhealthy lifestyle.

Even as our trust in medical science grows, however, we are troubled by diminishing confidence in our ability to make sound judgments about healthy, appropriate human behavior and lifestyles. In many of our cultural and intellectual circles, we often hear that questions of human behavior -- healthy or unhealthy -- are in fact highly subjective, utterly relative, and without any possible grounding in objectively verifiable truth. The apparent sharpness and clarity of our scientific understanding only adds to the impression of vagueness and subjectivity in our ethical understanding.

Linked to this declining faith in ethical judgment is a widespread erosion of those institutions that traditionally have generated, shaped, and sustained our ethical and cultural standards -- institutions like the family, neighborhood, church, school, and voluntary associations.

As a consequence of this institutional decline and ethical uncertainty, we have ever fewer sources of instruction in healthy, constructive behavior -- fewer shapers and molders of solid human character. We are no longer taught adequately how to discipline our own behavior, and we certainly are not prepared to speak to others about their behavior. After all, some of our intellectual elites would quickly remind us, any such advice would be judgmental, meddlesome, and ultimately arbitrary.

I leave it to the students and faculty of this splendid university to explore fully the profound issues of science, ethics, and philosophy into which we've been led by our course of inquiry. But from my practical standpoint -- as a physician, and as Secretary of Health and Human Services -- let me simply say this: every day, all about me, I see the toll of our ethical equivocation, the tragic price of our cultural indifference -- not only in the prevalence of preventable disease and injury, but also in the vast range of social problems afflicting the American people -- drug and alcohol addiction, escalating child abuse and neglect, children born to unwed teen mothers, families abandoned or never formed.

So many of these problems have their roots in the alienation, isolation, and lack of purpose and direction that follow from the collapse of ethical standards, and the institutions that generate them. And so I am firmly persuaded that we simply cannot continue to be indifferent, noncommittal, or uninvolved when it comes to the ill-advised behavior lying behind so much of our illness and suffering.

That is why I have travelled from one end of the country to the other over the past two years, calling for a renewed sense of personal responsibility on the part of every American citizen -- a new accountability for health decisions and for broader lifestyle choices -- in short, a new "culture of character."

By emphasizing character, I intend to call attention to the full array of personal values and qualities encompassed by that sturdy, time-honored word -- values like self-discipline, integrity, respect for others, perseverance, moderation, and a commitment to serve others and the broader community.

By emphasizing our culture, I seek to remind Americans that we can cultivate character in our citizens only by reinvigorating and shoring up those institutions that teach and nurture values and principles of acceptable behavior, especially the institutions of family and community.

I certainly came to appreciate, in my own experience, the critical value of strong families and communities, and the standards they nurture. The neighborhoods in Atlanta and Blakely, Georgia, where I grew up, were by no means wealthy, but they were genuine communities -- joined together in joy and sorrow, sharing our benefits and burdens, committed to common values and principles.

I was not just the child of my father and mother -- I was in fact a child of the entire neighborhood. When I was out of sight of the folks and thought I could get away with something, Mr. Jones or Mrs. Smith down the block was sure to step in and administer appropriate, corrective therapy -- whether I liked it, or not.

Now, I have to admit, there were times when all this attention to my personal life was not particularly welcome. But I have since come to appreciate just how critical that attention and discipline are. Through it I learned certain values -- values reinforced at every turn by my family, neighbors, church, and school -- values that carried me to medical school, and that carried you into your studies and professions -- values like self-esteem, self-discipline, the desire to learn, responsibility, and service.

In short, my neighborhood built around me a culture of character -- an ethic of personal responsibility. As my beloved mentor, the late Dr. Benjamin Elijah Mays, former president of Morehouse College, put it, I learned that "It is not your environment, it is you -- the quality of your mind, the integrity of your soul, the determination of your will -- that will decide your future and shape your life."

Translated into strategies that would mean healthier, longer lives for all citizens, a new culture of character calls upon Americans to end drug abuse; avoid the high risk behavior that spreads the AIDS virus; reduce consumption of alcohol; seek early prenatal care; improve eating habits; wear seat belts and take other necessary precautions; increase exercise; learn to resolve conflicts without resort to violence; seek the necessary medical examinations and vaccinations; and, yes, stop smoking.

Were we to follow these injunctions, studies have shown that we could eliminate 45% of deaths from cardiovascular disease, 23% of deaths from cancer, and more than 50% of the disabling complications of diabetes. Indeed, control of fewer than ten risk factors, such as poor diet, lack of early prenatal care, infrequent exercise, the use of tobacco, alcohol and other drug abuse, and failure to use seat belts -- could prevent between 40 and 70% of all premature deaths, a third of all cases of acute disability, and two-thirds of all cases of chronic disability.

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Just as important, a new culture of character in America, nurtured by revivified and strengthened families and communities, would do much to alleviate the alienation, isolation and despair that fuel teen pregnancy, violence, drug abuse and other profound social problems afflicting us. The lives of Americans would be healthier in every sense of the word.

Now, I have heard it said that my call to a new culture of character is in fact nothing more than a smokescreen, a subterfuge -- a way of diverting attention from a Federal government and a society that refuses to provide the resources necessary for better health care for all Americans. Indeed, some say that I'm "blaming the victim" by focusing on individual choices of behavior and lifestyle, rather than tackling the poverty that is truly the cause of poor health.

To be sure, poverty is linked to ill health and social dysfunction -- but let us never be guilty of suggesting to our citizens that first they must be wealthier, before they can be healthier. Many impoverished families and neighborhoods have sustained the values and institutions necessary for healthy, productive lives -- lives that will eventually lead them out of poverty.

To suggest that our poor and minority citizens cannot improve their own lives, by drawing on their own strong, traditional values and institutions, is not only inaccurate, it is patronizing and insulting. To counsel them to sit and wait patiently for massive new Federal (or other) programs is to counsel resignation, defeat, pessimism, and despair.

Ill-advised choices of behavior and lifestyle characterize all strata of American society. And so the call for a new culture of character applies with equal force to all Americans, regardless of income, race, sex, or other status. Indeed, I hope that call reaches all Americans, including comfortable cultural and intellectual circles, as well.

Let me be clear about another aspect of the "culture of character." It by no means puts the onus for better behavior exclusively on the individual, nor does it rely simply on a heightened sense of personal responsibility. That's why our culture -- the broader realm of social, economic, and political institutions that shape our lives -- figures centrally in my message. We must mobilize all those institutions in the cause of healthier, more productive lives for our citizens.

The Federal government, for instance, is playing a leadership role by marshalling all facets of society behind disease prevention and health promotion, as demonstrated most recently by our report of health goals for the nation, entitled Healthy People 2000 -- a careful, thoroughgoing strategy to meet certain clearly defined health goals by the turn of the century. We are also working to elevate the status of preventive services in our approach to health care delivery and health policy reform.

More broadly, the Federal government today is working to revitalize institutions like the family and local community, which cultivate healthier, life-sustaining values. This approach carries us beyond the attitude of the 60s and 70s -- as well as the 80s, when government retreated from active social policy.

We now know that Federal programs are most effective when they work through, and help to reinforce, active, indigenous community groups. And so today, we are providing resources and assistance to community coalitions that are striving to prevent the spread of AIDS; halt drug and alcohol abuse; provide early childhood development programs; counsel young minority males; reduce violence; bring expectant mothers into prenatal care programs; and a vast range of other activities.

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Workplace America also has a role to play in building a new culture of character. Businesses must become far more attentive to the health and lifestyle choices of their employees, both by discouraging adverse behavior like smoking and drug and alcohol abuse, and by encouraging positive behavior, like exercise and proper diet.

Equally important, some corporations must expect to be held accountable when they undertake actions that erode the culture of character. Heavily promoting alcohol and tobacco sales in low-income communities is one such reprehensible act. It preys on those who are most vulnerable -- who can least afford the consequences of the irresponsible behavior into which they are being lured, by the guile of Madison Avenue. While I am promoting the culture of character, they are promoting a culture of cancer. And I will do everything in my power to see that my voice is heard, and that my message prevails.

The media and related cultural leadership groups also have a vital role to play in shaping a new culture of character in America. If they can be persuaded to celebrate -- rather than to heap scorn upon -- solid, decent values and institutions, then Americans will be far more likely to adopt healthy lifestyles.

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A step in the right direction is the dramatic turn-about in Hollywood's and Madison Avenue's treatment of drug use. Where once it was accepted, today it is the target of a highly effective, voluntary multi-million dollar prevention campaign. This is a good example of what can be accomplished, if our media leaders can be mobilized behind healthier lifestyles.

Finally, within my own profession of medicine, health promotion and disease prevention must play a larger role. We must work to redress the imbalance in health care expenditures devoted to promoting health versus treating disease -- currently, only 4% of total expenditures go to prevention -- and we must make prevention a central part of the improved primary health care that we are striving to make available to all Americans. Above all, physicians must overcome their reluctance to venture into what may appear to be the purely personal, private behaviors of those to whom we minister, in order to give them sound, thoughtful counsel about the effect their choices have on their health.

This brings me to one final comment about my vision for a new culture of character in America. It is a culture in which we not only are more careful about our own health behavior, but also more attentive to the behavior of those around us -- our family members, friends, neighbors, and coworkers.

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We must have the courage to point out the dangers of unhealthy, self-destructive behaviors in those around us, as well as voice approval for their healthy behaviors. And when these judgments are rendered -- not out of smugness, or self-righteousness, or condemnation, but out of compassion, concern, and love -- when they come in the spirit of family and friendship -- then the message of a new culture of character will have discovered its most effective and profound voice.

