6 June—no visas have been issued by the Chinese. And this is a reminder that it takes two to coexist.

American scientists have wanted, for pragmatic as well as fraternal reasons, to open up relations with scientists on the Chinese mainland. There has been a rudimentary kind of communication between scientists here and there in the form of exchanges of publications and society proceedings. But there have been no visits and the barest minimum of correspondence (on testing of drugs in a few cases, for example).

The National Academy of Sciences, in concert with leading scholarly societies in other fields, has now formed a group to explore ways to improve communications and promote scholarly interchanges between scientists here and in mainland China. As Brown puts it, "We are looking forward to doing everything we can to extend the hand of friendship to colleagues in Cuba and mainland China and other countries with which there has been no regular contact."

Informed observers see no prospect of an immediate transformation in scientific relations. Certainly no encouragement has yet come from the Chinese.

One underlying difficulty may be the fact that the Western attitude that science is separable from politics goes against the ideological grain in mainland China. The view that science might be placed above class and above politics is regarded there as pernicious, in fact as reflecting a bourgeois taint. The Chinese teach that the scientist's first duty is involvement in the class struggle. Individualism and liberalism, characteristics which in the West seem to be held as virtues in a scientist, are viewed as the opposite in mainland China. Scientists are classed as intellectuals in China, and intellectuals at the moment seem to be in for a stiff course of "correction." Some observers, however, draw hope for better relations in science with mainland China from the precedent of the improvement in scientific relations with the Soviet Union from a near-zero point in the late 1940's. However frail the analogy, there is evidence that the United States is engaged in a general and apparently serious reappraisal of our China policy. This great diplomatic glacier is not likely soon to melt, but some think that science, and particularly medical science, is the area where it might recede a bit. At any rate, in view of the evolving official view toward scientific contacts and the acknowledged urgency of the need to strengthen scientific ties with developing countries, it appears that international scientific activities for this country are entering a period of greater emphasis and importance.

—JOHN WALSH

Public Health Service: Reorganizing the Doctors

When John F. Kennedy became President, he was reported to have been warned by advisers that he could expect the worst embarrassments of his administration to arise from activities of the Department of Health, Education, and Welfare. The warning turned out to be wrong: under Kennedy that distinction went to the CIA; HEW produced no disasters as spectacular as the Bay of Pigs. But the agency has been an albatross to successive presidents since its creation in 1953. Lyndon Johnson, who is reportedly anxious to prevent the substance of his Great Society programs—many of which are administered by HEW—from becoming lost in its bureaucratic wilderness, has been the first to authorize a serious effort to do something about it.

Johnson's prefect in this effort is HEW Secretary John Gardner, a man with his own ideas about organizational "renewal," and Gardner has been busy since his appointment tangling with the separate fiefdoms within HEW, whose independence has left previous Secretaries more slaves than masters of their turf. Now, having given the Social Security Administration and the Office of Education at least light goings-over, and giving James L. Goddard a pretty free hand at the Food and Drug Administration, Gardner is turning to the most independent fiefdom of all—the military-structured Public Health Service. The PHS is about to undergo a major reorganization that amounts to far more than an administrative facelifting. The reorganization reflects a new concept of what the government's role in health care should be. And its implications extend beyond health workers and the public to the biomedical research community. whose fortunes are linked to the PHS through the National Institutes of Health. Unless Congress objects, an unlikely possibility, the reorganization plan will go into effect next week.

The reorganization plan, formally proposed to Congress by the President on 25 April, follows the recommendations of Surgeon General William H. Stewart. Stewart, who was known to advocate reforms in the PHS before he became Surgeon General, in turn leaned heavily on the advice of a committee, headed by John J. Corson of Princeton, that studied the PHS last fall.* While the specifics of the plan appear to reflect the views of the new team of health officials at HEW (*Science*, 3 Dec. 1965) that the government should begin to exercise initiative in the health field, the influence of Gardner, who has frequently stressed in a general way the desirability of departmental unification and integration, is also discernible.

The heart of the reorganization plan is the strengthening of the department by transfer of authority over the PHS from the Surgeon General to the Secretary. The transfer of power does two things: First, it gives the Secretary the same direct authority over the PHS that he has over the other units of his agency. In the past, this has not been so: the Surgeon General has operated with a more or less independent charter from Congress, which meant that in many instances the highest departmental authority rested in a subordinate official. On the whole, this peculiarity was handled in a gentlemanly fashion,

* Other members of the committee were Robert Aldrich, former director of the National Institute of Child Health and Human Development; W. Palmer Dearing, executive director of Group Health Association; James P. Dixon, president of Antioch College; Harold Enarson, vice president of the University of New Mexico; Herman M. Somers, professor of political science at Princeton; and David Stanley, a senior staff member of the Brookings Institution. The committee's report has not been made public.

and no Surgeon General has exploited his position to override the veto of a Secretary. But it did leave the Secretary without power to supervise the internal workings of the PHS, and violated a cardinal principle of government set out by the Hoover Commission in 1949 (and cited by Johnson in proposing the reorganization) that "the department head should be given the authority to determine the organization within his department."

