

*Med Empire*

# HEALTH-PAC

HEALTH POLICY ADVISORY CENTER

Special Bulletin

#7 Winter 1969

*Editorial . . .*

## BEHIND THE CORPORATION FRONT

AS THIS BULLETIN GOES TO PRESS, THE ENABLING LEGISLATION FOR A NEW YORK CITY HEALTH AND HOSPITALS CORPORATION IS STILL SPREAD OUT ON THE DISSECTING TABLE IN ALBANY. STATES-MEN, CITY HOSPITAL AND BUDGET OFFICIALS, AND MEDICAL EMPIRE STAFFMEN ARE QUIBLING OVER THE DETAILS OF FINANCING, BOARD COMPOSITION AND DECENTRALIZATION. WHETHER OR NOT THIS PARTICULAR BILL SURVIVES MICROSURGERY, THE IDEA OF A HEALTH SERVICES, INC., SEEMS LIKELY TO LIVE. WITHIN A FEW MONTHS, THE QUESTION HAS CHANGED FROM *WHETHER TO HOW* TO INCORPORATE MUNICIPAL HEALTH SERVICES, IF NOT THIS YEAR, THEN NEXT YEAR.

It's time to back up from the drawing boards and ask whether the Municipal health facilities *should* be turned over to a corporation. This is not a "philosophical" question. Time is running out for the City's hospital system. If a corporation cannot solve the immediate problems of health service delivery, then it would be useless. If a corporation would aggravate the problems of health service delivery, then it would be *dangerous*.

We are not convinced that the proposed corporation would do any better than the present Health Services Administration (HSA) in dealing with the immediate problems of the Municipal health services system: financing, bureaucratic hang-ups, construction delays, and manpower shortages.

■ **Financing**, always unreliable, has become unsound and irresponsible. The mirage of Medicaid seems to have left many policy-makers with the persistent fantasy that health is a revenue-producing service. It is not. Medicaid inflated medical costs and thereby swelled the ranks of the "medically indigent"—making it all the more obvious that fees and private insurance will never stretch to cover medical costs. The historical fact that most public service corporations deal with revenue-producing services does not mean that the corporate form has a built-in green thumb when it comes to raising revenues. The only possible financial advantage of a corporation over HSA, is that a corporation would be politically less vulnerable than HSA, hence able to get away with tougher fee collecting mechanisms. But as we learned from the Medicaid fee-fiasco: Fees may keep people away from health facilities, but they don't bring money in [See Box, Page 11]. The only way out of the health financing crisis is through a redefinition of City, State and Federal spending mechanisms and priorities, and a firm public sector commitment to control the costs of medical care.

■ **Bureaucratic hang-ups**, once imposed to prevent Tammany-style corruption in the health and hospital agencies, now serve to gum-up daily operations, block innovations and atomize responsibility. We agree with the corporation-promoters that Municipal health agencies must be substantially freed from the red-tape dangling from the overhead agencies—the Budget Bureau, the Departments of Personnel, Public Works and Purchase, etc. Minute surveillance by shadowy overhead agencies is no substitute for true public visibility. But will the corporation be any freer from this punitive supervision than HSA is now? Probably not: As long as health services are financially dependent on tax funds, health policy will be guided by the Bureau of the Budget and health management will be

### What's New?

**WE APOLOGIZE** for the brief BULLETIN black-out: HEALTH-PAC was growing. As of 1969, HEALTH-PAC has tripled in size, adding to its full-time staff a physician, an urban planner, an urban health economist and a medical student intern. We are independently incorporated as a non-profit, staff directed research, planning and education cooperative.

This is a special issue. The first regular issue of the new year, coming soon, will carry our medical empire probe to the Bronx, with a case study on Einstein-Montefiore. Upcoming spring and summer issues will feature reports and analysis of: the bankrupt affiliation program for City hospitals, the crisis in ambulatory care and preventive services, the local and na-

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scrutinized by the other overhead agencies.

Suppose, though, that the corporation does manage to shake loose from the bureaucratic purse-strings. Would anything really change? The corporation will be directed by the same men (with a little help from their friends in the private sector) who now head HSA. Will these men suddenly become bold planners, inspiring leaders and fearless innova-

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tors? In fact, we wonder if they will even be able to get the corporation off the ground. Within the framework of government, they couldn't renovate the existing structure. By stepping outside, will they be able to construct a *whole new structure*?