My plea for a new culture of character, a new ethic of personal responsibility, is by no means intended to be a substitute for the changes that we must, indeed, make in our broader system of health care. In particular, government will have to be more active on behalf of those who are underserved by current health care arrangements -- especially our poor and minority citizens -- as I will discuss at another time.

But I believe that, as we struggle to overcome the barriers to healthier lives for all our citizens, we can learn much from the experience of the Black community in America. That experience teaches us that progress and reform are most likely to come when we pursue a two-fold strategy: first, strive to change the external circumstances that are unjust and holding us back; but second, strive to reinforce the strength of character necessary to survive and prosper in spite of adverse circumstances.

Neither strategy in isolation is sufficient; both strategies together cannot fail to bring significant progress and reform. Frederick Douglas, for example, worked not only to abolish the social circumstance of slavery; he also sought to build better individuals, by emphasizing the importance of character. "With character we can be powerful," he proclaimed. "Nothing can harm us so long as we have character."

In our time, the outstanding leaders of our community continue to pursue both strategies simultaneously. Dr. Martin Luther King, Jr. resolutely pursued changes in society's laws and institutions, so that one day his daughters would not be judged by the color of their skin. But at the same time, he worked to prepare people for the day when they would be judged by the "content of their character."

Similarly, Jesse Jackson's quest for social and economic change in the larger society is joined inseparably to a call for personal reform, for better character. As he put it, "When you drink liquor, and when you take drugs, and when you sell drugs, and when you shoot people and when you rob people . . . nobody can save you but you from yourself."

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So today, as we search for ways to insure that our expenditures for health care are wisely spent, and not wasted treating unnecessary and preventable disease -- more important, as we search for ways to bring healthier, safer, more fulfilling and productive lives to all our citizens -- let us pursue both strategies at once. Let us not only seek ways to change and improve our health care system -- let us search for ways to improve ourselves -- our behavior and lifestyles, our values, indeed, our very character.

A new culture of character is not the entire answer to the health care dilemmas we face. Nonetheless, it is an essential, crucial part of the answer. And it is a vital key to better lives for all Americans.

Thank you very much.

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Withdrawal/Redaction Sheet

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Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
03. Memo	From Ede Holiday to John Sununu Re: Health Reform Strategy Meeting w/Secretary Sullivan (1 pp.)	10/16/90	P 5	

Collection:

Record Group: Bush Presidential Records
Office: Chief of Staff, White House Office of
Series: Sununu, John, Files
Subseries: Cabinet Agencies Files
WHORM Cat.:
File Location: Sullivan (HHS)(1990)

Open on Expiration of PRA
 (Document Follows)
 By JP (NLGB) on 5/12/05

Date Closed:	12/14/2004	OA/ID Number:	29190-006
FOIA/SYS Case #:	1998-0004-F[1]	Appeal Case #:	
Re-review Case #:	2005-0426-S	Appeal Disposition:	
P-2/P-5 Review Case #:		Disposition Date:	
AR Case #:		MR Case #:	
AR Disposition:		MR Disposition:	
AR Disposition Date:		MR Disposition Date:	

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P-1 National Security Classified Information [(a)(1) of the PRA]
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Freedom of Information Act - [5 U.S.C. 552(b)]

(b)(1) National security classified information [(b)(1) of the FOIA]
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 (b)(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
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 (b)(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
 (b)(9) Release would disclose geological or geophysical information

THE WHITE HOUSE

WASHINGTON

October 16, 1990

MEMORANDUM FOR GOVERNOR SUNUNU

FROM: EDE HOLIDAY 

SUBJECT: Health Reform Strategy Meeting with Secretary Sullivan

This morning at 9:30 a.m., Secretary Sullivan is meeting with you and other White House Senior Staff to discuss the process and timetable for formulating the Administration's health reform proposals. There is a growing belief at the sub-Cabinet level that the current political environment is not right for a sweeping -- or even a modest -- health care reform proposal.

As you know, the President announced the creation of a DPC Health Policy Working Group in the State of the Union last January in the belief that health would be one of the key issues this year. Since that time, Under Secretary Connie Horner has been operating in near-secrecy, following what she understood to be your direction. The reform ideas HHS has been developing have been discussed periodically with a Deputies-level group, but they have not been subjected to hard analysis, review or interagency scrutiny.

In the nine months since the State of the Union, HHS has been studying different reform proposals. OMB, working independently, has been developing its own ideas for a health care reform package. We are concerned -- and HHS shares this concern -- that none of its options are feasible at this point in time. Either they are too expensive in the current budget environment or they would be disastrous politically. However, the DPC will be considering infant mortality proposals in the next few weeks that HHS views as a first step toward the broader reforms to come.

Secretary Sullivan will propose that instead of presenting a comprehensive proposal this January, he should conduct a series of five seminars around the country to open a dialogue with the American people on health policy. He believes these would both frame the issue and educate the public about the health care dilemma. He will propose that the DPC process should continue, leading to the development of a proposal by January, 1992.

There is an opportunity to integrate our health policy proposal over the next year into a broader theme of "empowerment." We recommend that any health proposal should focus on results, it should promote choice by avoiding centralized solutions, and should be budget neutral.



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

SEP 11 1990

MEMORANDUM FOR GOVERNOR SUNUNU

I am pleased to submit to you a copy of the attached report, Healthy People 2000: National Health Promotion and Disease Prevention Objectives.

On September 6, 1990, this report was released at the Healthy People 2000 national conference of leaders from the private sector, States, communities, and the Federal Government at the Omni Shoreham Hotel in Washington. As you know, the President addressed the conference in a written message which I was honored to present at the opening plenary session of the conference.

The report is the product of a three-year national effort, involving professionals and citizens, private organizations, and public agencies, including other Federal agencies, from every part of the country. It grew out of a strategy initiated a decade ago with the release of health objectives for the year 1990. The report contains a national strategy for significantly improving the health of the Nation over the coming decade. It addresses the prevention of major chronic illnesses, injuries and infectious diseases.

If you wish to discuss this report, I am available at your convenience.

As a memento of the release of the Healthy People 2000 report, I am sending you and the President our Healthy People 2000 T-shirts.

Louis W. Sullivan, M.D.
Secretary

Attachment



AC HAS SEEN

JUN 26 1990

MEMORANDUM FOR GOVERNOR SUNUNU

The purpose of this memorandum is to transmit to you information on AIDS which we discussed in our telephone conversation Sunday. The enclosed material includes information regarding spending on AIDS compared to other major diseases and a background paper on Federal assistance for the HIV/AIDS epidemic.

The cumulative number of reported AIDS cases in the United States since 1981 now exceeds 130,000 and is projected by CDC to reach 365,000 by the end of 1992. Currently, an estimated 1 million persons in the United States are HIV-infected. Through May 1990, 83,145 died from AIDS in the United States. During the years 1982 through 1989, cumulative Federal expenditures for AIDS reached about \$5.5 billion. Nearly 90% of the cumulative Federal AIDS spending comes from the Department of Health and Human Services. U.S. Public Health Service expenditures represent about 60 percent of the total Federal spending on AIDS. The level of Federal spending on HIV research and prevention is similar to funding for cancer and heart disease, both of which have a significantly greater impact on mortality. For example, the cumulative deaths for heart disease since 1981 is 6,894,904 and for cancer it is 4,150,473.

CONTENTS OF TABLES

Tables I through III are based on expenditures for the U.S. Public Health Service (PHS) only and do not include other Federal spending on AIDS. For cancer and heart disease, Tables I through III represent expenditures by the National Cancer Institute and the National Heart Lung and Blood Institute, respectively, not the entire PHS. Despite this difference in the methodology used for accounting expenditures, the relative relationship between spending for cancer and heart disease versus spending for AIDS as it relates to mortality rates will not change significantly.

Tables IV through VII include all Federal spending on AIDS.

Table I- Mortality and Funding Data by Disease

Table II- Deaths Reported by States on Death Certificates

Table III- Research, Prevention, and Control Expenditures--FY 1980 through FY 1990

Table IV- 1989 Federal Research, Education & Prevention Spending for Major Diseases

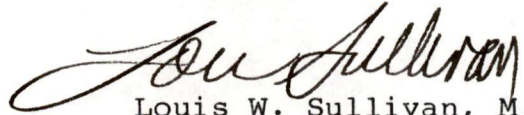
Table V- Growth in Federal AIDS Spending 1983 to 1989

Table VI- Federal AIDS Spending by Agency and Department

Table VII- Federal AIDS Spending by Type of Activity

If you would like to discuss any of this material in greater detail, I would be pleased to do so at your convenience.

Sincerely,

A handwritten signature in dark ink, appearing to read "Lou Sullivan", written in a cursive style.