Threat to Corps

Second, the transfer of authority to the Secretary is a covert threat to the power of the PHS corps of commissioned officers. It is important to recognize what the reorganization plan does not do: it does not abolish the corps. Abolition is said to have been among the recommendations of the secret Corson committee report; it is also a program that Surgeon General Stewart, himself a commissioned officer, has long been reported to favor. But, while Stewart evidently decided that the time was not ripe for so provocative a move, the transfer of power is likely to have a definite impact on the PHS's military hierarchy. It may mean, for example, that the Secretary will no longer have to follow military rank in assigning men to jobs, and that important posts can go more easily to outsiders. The weight of the officer corps' traditional veto will still be there, but the possibilities for circumvention are greatly enhanced.

While the reorganization plan does not abolish the corps, it does abolish the major divisions of the PHS. These divisions—the National Institutes of Health, the Bureau of State Services, the Bureau of Medical Services, and the Office of the Surgeon General—were fixed by law in 1944. The separate programs for research, aid to states and communities, direct medical services, and executive administration all had their place; additions to PHS responsibilities had to be assigned to one of the four components. Ultimately those responsibilities broadened to include 50 additional major programs. Meanwhile, the PHS budget rose from $52 million (in 1943) to $2.4 billion (in 1966); and its staff doubled from 17,000 to 34,000.

The Surgeon General has kept the details of his new plans fairly close to his chest: he is seeking approval of the idea of reorganization, and apparently wants to prevent haggling over specifics. The general outlines, however, have been made known. The plans include the strengthening of the Office of the Surgeon General and the creation of five major operating bureaus. Two of these are familiar faces—the National Institutes of Health, and the National Institute of Mental Health which is being detached from NIH and given separate bureau status. (The "new" NIH will include the Environmental Health Sciences Center being built in North Carolina; NIMH will take over existing PHS hospitals for drug addiction at Lexington and Fort Worth.) The other three bureaus are new.

The first, the Bureau of Health Services, will combine existing PHS responsibilities in providing direct medical care for federal dependents with programs to support the planning and construction of new health facilities and the development of new personal health services. It is designed, according to a memo from Stewart to Secretary Gardner, as "a central resource for improving the quality and accessibility of health care for the American people. It will have the . . . responsibility to . . . maintain effective working relationships with private medicine, public and private institutions and organizations in the health care field, and to stimulate and support innovations in the delivery of health care." In other words, if Stewart succeeds in his efforts to have the PHS play a major role in health care, the Bureau of Medical Services will be at the heart of it.

A second unit, the Bureau of Health Manpower, will "carry out our present and anticipated programs in the manpower field" and "administer programs of school construction, student assistance, and educational support. It will be involved in every stage of professional and paramedical training. . . ."

The third unit—the Bureau of Disease and Injury Prevention and Control—seems to be composed of about everything that's left. It includes all the agency's activities in environmental health (air pollution, pesticides, solid waste disposal, radiological health, and others) except the research activities of the North Carolina unit, and a number of other programs that have to do with infectious diseases and quarantining, chronic illness, and accidental injury.

Together, Stewart expects his new creations to be the backbone of an organization that, for the first time, will assume "central responsibility for health on behalf of the people." "I believe [the PHS] is capable of exercising a form of leadership in health that is now impossible," he told Gardner. "There is, in medicine and its allied sciences, a leading edge of research and development which is piercing the frontiers of existing knowledge. This advance requires support and guidance in directing its efforts toward those needs which are greatest. Also required is a strong movement that will convert science into practice and channel new developments into the mainstream of medicine. Both of these are logical functions of the Public Health Service, stemming from the stature of leadership to which we aspire."

The idea of "national leadership in health" includes not only Stewart's notion that the Surgeon General "should be the individual to whom the public may turn when their expectations for health care are not being fulfilled," but also Gardner's view (expressed in recent testimony before Congress) that it should be "the agency to which organizations and individuals throughout the government turn for advice on all matters related to health." The PHS, Gardner said, "should provide professional guidance for the health-related activities of other agencies of HEW and the Federal Government." If the language is vague, the intent is clear: the United States is to join the ranks of countries with active, responsible, national health agencies. Whether there will be equally coherent policies for the agency to administer is another question.

Environmental Health Slighted?

The reorganization plan has two major difficulties. One, cited by Stewart in his memo to Gardner, is the role of environmental health. Stewart singled out only the problems of coordination between the research programs of the Environmental Health Sciences Center and the other programs within the Bureau of Disease and Injury Prevention and Control. Other observers, however, have feared that in the new concern for personal health services the role of environmental health programs has been overlooked or downgraded. While officials deny any such intention, the conglomerate nature of the new bureau may produce that result: whatever else may be said, it certainly

cannot be argued that the enforcement activities of the division of air pollution, for instance, have been upgraded. The PHS role in environmental health has always been weak; nothing in the new plan appears to make it stronger.