■ **Construction** has slowed to the point that health facilities are often obsolete before they even open. Corporation promoters blame the lethargic pace of City construction on red-tape, much of it emanating from the Department of Public Works. We agree that procedures for hiring architects and builders must be streamlined. Perhaps the corporation would even be able to cut some corners. However, most of the lag in construction occurs long before the architectural phase, in the initial phases of planning and site selection. In a typical project scenario, the community is "involved" only as a formality—well after the basic program design and site have been cleared with appropriate real estate, construction and private hospital interests. When a community rejects the rubber-stamp role and tries in desperation to assert its own priorities, *then* the delays begin. How will the corporation cut these delays? It will certainly be no *more* sensitive to local needs than HSA. In fact, it is designed to be a lot less sensitive. Perhaps its promoters believe that the corporation, being more anonymous and efficient than HSA, will be able to simply by-pass the community in the planning process. But as HSA's experience shows, tip-toeing around the "target population" is the quickest way to get to an impasse.

■ **Manpower** is critically short at all levels in the Municipal health system. The proposed corporation's enabling legislation offers no explicit solutions, but the intention is clear. Budget officials and leading private participants in the affiliation program would like Municipal health agencies to enjoy the same hiring and firing freedom as do private agencies. Their unspoken hope is that the corporation will manage to shake loose from the civil service, clear out the "dead-wood", and purchase fresh talent at market prices.

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**tional debacle in health costs and financing, the implications of Medicaid and health budget cutbacks, the madhouse of mental health, and the growing insurgency among community organizations, health workers and health-profession students. We are planning a special report, "Citizens' Guide to a Sick City," as a guide to health issues for special use during this year's mayoralty campaign, and also are working on a "Citizens' Guide to Health Rights."**

**Our new offices—a floor-through loft at 17 Murray Street— have increased our capacity for seminars, workshops and library facilities. HEALTH-PAC will continue to work with you, and we hope you call or come by to share your ideas with us.**

Published by the Health Policy Advisory Center, Inc., 17 Murray Street, New York, N.Y. 10007. (212) 227-2919. Staff: Robb Burlage, Vicki Cooper, Barbara Ehrenreich, Oliver Fein, M.D., Ruth Glick and Maxine Kenny. © 1969.

We do not believe that a personnel purge or a few fat new job titles will solve the City's health manpower problem. In fact, the shortage will never be met within the present "dual (public and private) system" of health facilities. As long as manpower is scarce, the public sector (incorporated or not) and the private sector will compete through continually escalating salaries, hence skyrocketing costs. Furthermore, the shortage will never be met within the existing skewed system of health-workers' salaries. Physicians'—especially specialists—salaries have been leapfrogging from one facility to the next, year by year. What's left over in tight hospital budgets for paraprofessionals and doctors-in-training is bound to be low, and unalluring. The manpower shortage will only be met when the total structure of medical education and professional values is challenged from the bottom to the top—obviously not a task the corporation was designed to take on.

These problems—financing, bureaucratic hang-ups, construction delays and manpower shortages—are not insoluble. In the last four years we have seen the beginnings of many needed reforms in the Municipal health service delivery system such as crash programs for hospital construction, program budgeting, and the creation of "Health-S.P.A.C.E.", an imaginative new planning unit within HSA. But so far these are only "demonstration" projects—they hint at what could be done, given the will to carry it through. Now the Lindsay administration, in a frantic dash to the finish line, seems about to drop the ball. The chrome-plated corporation plan may distract some of the public, some of the time, but it won't *solve* anything. In fact, it will make some old problems—fragmentation and unaccountability—much worse.

■ **Isolation and fragmentation** of health services, and of Municipal services in general, seem not to have concerned the corporation designers. They say they intend to incorporate the hospitals and leave the Health Department facilities in the City government. Then how will Health Department preventive services (mainly screening and diagnostic) and decentralized medical services (Neighborhood Family Care Centers) be coordinated with hospital services? The creation of HSA was a small step towards integration of preventive and treatment services, hospital and community facilities; the corporation will be a giant step backwards.

Suppose though, that the corporation designers *have* read the Piel Report [See "Taking Care of Business," Page 4; and BULLETIN No. 1], are hip to the dangers of health service fragmentation, and really plan to incorporate *all* health services together. Then the problem would be coordination of health services with any other agency in the City. To carve "health" services still further away from housing, sanitation, welfare, education, etc., is to freeze in an archaic definition of health care—one which precludes any meaningful assault on environmental causes of illness.