Louis W. Sullivan, M.D.
Secretary

Enclosures

Table I

Mortality and Funding Data By Disease

Disease	Number of Deaths 1989	Cumulative Deaths Since 1981	(\$ in Millions)		(Actual Dollars)	
			FY 1990 Request	FY 1990 Appro	Funding per Death Request	Funding per Death Appro
Breast Cancer...	43,300	357,199	\$78.1	\$80.0	\$1,803	\$1,848
Cervical Cancer.	6,000	43,365	\$16.9	\$17.3	\$2,814	\$2,883
All Cancers.....	502,000	4,150,473	\$1,494.7	\$1,484.0	\$2,977	\$2,956
Heart Disease....	785,470	6,894,904	\$694.8	\$673.0	\$885	\$857
AIDS.....	21,771	83,145	\$1,600.0	\$1,585.8	\$73,492	\$72,840

NOTE: See Table III for explanations and footnotes

TABLE II

Deaths reported by States on Death Certificates

	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>	<u>1988*</u>	<u>1989</u>	<u>Cumulative</u>
Heart Disease.....	753,884	755,592	770,432	765,114	771,169	765,490	760,353	767,400	785,470	6,894,904
Cancer (All).....	422,094	433,795	442,986	453,492	461,563	469,376	476,927	488,240	502,000	4,150,473
Breast Cancer (Female).	36,483	37,414	37,979	39,472	40,093	40,539	40,899	41,020	43,300	357,199
Cervical Cancer.....	4,815	4,631	4,651	4,564	4,508	4,558	4,425	5,213	6,000	43,365
AIDS.....	161	446	1,459	3,313	6,683 **	11,166	14,920	18,716	21,771	78,635 ***

* Provisional Data -- Based on 10% Sample.

** Includes 159 deaths in which the year is unknown.

*** Including deaths through May of 1990, total deaths are 83,145.

Source: Vital Statistics (Tom Dunn)

June 26, 1990

TABLE III

Research, Prevention, and Control Expenditures -- FY 1980 through FY 1990

(Dollars in thousands)

	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u> <u>Estimate</u>	<u>Cumulative</u>
Cancer (All).1/.....	\$999,869	\$989,355	\$984,217	\$977,828	\$1,076,391	\$1,169,654	\$1,159,241	\$1,339,082	\$1,379,383	\$1,448,731	\$1,483,990	\$13,007,741
Diabetes.2/.....	\$134,262	\$147,882	\$148,483	\$165,271	\$177,982	\$188,971	\$189,188	\$234,152	\$240,882	\$258,206	\$264,206	\$2,149,485
HIV/AIDS.3/.....	---	---	\$5,555	\$28,736	\$61,460	\$108,618	\$233,812	\$502,455	\$962,018	\$1,300,034	\$1,585,878	\$4,788,566
HIV/AIDS (NIH only).....	---	---	\$3,355	\$21,668	\$44,121	\$63,737	\$134,667	\$260,907	\$473,285	\$601,316	\$743,532	\$2,346,588
Heart Disease/Stroke.4/.....	\$338,985	\$351,505	\$361,644	\$398,284	\$445,240	\$501,452	\$521,481	\$582,618	\$605,179	\$640,097	\$647,700	\$5,394,185

1/ NIH National Cancer Institute appropriation only.

2/ NIH Research Institutions only.

3/ All agencies of the Public Health Service (FDA, HRSA, IHS, CDC, NIH, ADAMHA, AHCPR, OASH).

4/ NIH National Heart, Lung and Blood Institute appropriation only. Table III includes stroke research expenditures, Table I includes only heart disease research.

Note: Except for AIDS, the figures on this table represent a fair approximation of research and prevention activities in each of these disease areas supported by the National Institutes of Health. The HIV/AIDS figures represent all support provided through the Public Health Service including research, prevention regulation and treatment demonstration funds. Comparable comprehensive figures for the other disease areas, such as cancer, are not available. The table does include HIV/AIDS NIH expenditures only (shaded).

June 26, 1990

TABLE IV.

1989 FEDERAL RESEARCH, EDUCATION, & PREVENTION SPENDING FOR MAJOR DISEASES

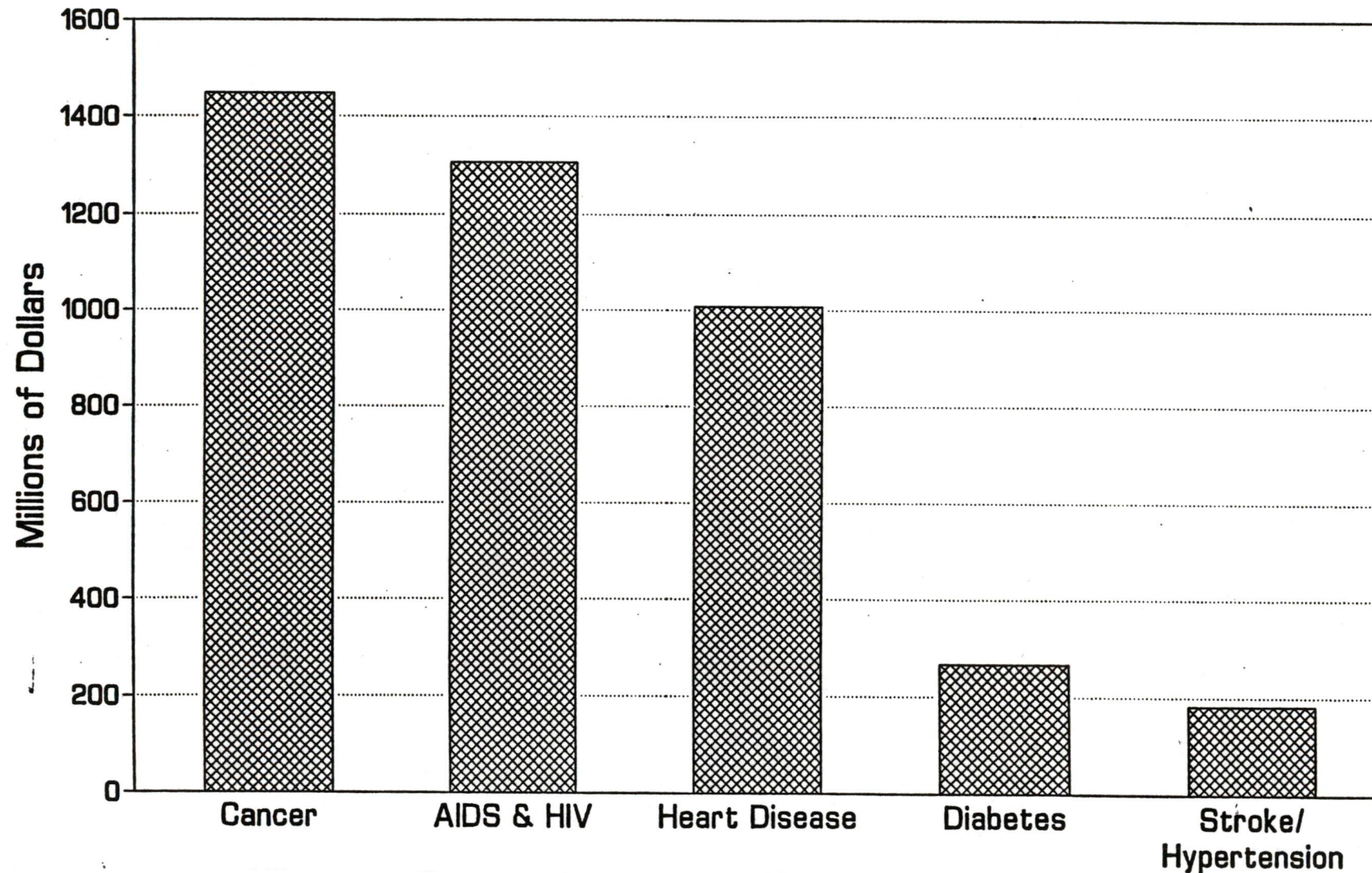


TABLE V.