Dissatisfaction with the apparent underplaying of environmental health has been responsible, in fact, for the little bit of Congressional opposition to the plan that has arisen. HEW officials have been reported willing to compromise by changing the name of the bureau to the Bureau of Environmental Health; they have not proposed a redrawing of the functions of the new unit. What's in a name remains to be seen.

Role of NIMH

A second peculiarity in the reorganization plan is the creation of a separate National Institute of Mental Health. The chief argument against severing NIMH from NIH comes from the growing cadre of health care specialists, both in and outside the Public Health Service, who believe that it is inappropriate to separate physical and mental health—that both components should be included in comprehensive, integrated, health care packages. The same idea is implicit in the proposal made by the Corson committee but not adopted by Stewart at this point, which called for creation of a PHS bureau to deal comprehensively with the health problems of children. While reportedly impressed with the logic of such a bureau, Stewart is said to have felt that he had already set enough things to churning, and that a comprehensive child health bureau ought to wait.

A second argument has less to do with the separation of NIMH per se than with its existing combination of research and community programs, and with the heaping on it of new management responsibilities in the form of the PHS hospitals for addicts. Concern over this combination was expressed by NIH director James Shannon during hearings before the House Appropriations Committee last spring. "Our feeling is that in an area of science—particularly one such as mental health, which is not adequately developed at the present time—the chances of developing critical new knowledge become much less when it is centered in an organization whose primary thrust is a community services program," Shannon told the committee. "The top management will tend to deal with the things that are most urgent, and the things which are most urgent usually relate to the services that must be delivered. It is my feeling that if the science segment of mental health moves into an organization external to NIH, the development of new knowledge will suffer very substantially."

Support for the separation of NIMH is reported to have come mainly from an empire-building mental health lobby; it also reflects the views of a former key NIMH official whose spirit appears to have haunted the deliberations. Observers, official and unofficial, believe that, in yielding to the pressures for a separate NIMH, PHS planners were yielding to political forces and medical ideas long obsolete. "It goes in a direction precisely the opposite of what is needed," commented one official. "The failure to begin integrating health services, to try to alleviate the special stigma of mental illness, is a tragedy." Even PHS officials who worked on the plan feel that the decision regarding NIMH is its least satisfactory provision; they hope that in due course the agency will somehow find its way back.

Implications For NIH

Implicit in the reorganization plan is the answer to a long-debated question about the future of NIH. Within NIH there has long been a feeling that perhaps the research agency would fare better on its own. The agency's $1.3-billion budget is about equal to that of the entire Department of Labor, but NIH is only in the third echelon of a large, diverse bureaucracy; it has sometimes lacked access to the department's chief policy-makers; it has certainly lacked the bureaucratic independence for which it has always envied NSF.

NIH's dissatisfaction has been more or less reciprocated by the rest of the Public Health Service, which has regarded with jealousy NIH's prestige, its budget, its connections, its congressional friends. NIH, with its clear mandate from Congress to support biomedical research, its strong leadership, its impressive constituency, and its relatively untroubled political relations, has always more or less stolen the show; the rest of the PHS, operating without a mandate in the politically more controversial areas of health care; burdened with fragmented leadership and splintered programs, has tagged behind.

Nonetheless, faced with an opportunity to cut the ties that bind, NIH and the PHS became like the bickering couple who decide at the last moment not to go through with a divorce. For the reoriented PHS, keeping NIH in the family offers the opportunity to try to develop some correlation between areas of research and areas of medical need. For NIH, there is frank acknowledgment that the basic research effort gains protection from its identification with health. Had the PHS umbrella been dropped, NIH would have had to go it alone as a basic research agency, like NSF, or perhaps emphasized its education and training functions—paths that are far more perilous. In the end, the decision to stay in the PHS had the full support of Shannon and other top NIH officials.

The decision means not that NIH will be "downgraded" but that, as the other new bureaus take shape, NIH will begin to lose its unique status and visibility. Stewart and his staff have already moved from downtown Washington to the NIH campus in Bethesda in a symbolic assertion of who the boss is that has somewhat preceded the reality. But Shannon is slated to retire relatively soon, and it is likely that, when his successor is installed, image and reality will be more tightly entwined. At the same time, maintenance of the PHS link suggests that NIH may be increasingly involved in health care; it is already involved to some extent through its responsibility for administering the heart, cancer, and stroke regional medical programs, and in a number of other ways. But it would not be surprising if the agency's distinct character as chiefly an agent for basic research continued to ebb somewhat and its connections with health care continued to increase.

Apart from its specifics, one of the best features of a reorganization plan, in the eyes of the reorganizers, is that it throws an agency wide open. Jobs are abolished; people leave; a fluidity develops beyond what the charts outline; new appointments can be made. What will happen then? Certainly the specifics of the new direction, the substantive policies that the Surgeon General means to pursue, are not in the plan itself, and when they emerge they will not necessarily be very dramatic. PHS and HEW officials responsible for the plan mean no upset to the basic concept of private-public partnership that characterizes American medicine. They do appear to hope that the public partner will henceforth be a stronger one.—ELINOR LANGER