■ **Lack of public accountability** is so much a feature of HSA now that it may be hard to believe that we have anything to lose in a corporation. But we have a lot to lose. Unresponsive as the present health bureaucracy is, it is directly beholden, on all major policy questions, to elected officials—the Mayor, the Council and the Board of Estimate. It is part of an elected administration which is subject to routine periodic review, and possible dismissal. Not so for a corporation. The only point at which the public can directly influ-

# CORPORATION: Who and What?

THIRTEEN DIRECTORS would head up the Corporation. Out of these, seven would be City officials, serving *ex-officio*: the Health Services Administrator, Commissioner of Hospitals, Commissioner of Health, Commissioner of Mental Health, Chief Medical Examiner, Human Resources Administrator, and the Deputy Mayor-City Administrator. Five directors are to be appointed by the Mayor to serve overlapping five year terms. The above 12 directors will appoint a chief executive officer (his powers are not defined in the legislation), but the Chairman of the Board must be the Health Services Administrator. Small as the board of directors is, power could be concentrated still further within it. Seven would be a quorum and a majority of a quorum—or four men—could make decisions.

Initially there would be only a single Corporation. At some time greater than two years after its own establishment, it may create wholly owned subsidiary corporations for different regions of City. The subsidiaries would have whatever powers the central Corporation should choose to give them, except collective bargaining. There is nothing in the legislation to rule out giving different powers to different subsidiaries. Subsidiary corporations would have boards of directors of 9-15 people, all to be appointed by the Mayor on the recommendation of the central board.

Health and Hospitals Corporation would have most of the powers now enjoyed by HSA: to operate, maintain and construct health facilities, to establish and collect fees, to make contracts such as affiliation contracts, etc. Some of the new powers of the Corporation, relative to the present HSA would be:

- To acquire and dispose of health facilities, e.g., to a voluntary hospital, with the approval of the Board of Estimate.
- To float its own bonds to finance construction of facilities, thus to establish its own capital reserve fund.
- To hire its own contractors for construction without going through the Department of Public Works.
- To set up its own employee system. Old employees may remain in the civil service, but new ones will not be in the civil service.
- To administer its own budget to a certain extent. The Corporation will have its own bank account and will not depend on the Controller to write checks. Thus it will not be subject to a preaudit by the Budget Bureau for every change.

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ence the general policies and purpose of the corporation is in the framing of its enabling legislation, which, for all practical purposes, is wrapped up. After the legislation is adopted, the corporation's general purpose and form can be altered only by introducing new legislation.

In their year to year operations, corporations are also free from ordinary mechanisms of public review and scrutiny. The only visible part of the corporation's budget will be the City tax levy appropriation, an undifferentiated lump sum. Corporate directors would have longer tenure than elected officials and would be much harder to remove than are appointed officials within HSA. Finally, the records and contracts of the corporation would be open to official investigators, but not necessarily to the general public. (For what it's worth, you can now walk into 125 Worth Street and demand to see affiliation contracts, contracts with private consultants, etc.)

The corporation-promoters believe that they have solved the problem of accountability. Health and Hospitals, Inc., will not run off on its own track like the Port Authority—it will be regulated by what remains of the bureaucracy at 125 Worth St. Supposedly, HSA, once relieved of the burden of operating its own facilities, will become a vigorous agent of accountability, eager to set standards and evaluate services. We think that it will take more than an administrative gimmick to inspire and empower HSA to regulate any services: its own, a corporation's, or those of the private sector. (Actually, the language of the enabling legislation does not even clearly empower HSA to regulate the corporation.) In fact, HSA, the corporation's "agent of accountability" will more likely become just another layer of bureaucracy, still further muffling public criticism and control. For one thing, sandwiching HSA between the corporation and the public means a whole new layer of contracts—those linking HSA and the corporation. Nothing will be solved by burying the already-leaky affiliation contracts under a new layer of paper.

Lack of public accountability is a more serious problem

for a corporation than it is for a government agency. To the extent that a corporation sells bonds to finance improvements, it must be fiscally attractive to the bond-holders. (Public corporation bonds cost a lot more than lottery tickets. Only outfits like First National City Bank can afford them.) Thus corporations automatically have a constituency other than either providers or consumers—the bondholders. A sudden cut in operating funds—as after a Medicaid cutback, wouldn't release the corporation from its obligations to pay off the interest on its bonds. Since the corporation (as described in the present proposal) would have no similar *legal obligation* to its users, it could meet its debts by either cutting services or raising fees. Since the users would have no routine, direct access to decision making in the corporation, they would have no way of competing with bondholders for a tight budget.