Growth in Federal AIDS Spending 1983 to 1989

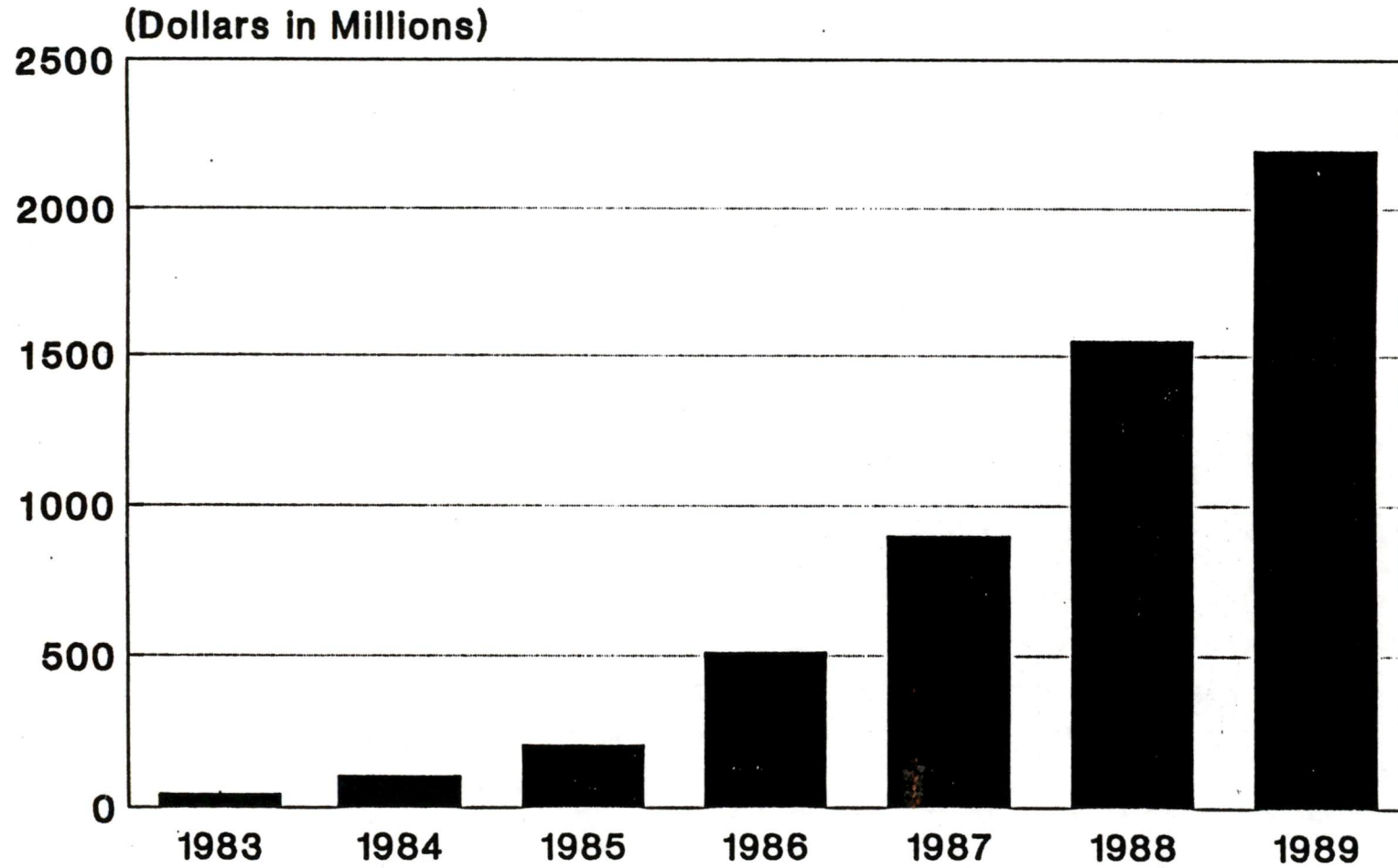
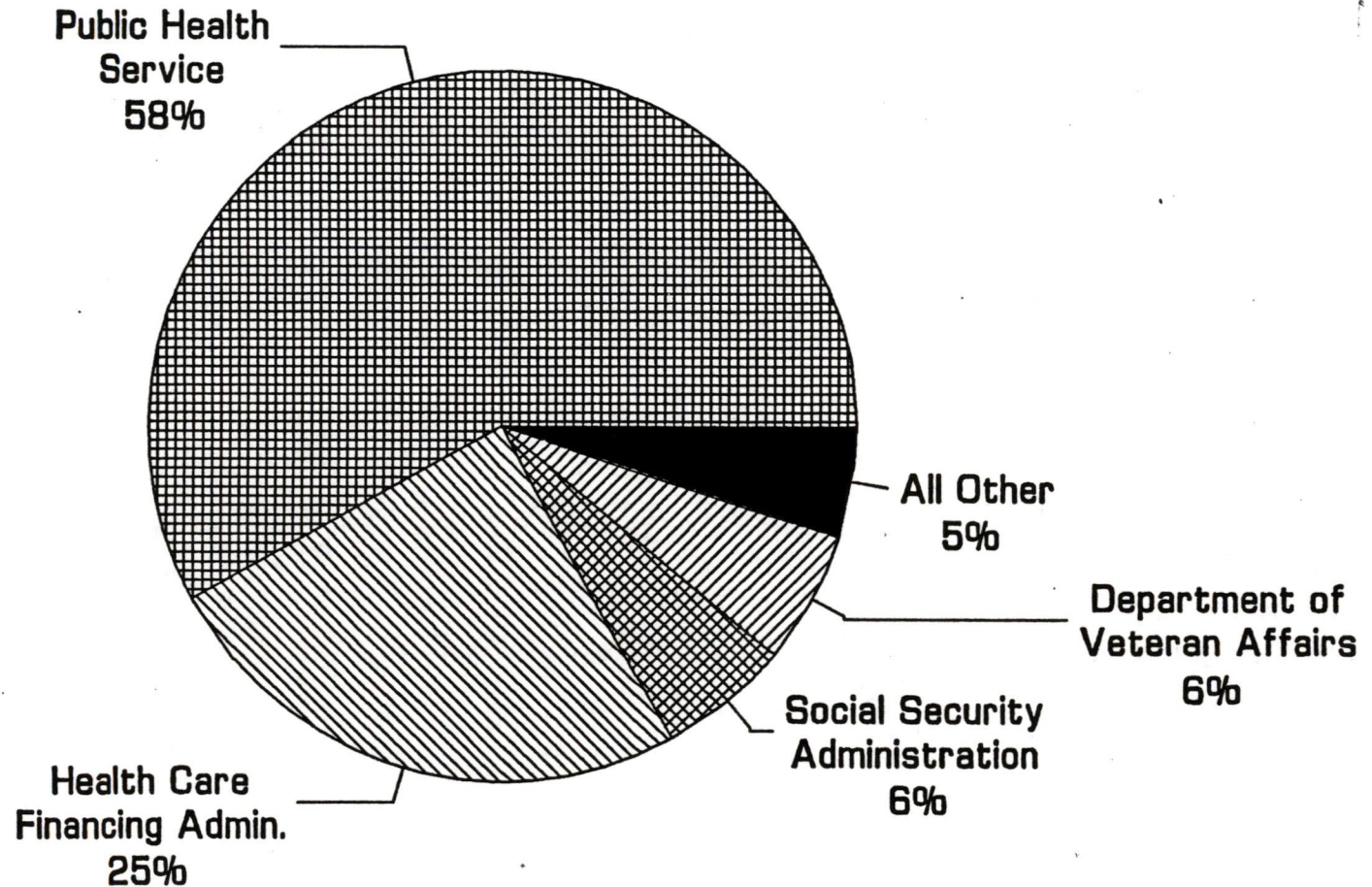


TABLE VI.

FEDERAL AIDS SPENDING BY AGENCY & DEPARTMENT

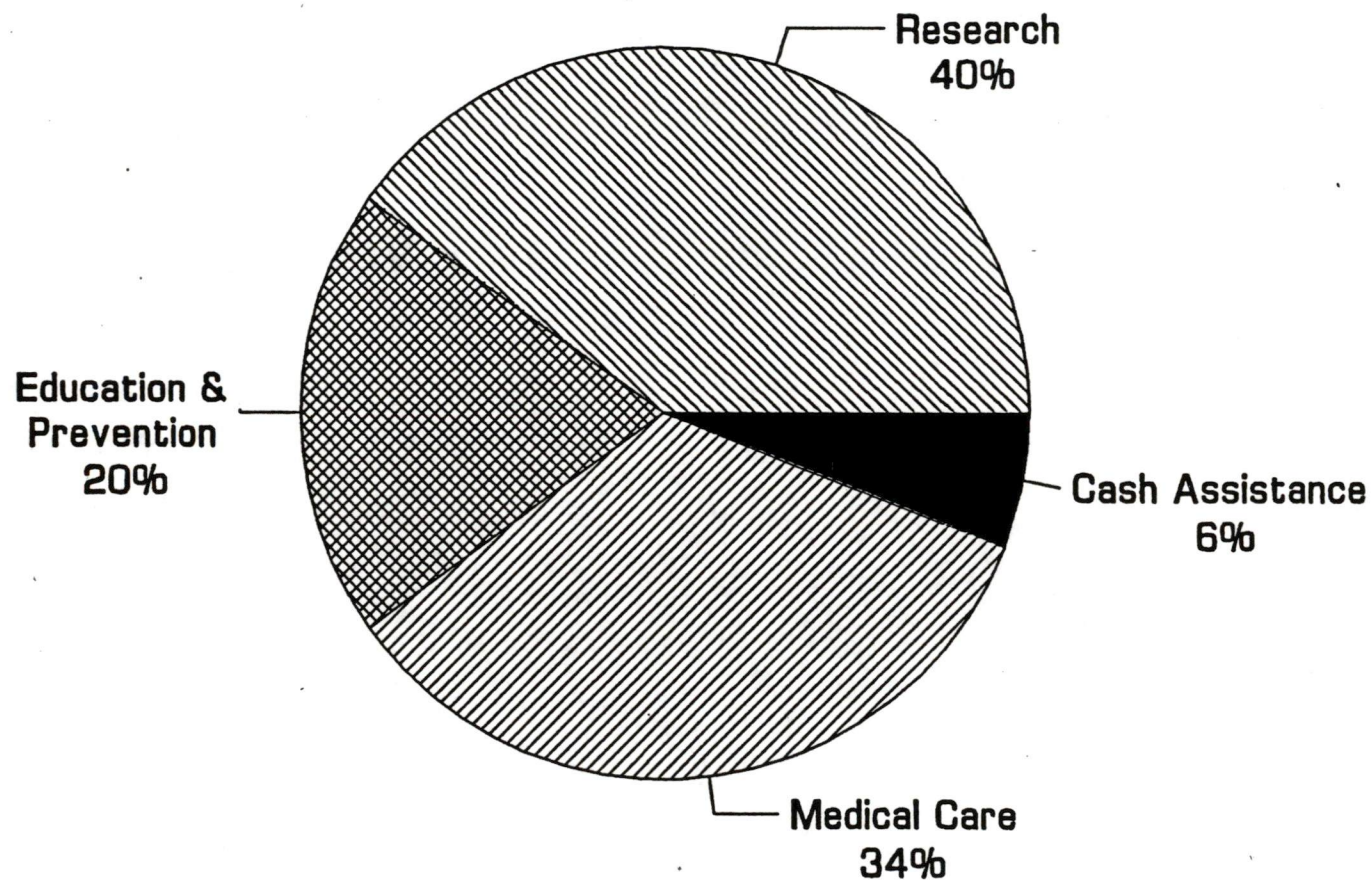


\$5.5 Billion Total

Cumulative 1982 through 1989

TABLE VII.

FEDERAL AIDS SPENDING BY TYPE OF ACTIVITY



\$5.5 Billion Total

Cumulative 1982 through 1989

FEDERAL ASSISTANCE FOR THE HIV EPIDEMIC

National Perspectives on the HIV epidemic

The cumulative number of reported AIDS cases now exceeds 130,000 and is projected by the CDC to reach 365,000 by the end of 1992. An estimated 1.0 to 1.5 million persons in the U.S. are HIV-infected and will need ongoing medical care, probably beginning early in the course of infection--well before they have progressed to the stage of AIDS. Recent clinical trials suggest that many (up to 600,000) apparently asymptomatic infected persons could benefit from prophylactic doses of high-cost, but low-dose, AZT. In addition, other helpful--but potentially expensive--drugs for AIDS and the associated opportunistic infections are under development.

The nature and impact of AIDS is different in several critical respects from those of most other diseases, even those diseases which currently affect many more people. And, that the cumulative effect of these differences creates a unique public health problem that merits carefully circumscribed Federal support.

AIDS is a Classic Public Health Epidemic

The contagious nature of HIV infection and the continually growing impact of the infection make it a classic public health epidemic. As such, AIDS is not very different from prior Federal efforts throughout U.S. history to help States cope with other epidemics such as sexually transmitted diseases, tuberculosis, and Hansen's disease.

As is true for other public health problems, help at the national level has been provided because it is in the interests of both society as a whole, and the individual affected by the disease. AIDS is a new, highly visible disease whose dramatic impact elicits a humanitarian response.

Finally, the magnitude of the epidemic is not fully expressed by comparisons with present mortality rates for other illnesses because HIV-related deaths are increasing at such a rapid rate.

- 0 In 1986, there were about 148,000 deaths from cerebrovascular disease (e.g., stroke, aneurysms, etc.), about 75,000 deaths from chronic obstructive pulmonary disease (COPD), and about 10,000 from HIV-related illness--ratios of 14 to 1 and 7 to 1, respectively.
- o By 1992, the ratios are expected to be much closer, about 2 to 1 for cerebrovascular versus HIV-related deaths, and 1.3 to 1

for pulmonary (COPD) to HIV deaths.

Over the one year period from 1988 to 1989, the death rates for three of the leading causes of death (heart disease, cancer, cerebrovascular disease) showed small increases or even decreases, but the HIV-related death rate increased by 31%. Such rapid growth is also reflected in measures of years of potential life lost, a measure which accounts for age at death. Because 81 percent of AIDS cases have occurred in persons under the age of 45, the years of potential life lost attributable to HIV-related disease increased by 44.8 percent in a one year period. The young age of those who have died due to AIDS is also reflected in the fact that HIV infection is now the tenth leading cause of death, but ranks seventh in the number of years of potential life lost.

Need for Federal Assistance

The magnitude of the disease, its rapid growth, evolving treatment regimens, and the high cost of experimental treatments have created considerable demand for additional Federal assistance in support of HIV-related prevention and control efforts.

Proposals for special Federal financing for AIDS prevention and control have been questioned on the grounds of equity, since the Federal government does not provide similar special financing for persons with other chronic and life-threatening illnesses, such as diabetes and heart disease.

Of \$2.2 billion spent by the Federal government on activities related to AIDS in Fiscal Year 1989, about one-third was related to the provision of medical care for persons with AIDS or HIV infection. Most Federal funds for care were provided through entitlement programs, including Medicaid (\$490 million), Medicare (\$55 million) and the programs of the Departments of Veterans Affairs and Defense (\$118 million). The overall (Federal and non-Federal) medical care costs of treating persons with AIDS was estimated to be about \$4 billion in FY 1989.

As is true with other diseases, the majority of services and reimbursements provided by Federal programs to persons with AIDS or HIV-related illnesses are provided as part of a general medical benefit and are not tied specifically to any special HIV-related benefit. However, some special, narrowly focused monies also have been available through the Public Health Service. In FY 1990, PHS expects to operate a few programs which help fill gaps in the delivery of the health care related to HIV infection:

- o grants for service and pediatric AIDS care demonstrations;
- o supplemental funds to community and migrant health care centers;

- o renovation of non-acute facilities for AIDS patients; and,
- o AIDS-related treatment provided through clinical and drug treatment research and clinical trials.

Highly Focused Economic and Social Impacts

Illnesses such as diabetes and heart disease tend to be spread throughout the population in the various States, whereas the AIDS epidemic has hit only a handful of locales very hard:

Five states--California, Florida, New Jersey, New York and Texas--account for two-thirds of all reported AIDS cases. Over half are concentrated in 10 metropolitan areas.

At the other extreme, eight other States have had fewer than 100 cases of AIDS through July 1989.

This unusual geographical concentration of high-cost AIDS patients has had a devastating impact on the social and health care delivery systems of the areas affected. This situation is likely to get worse, since the number of persons with AIDS is expected to quadruple by 1992 and new and expensive treatments are creating a larger population of persons needing care.

FEDERAL ASSISTANCE
FOR THE HIV/AIDS EPIDEMIC

National Perspectives on the HIV/AIDS Epidemic

The cumulative number of reported AIDS cases now exceeds 130,000 and is projected by the CDC to reach 365,000 by the end of 1992. An estimated 1.0 million persons in the U.S. are HIV-infected and will need ongoing medical care, probably beginning early in the course of infection--well before they have progressed to the stage of AIDS. Recent clinical trials suggest that many (up to 600,000) apparently asymptomatic infected persons could benefit from the prophylactic high-cost, but low-dose, AZT and other medications. In addition, other helpful but potentially expensive drugs for AIDS and the associated opportunistic infections are under development.

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As is true for other public health problems, help at the national level has been provided because it is in the interests of both society as a whole, and the individuals affected by the disease. AIDS is a new, highly visible and lethal disease whose dramatic impact elicits a humanitarian response.

The magnitude of the epidemic is not fully expressed by comparisons with present mortality rates for other illnesses because HIV/AIDS-related deaths are increasing at such a rapid rate.

- o In 1986, there were about 148,000 deaths from cerebrovascular disease (e.g., stroke, aneurysms, etc.), about 75,000 deaths from chronic obstructive pulmonary disease (COPD), and about 11,000 deaths from HIV/AIDS-related illness--ratios of 14 to 1 and 7 to 1, respectively.
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Proposals for special Federal financing for HIV prevention and control have been questioned on the grounds of equity, since the Federal government does not provide similar special financing for persons with other chronic and life-threatening illnesses, such as diabetes and heart disease.

Of \$2.3 billion spent by the Federal government on activities related to AIDS in Fiscal Year 1989, about one-third was related to the provision of medical care for persons with AIDS or HIV infection. Most Federal funds for care were provided through entitlement programs, including Medicaid (\$490 million), Medicare (\$55 million) and the programs of the Departments of Veterans Affairs and Defense (\$228 million). The overall (Federal and non-Federal) medical care costs of treating persons with AIDS was estimated to be between \$1.1 and \$1.6 billion in 1989 (based on an average cost of \$36,000-50,000 per patient for care from the onset of illness to death).

As is true with other diseases, the majority of services and reimbursements provided by Federal programs to persons with AIDS or HIV-related illnesses are provided as part of a general medical benefit and are not tied specifically to any special HIV-related benefit. However, some special, narrowly focused monies also have been available through the Public Health Service. In FY 1990, PHS expects to operate a few programs which help fill gaps in the delivery of the health care related to HIV infection:

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Five states--California, Florida, New Jersey, New York and Texas--account for two-thirds of all reported AIDS cases. Over half are concentrated in 10 metropolitan areas.

At the other extreme, seven other States have had fewer than 100 cases of AIDS through May 1990.

This unusual geographical concentration of high-cost HIV/AIDS patients has had a devastating impact on the social, medical care and public health delivery systems of the areas affected. This situation is likely to get worse, since the number of persons with HIV/AIDS is expected to quadruple by 1992. New, effective and costly treatments, coupled with the need to intensify prevention services will result in a larger population of persons benefiting from the Federal response to the HIV/AIDS epidemic.

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Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
04a. Memo	From Louis Sullivan to John Sununu Re: Sixth International Conference on AIDS (1 pp.)	6/20/90	P5	

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Subseries: Cabinet Agencies Files
WHORM Cat.:
File Location: Sullivan (HHS)(1990)

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Re-review Case #: 2005-0426-S	Appeal Disposition:
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AR Case #:	MR Case #:
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 (b)(9) Release would disclose geological or geophysical information



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUN 20 1990

151964
THE CHIEF of STAFF
has seen

MEMORANDUM FOR GOVERNOR SUNUNU

As you are aware, the Sixth International Conference on AIDS begins today in San Francisco, California and runs through Sunday June 24, 1990. Because the news coverage of this conference is not likely to be favorable to the Administration, I thought you might be interested in some background against which to read the media reports.

I am scheduled to address the conference at the closing ceremony on Sunday. Approximately 12,000 participants are expected to attend, including scientists, health-care professionals, policy makers, gay and civil rights advocates and others concerned about AIDS and HIV infection. Controversy surrounding this year's conference is particularly keen for a number of reasons and tensions are unusually high. Issues of concern include: discrimination against people with AIDS; United States immigration policy related to HIV infected persons; accessibility to treatments; and, the current level of funding for AIDS related research and services.

I am also providing a separate summary of likely media issues and talking points prepared for the White House Press Office.

I am available to discuss any of these issues in greater detail at your convenience.