None of this would surprise the corporation-promoters. They know as well as we do that the corporation may not solve anything, and may in fact introduce a host of new problems. Then why have they worked so hard for a corporation for so many months? Not all the push comes from private institutional needs. Running through the corporation-promotion rhetoric is a liberal, civic-reform-minded zeal to "rationalize" city services. The claim is that the health system must be cut free from cumbersome political processes to develop the flexible management style of modern business.

True, health services must be freed from the existing paralyzing bureaucracy of City government. But this does not imply that we have to carve the Municipal health services out of the City government. The other choice is to free the *City government* from the paralyzing bureaucracy, and keep health services in a truly public agency. We feel that there is no other responsible course for the City. Think about it. Where will health services go when they are "carved out" of the City government? Not into the abstract world of the Piel Report's flow charts. Health Services, Inc., will be where

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# TAKING CARE OF BUSINESS

CONDITIONS IN THE MUNICIPAL HOSPITALS haven't rated an exposé in almost a year. The atrocious conditions are still there: underpaid staffs, obsolete equipment, unsafe plants, minutely fragmented care, and so on. But the news value's gone. Everyone knows—the municipal hospitals are chronically ill.

Deterioration of the hospitals has been matched by the erosion of the public will to save them. The City's strategy—if it can be said to have one—is an evasive search for quick ways out. Basic issues of public responsibility have been set aside and forgotten during the frantic search for technical fixes which will be cheap, quick and agreeable to private interests. The Wagner-Trussell affiliation program was the first dimestore patent medicine remedy for the hospitals. Now the City has come up with a second—a plan to turn the Municipal hospitals over to a "Health and Hospitals Corporation." In this issue, HEALTH-PAC traces the corporation idea from Medicaid-inspired give-away schemes to the current Health and Hospitals, Inc., proposal.

## Medicaid Forces Issue

It was clear by 1966 that the affiliation program hadn't solved everything for the City hospitals and may even have made things worse [See BULLETIN No. 6]. Neither partner to the affiliations, Municipal or voluntary, was satisfied with the other's performance. Consumers, taxpayers and municipal hospital workers were least satisfied of all. Distrust was beginning to erupt into public exposés of the affiliation program.

Then Medicaid hit New York City. It struck at the heart of New York City's "dual (read two-class) system." With Med-

icaid, the poor had a choice. The City could not continue to operate the Municipal hospitals as second-class, charity institutions, simply because no one would choose to use them. This left the City with two basic choices: (1) not to continue to operate its hospitals as second class institutions (that is, use the new Medicaid revenues to improve them) or, (2) not to operate its hospitals at all.

The second alternative, that the City should leave "the hospital business" to the private sector, was promoted by the most liberal elements of the private medical establishment: The New York Academy of Medicine and Martin Cherkasky, innovative director of Montefiore Hospital. The private sector should have been caring for the poor all along, they argued, but it just hadn't been financially feasible. With Medicaid, they would gladly assume this long-overdue responsibility. The assumption implicit in the give-away argument was that the public role in the health system is simply to fill in the gaps left by the private sector. The delivery of health services to the poor had been one of those gaps, but Medicaid had, for medical purposes, eliminated the poor. The gap was gone and the City health agencies could recede to some other area of private oversight.

But the clincher in the give-away argument was the charge that the City just couldn't run modern hospitals anyway. All the leaders of major voluntaries and medical schools agreed on this point. In Cherkasky's words, continued operation of the Municipal hospitals out of distrust of the private sector would be, "sentimental attachment to an outmoded system,"

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HSA is now: a piece in the larger structure of the city's private health "industry." The difference is that the corporation will be a more movable piece—easier for the private medical empires to divide, appropriate, and control.

We object in simple self-defense. The private medical empires have consistently placed institutional needs above the human needs of the communities [See BULLETIN No. 6 and the forthcoming issue on the Bronx]. They have provided such medical care as it suits them to provide. What is left over—the care of the poor, the uninsured and the uninteresting—is left over for the Municipal system. This, in the words of HSA's Dr. James Haughton, is the core problem of the Municipal hospitals: they have become a "residual system"—underpaid scrub-nurse to the elite citadels of private medicine. To evade this problem, to focus myopically on the red herring of "government red-tape," is more than an error of analysis—it is a betrayal of public trust.

Why do the public officials among the corporation-promoters ignore, or seem to ignore, the political realities of New York City's health power structure? If we take their word for it, they really do not believe that there are any political dimensions to the problem of health services delivery. Delivery of health services they claim, is like the delivery of clean water—a *technical* problem. Goals and policies they will concede to the political arena, but delivery itself is seen

as purely technical, and need be no more accountable to the public than it is explainable.