Sincerely,

Louis W. Sullivan, M.D.
Secretary

Enclosures

Withdrawal/Redaction Sheet

(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
04b. List	Highlights of Issues Surrounding the Sixth International AIDS Conference (3 pp.)	6/20/90	P-5	

Collection:

Record Group: Bush Presidential Records
Office: Chief of Staff, White House Office of
Series: Sununu, John, Files
Subseries: Cabinet Agencies Files
WHORM Cat.:
File Location: Sullivan (HHS)(1990)

Open on Expiration of PRA
 (Document Follows)
 By JP (NLGB) on 5/12/05

Date Closed: 12/14/2004	OA/ID Number: 29190-006
FOIA/SYS Case #: 1998-0004-F[1]	Appeal Case #:
Re-review Case #: 2005-0426-S	Appeal Disposition:
P-2/P-5 Review Case #:	Disposition Date:
AR Case #:	MR Case #:
AR Disposition:	MR Disposition:
AR Disposition Date:	MR Disposition Date:

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

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**HIGHLIGHTS OF ISSUES SURROUNDING
THE SIXTH INTERNATIONAL AIDS CONFERENCE**

- o Intensive, If Not Violent, Demonstrations are Planned by AIDS Activists; Media Coverage may Pander to the Demonstrators Instead of Covering the Conference

Activist events surrounding the conference are likely to get at least as much attention as the scientific and other presentations. A good deal of attention has been paid to a published "call to riot," and rumors about provocative acts have been rampant. However, most activist leaders say they are anxious to prevent violence.

ACT UP (AIDS Coalition to Unleash Power) has organized a number of marches, demonstrations and "civil disobedience" events, beginning Tuesday:

June 19 -- March on INS facilities
June 20 -- "Civil Disobedience" at conference opening
June 23 -- HIV/AIDS March
June 24 -- "Civil Disobedience," confronting Secretary Sullivan at conference closing

There are rumored reports of more extreme actions such as tainting food with AIDS infected blood and even pouring infected blood on police and government officials.

AIDS activists hope to promote the following messages by their demonstrations: Treatments are still not sufficiently accessible to people with AIDS; discrimination continues against those with AIDS; universal access to health care should be a right; AIDS funding should be increased; "disaster relief" is needed in heavily impacted communities.

The conference and surrounding events will receive saturation news coverage. ABC will be broadcasting its network news from the conference, and will lead its Wednesday night broadcast with a story on the Reagan/Bush response to AIDS (Dr. James Mason, Assistant Secretary for Health, was interviewed for the piece). Drs. Fauci of NIH, Curran of CDC, and others will be available to the media during the conference and will try to keep the focus on the information being shared by conference participants.

o Several Governments are Boycotting Against the United States Policy on Travel of HIV-Infected Persons

Despite the recent changes to lessen the impact of U.S. policy on HIV-infected foreign travelers attending the AIDS conference, there continues to be considerable concern, both in this country and abroad, about the potentially discriminatory nature of U.S. policy. To protest these policies, a number of foreign governments, and national and international organizations intend to boycott the conference. These include the 12 countries of the European Community, the European Parliament, Canada, and the International Red Cross and Red Crescent Societies.

In a further development related to the International AIDS Conference scheduled to be held in Boston in 1992, according to a June 15, 1990 New York Times report, Harvard University stated that it would cancel its plans to be the host of the conference unless the U.S. removed travel restrictions on people infected with the HIV.

o Self-Proclaimed Homosexual Aliens Seeking Admission into the United States

Under the Immigration and Nationality Act, one of the grounds for exclusion of aliens from the U.S. is if they are "afflicted with psychopathic personalities, sexual deviation, or a mental defect." While the Immigration and Naturalization Service (INS) does not routinely inquire as to whether temporary visitors are homosexuals, when an individual self-declares that he or she is homosexual, INS denies admission based on that exclusion.

In most of the country, INS can do this without HHS involvement. However, the Department of Justice (DOJ) interpretation of a 1983 U.S. Court of Appeals decision in San Francisco, is that INS cannot exclude these self-proclaimed homosexuals in the Ninth Judicial Circuit (including San Francisco) without a medical certificate issued by Public Health Service (PHS) physicians. Since it is not possible to determine sexual preference from a medical examination, PHS had refused to issue such certificates until it was directed by DOJ to do so in 1984. Under this directive, PHS physicians record that the alien self-proclaimed his or her sexual preference, then issue the required medical certificate.

In an unpublished 1985 decision, a U.S. District Court in San Francisco declared that INS could proceed only on the

basis of a meaningful medical examination. As the Court decision was unpublished, senior HHS officials learned of the decision only a few days ago when the Department received a letter from the ACLU that included a copy of the decision. In this letter, the ACLU claimed that the medical examination required by the INS was not meaningful, and therefore could not be used as grounds for exclusion. The ACLU also stated that it will sue INS and PHS if the existing practice continues.

Withdrawal/Redaction Sheet

(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
05. List	From Louis Sullivan to John Sununu Re: NIH Director (2 pp.)	5/17/90	(b)(6)	

Collection:

Record Group: Bush Presidential Records
Office: Chief of Staff, White House Office of
Series: Sununu, John, Files
Subseries: Cabinet Agencies Files
WHORM Cat.:
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AR Disposition Date:		MR Disposition Date:	

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Bush's health chiefs must toe abortion line

By Joyce Price
THE WASHINGTON TIMES

The Bush administration acknowledged yesterday it will use an anti-abortion litmus test to screen candidates for the government's top health policy jobs, including surgeon general, but said it will not use such screening for senior-level scientific posts.

"For people who are being considered for policy-making positions in the health field, we'll still certainly ask them for their position on abortion, fetal tissue research, AIDS — the whole range of issues that they would have to be directing federal policy on," White House Press Secretary Marlin Fitzwater said.

"But for those jobs that are essentially technical, or below the assistant secretary level, the answer is no," Mr. Fitzwater said.

The highly visible position of surgeon general is directly beneath that of assistant secretary, but Mr. Fitzwater made it clear anyone hoping to be surgeon general also must pass a litmus test. "We certainly would want to know that they support the president's position," he said.

Mr. Fitzwater's remarks ex-

panded those made Sunday by Health and Human Services Secretary Louis W. Sullivan at a meeting of the Association of American Medical Colleges. Dr. Sullivan said the so-called litmus test would not be used to gauge applicants for top scientific jobs in the federal government.

"Standards of scientific and administrative excellence and leadership" should prevail in the selection of research administrators for the

tion.

Bob Schermund, spokesman for Dr. Sullivan, said yesterday the HHS secretary supports the White House's contention that the surgeon general "should share the administration's position (on key issues) and defend the administration's position."

White House and HHS officials have been shaken by a report that a White House aide used the divisive abortion question to screen a can-

abortion opponent, was promoted to assistant U.S. health secretary. Dr. Mason also is serving as acting surgeon general until that position is filled.

Leaders of some conservative organizations said the directors of NIH and CDC also should hold the president's anti-abortion stance.

"It seems to me they should have the same positions as the president," said Totie Ellis, vice president of the Eagle Forum, a conservative pro-family group.

H. Edward Rowe, head of the National AIDS Prevention Institute, said: "We don't want to tell people in lower-ranking positions what to believe, but I think people in high-level positions should... reflect the president's viewpoints. The directorships of NIH and CDC are both pretty high positions."

Published reports indicate that Dr. Antonia Novello of the Institute of Child Health and Human Development, who is expected to be appointed surgeon general to replace Dr. C. Everett Koop, also was asked about her views on abortion by a White House aide. Mr. Schermund said Dr. Novello opposes abortion.

• This report is based in part on wire service reports.

Leaders of some conservative organizations said the directors of NIH and CDC also should hold the president's anti-abortion stance.

National Institutes of Health, the national Centers for Disease Control and other major federal agencies, he said.

But Dr. Sullivan defended questioning candidates for top health jobs on their abortion views, saying the president needs to pick policymakers who "reflect the broader values and priorities, as defined in his commitments to the public." He did not specifically mention the surgeon general as being such a posi-

tion. The candidate for National Institutes of Health director, **Dr. William Danforth, chancellor of Washington University at St. Louis,** reportedly was asked about his abortion views last summer and made it clear he did not want the job if he had to worry about such political issues.

The NIH directorship has been vacant since July. The CDC directorship also is vacant because former CDC chief Dr. James O. Mason, an

Ideological Test for Federal Jobs Worries Doctors:

By PHILIP J. HILTS
Special to The New York Times

WASHINGTON, Oct. 21 — As several prominent medical authorities express concern over the Bush Administration's considering ideological issues for those seeking scientific jobs, Assistant Secretary of Health James O. Mason has said the Administration should concentrate more on the scientific qualifications of candidates.

Worry about the ideological tests has grown since it became known that White House officials had questioned a candidate for director of the National Institutes of Health, Dr. William H. Danforth, about his views on abortion and fetal tissue research, both of which the Administration opposes.

Dr. Danforth, the chancellor of Washington University in St. Louis, withdrew this summer as a candidate for the post. Medical colleagues who spoke with him later said he told those who questioned him that if they were asking questions they wanted answered, he would not be interested in the job.

Dr. Antonio Novello, the Administration's choice for Surgeon General and a foe of abortion, was asked by White House officials about her position on the issue in advance of being nominated, Administration officials said.

Dr. Mason said officials at the level of the health institutes' director have so many scientific questions before them that they should not worry about politics but simply pass politically sensitive questions to him or the Secretary of Health, Education and Welfare.

He said in an interview Friday that he believed "the scientific and management capability of the individuals has to be the overriding matter in this."

"The President has a right to apply any test he wants," Dr. Mason went on, "but you certainly can't override the science management side of this."

He said he was concerned about the incident with Dr. Danforth and the possibility that someone with strong qualifications in other areas would be discouraged from taking the job of directing the health institutes, or taking other positions because of the questions about their views on abortion.

"I would hate to discourage anyone with strong qualifications," he said, "but I wouldn't say that the President doesn't have the right to ask those questions."

He said that the top health jobs in the country, those of Secretary of Health and Human Services and his job as Assistant Secretary, are where policy questions such as abortion come up and where they are answered.

A White House spokeswoman, Alixe Glenn, said that political appointees to the Department of Health and Human Services were being asked their positions on abortion and other issues but added that the questioning a political test. Among such political appointees are the Surgeon General and the director of the health institutes.



Dr. James O. Mason, Assistant Secretary of Health, who feels that the Administration should concentrate on the scientific qualifications of candidates, not on their personal views on issues like abortion.

Should the criterion be ability or political beliefs?

Those who are appointed to such high-level jobs should be "willing and able" to defend the Administration's position on abortion, Ms. Glenn said.

Dr. Mason opposes abortion and his superior, Dr. Louis W. Sullivan, the Secretary, has declared himself opposed to abortion as well. Dr. Mason is a former director of the Centers for Disease Control. He was named to his job by President Bush in April and confirmed by the Senate later that month.

At least two senior medical officials, the president of the Institute of Medicine at the National Academy of Sciences and the dean of Harvard Medical School, have met with Dr. Sullivan and expressed concern about the questions, an Administration official said.

Daniel Tosteson, the dean of the Harvard Medical School, said he was very concerned about the issue. "I think that the criteria for choice of an N.I.H. director should include commitment and capability of improving the quality of medical research and should not in-

clude partisan political considerations," he said.

"The U.S. is clearly a leader in the world in biomedical research," Dr. Tosteson said. "That position is in no small part due to programs of N.I.H., an extraordinarily successful agency." He said that, historically, the institutes had not been politicized.

Other senior medical officials said a political chill has come over the appointment process at the health department, putting jobs like that of the health institutes director and the director of the Centers for Disease Control in the political arena.

One senior health institutes official who asked not to be named said: "Political opinions have not been considered on these jobs in the past. People in academia feel that it is worrisome that it is happening now. These are jobs where the primary attention should be on science."

Dr. Mason is in charge of the Public Health Service, an agency with 40,000 employees and other health agencies, including the Food and Drug Administration, the National Institutes of Health and the Centers for Disease Control.

There are about 165 political appointments in the health department and officials there said that those being picked for the jobs are drawn from a White House list of candidates. Three of the jobs yet to be filled are Surgeon General and the directors of the health

institutes and the Centers for Disease Control.

Part of the concern among medical and scientific leaders has come because several prominent candidates for the health institutes director have withdrawn from consideration, including Dr. Danforth, Dr. Roy Vagelos of Merck and Company, Dr. Leon E. Rosenberg, dean of the Yale University School of Medicine, and Dr. Philip Leder of the Harvard Medical School.

Considered the most influential biomedical job in the world, the position of health institutes director involves running the largest medical research effort.

One prominent medical official said the health institutes position would be harder to fill with a well-qualified candidate because the best candidates would be offended just by the asking of questions about loyalty on abortion and other political questions irrelevant to the scientific jobs.

"I find it abhorrent that people would be picked for their preconceived views, and not for their expertise alone," said Dr. Myron Genel, associate dean for governmental affairs at the Yale School of Medicine. "We just have to hope that the people being selected for their positions on abortion and fetal tissue research will be able to separate their private views from their public responsibilities."

On one issue about which candidates are being questioned, Dr. Mason said he opposed research involving transplants of fetal tissue obtained from abortions. Federal funding for the research is now banned, but two panels of the health institutes recommended doing the research because of its promise in treating such diseases as Parkinson's disease and diabetes.

On another issue, Dr. Mason said the ethical panel of the health department, which was disbanded a decade ago after disputes about research on in vitro fertilization, is not needed. Members of Congress and others have urged the Administration to reinstitute the Ethics Advisory Board.

Federal funding of research into in vitro fertilization, also under a ban, may not begin unless the Ethics Advisory Board issues a report on the issue. In vitro fertilization is the joining of sperm and egg in a laboratory dish, for later implantation into the womb and is an increasingly common method of overcoming infertility.

Dr. Mason said the question of whether in vitro fertilization research goes ahead with Federal money is a separate policy question which need not be connected to the revival of the board. He said he has not reached an opinion on whether the work should go ahead.

Science Mag.; 10-6-89

Abortion: Litmus Test for NIH Director

Washington University chancellor William Danforth is (or was) on the short list for the NIH director's job. Last week, he got a call from someone in the White House personnel office who had just two questions on his mind. "What are your views on abortion?" he reportedly asked Danforth. "And what are your views on fetal research?" Danforth told a colleague that his response was simple and direct. "If that is all you want to know, I'm not your man."

In a telephone interview with *Science* shortly after word of the White House call spread through inside circles in Washington, Danforth said he preferred not to comment "on what someone did or did not ask me," but he was not at all reluctant to comment on the chances that he would become director of the National Institutes of Health. "It's not my thing," said Danforth. "I am wedded to Washington University where I have been chancellor since 1971."

Danforth is out. The "A" word is in.

If the White House insists on an NIH director who is opposed to abortion, the search might as well begin anew because no one on the current list of candidates (*Science*, 15 September, p. 1181) has taken a strong pro-life stance. Furthermore, none believes that abortion should be the litmus test in any case.

News of the "abortion call" has reinforced the idea that the only way to depoliticize the NIH directorship is to establish it in law as a 6-year position that survives changes in Administration. The National Science Foundation directorship is a precedent for this and a couple of biomedical leaders are hoping that sympathetic members of Congress can be persuaded to introduce such a bill.

NIH has been without leadership at the top since the end of July when former director James B. Wyngaarden resigned after 7 years at the helm because Louis Sullivan, President Bush's Secretary of Health and Human Services, wanted him out. As the Wyngaarden case illustrates, even a mandated 6-year term would not be sufficient to "depoliticize" a job that is, after all, a Presidential appointment.

Wyngaarden, however, is not out of work. This week he will join the White House Office of Science and Technology Policy (OSTP) as an associate director to presidential science adviser D. Allan Bromley.

Meanwhile, the NIH director's office is vacant and is likely to remain so for quite a while.

■ BARBARA J. CULLITON

NEWS & COMMENT

The Debate Over Choosing Health Officials

By Larry Thompson
Washington Post Staff Writer

The Bush administration's prescription for the next surgeon general is proving to be hard for a lot of doctors to swallow. It seems to say that if scientists want a government science job, they have got to pass a political litmus test.

Antonia Novello is the White House choice to succeed Surgeon General C. Everett Koop—in part because she seems to have the right answer to a final question

ANALYSIS

being put to all those seeking senior positions in the Department of Health and Human Services:

What's the candidate's position on abortion?

Novello reportedly is against it.

But others before her, and for other health posts in the administration, do not oppose abortion. That caused a number of highly respected scientists either to be disqualified or to remove themselves from consideration.

To many observers, this constitutes a judgment on a candidate's fitness to serve based on this single, emotionally charged issue.

The scientific community has reacted with outrage.

"I am, frankly, quite distraught that this kind of a litmus test is being applied to our top scientific leadership," said Robert Petersdorf, president of the Association of American Medical Colleges, who spends a lot of time worrying about the National Institutes of Health, which funds much of the

research at his members' institutions. "Politicizing these appointments with that kind of litmus test is highly inappropriate."

The very concept of a litmus test has a "chilling effect," said several scientific leaders who asked not to be identified. They claimed that it will prevent many experts from even considering such administrative positions.

At least one biomedical leader feels that the abortion question essentially creates a "blacklist" of names of qualified scientists who cannot serve in public office.

No one knows the passions surrounding abortion and public service better than Health and Human Services Secretary Louis Sullivan, formerly president of the Morehouse School of Medicine in Atlanta. When Sullivan was questioned about his views on abortion after he was nominated, his answers about his personal feelings nearly cost him his job. He now says he supports the president's position.

The White House and antiabortion activists defend the practice of asking candidates about their abortion views, claiming that Public Health Service policies are intimately involved in these issues.

"Specifically, for health-related jobs, issues such as abortion and other important health policy matters are discussed with potential candidates," said White House spokeswoman Alexi Glenn, confirming the practice but denying it is a litmus test. "It is important that the president's appointees to these positions be willing and able to defend the president's positions and articulate his policies."

Whether this approach will prove acceptable to the voters may be tested in the Virginia governor's race, where abortion has been hotly debated. Democrat L. Douglas Wilder has charged that Republican rival J.

"Politicizing these appointments with that kind of litmus test is highly inappropriate."

Robert Petersdorf

President

Association of American Medical Colleges

Marshall Coleman, who opposes abortion, would use a litmus test for political appointees if elected.

Although candidates for jobs in other federal departments are not asked about abortion, they are asked if they can support the president's policies for their area, said Douglas Johnson, legislative director of the National Right to Life Committee in Washington.

For the health service jobs, Johnson said, abortion "is directly related to those positions because they are directly responsible for taking the policy position Bush took during the campaign."

Yet, Johnson said, "I reject the concept that this is a simple litmus test."

Members of the scientific community disagree, and the debate has begun to raise furor among those now worried about vacancies in several key administrative jobs, such as director of the National Institutes of Health, the Centers for Disease Control, the Health Care Financing Administration and the Health Resources and Services Administration, among others.

Even members of Congress specializing in health issues have grown concerned.

"Litmus testing doesn't choose the best people for the job," said Rep. Henry Waxman (D-Calif.). "Bush personnel people seem to presume that if a researcher disagrees with them on funding for abortion for rape victims, then the researcher cannot be trusted on anything else—TB control, smoking, cancer research. It's a strange view, sort of guilt by association, and it means that many of the best people won't even be considered."

That already has become evident.

In a recent interview with the Associated Press, Burton J. Lee, the president's personal physician, has said that he was interested in the job of surgeon general but took himself out of contention because he disagrees with the president's position on abortion.

Earlier this month, Science magazine reported that William H. Danforth, chancellor of Washington University in St. Louis, was a leading candidate for the job of NIH director. At the end of the review process, he was contacted by White House personnel and asked about his views on abortion and fetal tissue research.

Danforth, according to Science, replied: "If that is all you want to know, I'm not your man."

Danforth—brother of U.S. Sen. John Danforth (R-Mo.), who has opposed abortion throughout his public life—now refuses to discuss the episode, saying in a printed statement: "I have not been offered the [NIH director's] position and any conjecture about my candidacy, possible conversations with White House representatives and others, as well as statements attributed to me, are simply irrelevant."

The other three scientists consistently identified as being on the short list for the NIH job—Philip Leder, chairman of genetics at Harvard Medical School; P. Roy Vagelos, chief executive officer of the pharmaceutical manufacturer Merck & Co., and Leon Rosenberg, dean of the Yale University School of Medicine—say they are not interested.

And all of this comes at a time when the government already has problems filling key positions because of comparatively low pay, economic disclosures and even reorganization of personal finances that are required of candidates to prevent conflicts of interest.

This also comes at a time when the NIH director and other public health leaders are confronted with making decisions about issues related to abortion, such as the use of fetal tissue, obtained during an abortion, in research and in the treatment of human diseases.

There has been a 1½-year ban on federal funding for fetal tissue research, slowing work in the use of these tissues to treat diabetes and Parkinson's disease. One research expert pointed out that because whatever work is going on is privately funded, it is outside the normal public review process that tends to ensure it is up to current scientific standards. It actually might be better to have fetal tissue research allowed so the NIH could review the studies, but current reports suggest the Bush administration is going to continue the ban on federal funding for all fetal tissue research.

A rumor circulated among the scientific community that political leaders in the White House were so upset with doctors for making this a public issue that they were thinking about making a purely political appointment for NIH director instead of choosing someone from the research community, as has been the tradition.

"If the political people in the White House are unhappy with the scientists, they should know the scientists are equally unhappy with the White House," Petersdorf said. "Unfortunately, the NIH director's job is now a political appointment. It didn't use to be that way."

William H. Danforth

Present Positions: Chancellor, Washington University, St. Louis, Missouri, July 1, 1971 --.
Professor of Internal Medicine, Washington University School of Medicine, May 12, 1967 --.

Date and Place of Birth: April 10, 1926, St. Louis, Missouri.

Marital Status: Married 1950, Elizabeth Gray, four children.

Education: Westminster College, Fulton, Missouri, 1944-45.
Princeton University, A.B., 1947.
Harvard Medical School, M.D., 1951.

Positions: Intern in Medicine, 1951-52,
Assistant Resident in Medicine, 1954-55, both at Barnes Hospital, St. Louis, Missouri.
Assistant Resident in Pediatrics, 1955-56, St. Louis Children's Hospital, St. Louis, Missouri.
Resident in Medicine, Barnes Hospital, 1956-57.
Fellow in Cardiology, 1957-58,
Instructor in Medicine, 1957-60,
Postdoctoral Fellow of the National Institutes of Health in Biochemistry, 1961-63,
Assistant Professor of Medicine, 1960-65,
Associate Professor of Medicine, 1965-67, all at Washington University.
Program Coordinator, Bi-State Regional Medical Program, 1967-69.
President, Washington University Medical School and Associated Hospitals, September 1965 - October 1971.
Vice Chancellor for Medical Affairs, Washington University, July 1, 1965 - June 30, 1971.

Hospital Appointments: Barnes Hospital, 1958 --.
Veterans Administration Hospital, St. Louis, Missouri, 1958-61.

Military Service: U.S. Navy, 1952-54.

Awards: Newton D. Baker Award (1967).
Annual Brotherhood Award, National Conference of Christians and Jews (1973).
St. Louis Globe-Democrat Man of the Year Award (1977).
Sales and Marketing Executives of Metropolitan St. Louis's Executive of the Year Award (1980).
Human Relations Award, American Jewish Committee, St. Louis Chapter (1980).
Lamplighter Award, St. Louis Chapter of Public Relations Society of America (1986).

Honorary Degrees:

D.Sc., Westminster College, 1971.
D.Sc., Southern Illinois University-Edwardsville, 1973.
D.H.L., Culver Stockton College, 1974.
L.L.D., Alderson-Broadbent College, 1977.
D.H.L., Hebrew Union College-Jewish Institute of Religion, 1977.
LL.D., Maryville College, 1978.
HH.D., School of the Ozarks, 1980.
D.Sc., University of Missouri, 1981.
LL.D., Saint Louis University, 1982.
D.H.L., Nebraska Wesleyan University, 1984.

Positions and
Memberships:

National Institutes of Health, Cardiovascular Study Section, 1966-70; Chairman, 1966-70.
National Institutes of Health, National Advisory Heart and Lung Council, 1970-74.
National Institutes of Health, Director's Advisory Committee, 1980-84.
St. Louis Department of Health and Hospitals, Joint Advisory Board, 1966-71.
St. Louis Comprehensive Health Center, Board of Directors, 1969-71.
St. Louis Medical Society, 1973 --.
Bi-State Regional Medical Program, Advisory Committee, 1967-71.
Organization of University Health Center Administrators, Secretary and Treasurer, 1970.
The Danforth Foundation, Chairman, 1966 --.
American Youth Foundation, Board of Trustees, 1963 --.
St. Louis Christmas Carols Association, President, Board of Governors, 1958-75; Chairman, 1975 --.
Boy Scouts of America-St. Louis Area Council Advisory Board.
Princeton University, Board of Trustees, 1970-74.
National Academy of Sciences, Member of Institute of Medicine, 1971 --; Member of Council, Institute of Medicine, 1977-79.
Washington University Medical Center, President, 1965-71; Board of Directors, 1972--; Member, Executive Committee, 1987 --.
Washington University Medical Center Redevelopment Corporation, Chairman, 1973-84; Vice Chairman, 1984 --.
Keystone Center, Board of Trustees, 1975-87.
Independent Colleges and Universities of Missouri, President, 1979-81; Member, Executive Committee, 1985-87.
Fellow, American Association for the Advancement of Science, 1982 --.
Fellow, American Academy of Arts and Sciences, 1982 --.
Fellow, Academy of Science of St. Louis, 1985 --.

Positions and
Memberships

Chairman, United Way of Greater St. Louis, 1984 and 1985.
Member, Council on Foreign Relations, Inc., 1984 --.
Chairman, Presidents Council, University Athletic Association, 1988-90.
Association of American Universities
Chairman, 1982-83.
Member, Executive Committee, 1977-1984.
Member, Health Education Committee, 1977-1987,
Chairman, 1977-81.
Biomedical Research Committee, 1987 --.
Member, AAU/NASULGC Joint Health Policy Committee, 1978-1986, Chairman, 1978-1981.
Mallinckrodt, Inc., Board of Directors, 1973-1983.
McDonnell Douglas Corporation, Board of Directors, 1976 --.
Ralston Purina Company, Board of Directors, 1969 --.

We expect the President -- as part of his constitutional duties of office -- to help shape research priorities through the selection of his cabinet and other major public officers, and subsequently, through their supervision of the research apparatus of the Federal government.

In his choice of those top officials, including the Secretary of Health and Human Services and the Assistant Secretary for Health, it is necessary and proper that the President should seek individuals who not only possess expertise, but who also reflect the broader values and priorities, as defined in his commitments to the public.

In the case of research administrators beneath that level, however -- the leadership of the National Institutes of Health, the Centers for Disease Control, and other major Federal agencies -- it has been our policy that standards of scientific and administrative excellence and leadership prevail in the selection process.

Only in this fashion can we insure the integrity of the scientific process. Only in this fashion can we maintain the confidence of the scientific community -- and of the general public.

As important as this matter is, however, there are other important issues today complicating the choice of one of those top research leaders -- the Director of NIH. Among those issues are: an array of challenging and difficult management questions; a less-than-competitive pay scale; increased competition for top personnel with universities and the biomedical industry; and difficulties with the institute's infrastructure.

During the coming weeks, I will bring together leaders from across the health care and biomedical research spectrum -- including individuals in this room today -- to evaluate the structure, procedures, responsibilities, and mission of NIH.

In the course of our search for strong scientific and administrative leadership, we will consider ways to enhance the authority and attractiveness of the position of Director. Based on these considerations, we will continue to seek a Director worthy of the confidence and respect of the scientific community, and of all Americans.

Much is at stake in our consideration of these questions. As Alan Gregg reminded us, our continued capacity to conquer disease and vanquish ignorance turns on our ability to preserve the integrity of the scientific process. So does our capacity to remain the economic and technological leader of the free world.

This Administration appreciates the magnitude of those responsibilities. It has accepted them -- and it will meet them.
That I pledge to you, today.

Thank you very much.

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