This attitude reveals a profound misunderstanding of what health services are all about. It attributes the technical proficiency of the health care *production* system to the totally underdeveloped health care *organization* and *distribution* system. No one questions the research behind a drug's development when he gets a prescription. But we may question the cost of the drug, the three-hour wait to see the doctor, or the two-bus trip to the clinic, or the hard benches in the waiting room. And in questioning these things, we are not trespassing on the elite territory of some highly developed science (not that it would matter if we *were!*). There may be a Kaiser clinic here or a Neighborhood Medical Care Demonstration there, but there is no general "technology" of the delivery of high quality care on a massive scale. There is none because it has never been attempted. The attempt, if it is made, will not depend on another dose of systems analysis. It will grow out of the emerging mobilization of consumer groups and the new breed of health workers, as part of the general movement to restructure the quality and equality of American life. It will seek new definitions of health care as a community enterprise and a human right—not as a "commodity" to be sold by "vendors," bought by "consumers," and managed by "corporations." □

[October, 1967]. Thus, the argument went, New York City didn't need the Municipal hospitals and couldn't run them even if it did.

Still, the City did not give away the hospitals. Though there were many political reasons for keeping them, there was also an overriding practical reason: Not all the Municipal hospitals would find takers in the private sector. The Municipal hospitals were by and large, physically unattractive. Just to get the hospitals in shape to give away, the City would have to undertake hundreds of millions of dollars and many years of renovations. More important, though, few medical empire leaders shared Cherkasky's boundless appetite for expansion [See next BULLETIN]. Staid institutions such as Columbia and NYU were just not interested in taking on massive new burdens of patient care.

But there was a more fundamental reason why the private sector was not unanimously enthusiastic about a City withdrawal from the hospital business. As many medical leaders would explain, the whole pattern of medical research and education in this city and country has been based on the existence of a lower class of patients and a corresponding class of hospitals. The indigent patients have been the source of that essential commodity—teaching material. At stake was the power to select teaching material and allocate it to teaching hospitals, while allocating less interesting poor patients to other hospitals. In a truly one-class hospital system, this power to allocate patients according to institutional needs would very likely be lost. For instance, Dr. Ray Trussell, then Dean of Columbia P & S, explained why he was not interested in having all the Municipal hospitals turned over to private control: "One of the reasons for the Municipal hospitals is to take care of patients nobody wants." When asked whether certain patients were unwanted because they couldn't pay for care, he said "No, because they're not . . . interesting cases," [October, 1966]. Dr. Lewis Thomas, Dean of NYU College of Medicine, publicly agreed. [See Box, Page 7]

### Band-aids For City Hospitals

With some of the most powerful leaders of the private medical establishment urging continued City operation of its hospitals, the City had very little choice *but* continued operation, if only by default. The City would have to hold on to the Municipals even if it did want to give them away eventually—just to patch them up a bit. Thus in February 1967, Mayor Lindsay announced his determination to continue to operate the Municipal hospitals and to improve them to the level of the good voluntaries.

The City's approach was cautiously introspective. If the Municipal hospitals were in trouble, it would be dealt with internally. Voluntary hospitals, in spite of their intimate affiliations with Municipal hospitals, would be treated as innocent bystanders while the City got its own house in order. But even within the narrow confines of the Municipal system, no one really knew where to begin. One City official said that it took two years to figure out "the system" of tangled webs of authority scattered throughout the many overhead agencies—before the administration could begin to map out any offensive strategies.

First there are the civil service regulations: these made it difficult to attract new people and virtually impossible to fire any old ones. Then there are the purchasing regulations, which can add up to a delay of up to three months between requisition and delivery. Then there are the laws and regulations dealing with construction, which, combined with red-

tape in the Department of Public Works, contribute to the City's current construction rate of more than 10 years per hospital.

The biggest handicap, though, according to many City hospital officials, is the budget process. NYC's line-item budget spells out each hospital's budget down to the last dishwasher and part-time chaplain. Money is not appropriated for *programs*, such as ambulatory care or emergency service, but for *lines*, i.e., job titles. Tactics at the hospital level are determined by what lines are available, not by how much money there is to spend. And, once the budget is set for the year, it takes minor heroics to change it in the slightest way.

### Web Of Purse Strings

What gripes the hospital officials, though, is not so much the process, as the fact that they have very little control over it. Even in drawing up the budget, the Department of Hospitals plays what is essentially an advisory role to the Bureau of the Budget. And once the budget is "put to bed," or finally approved, it is still very much awake as far as the Budget Bureau goes. If a hospital administrator should manage to save some money, the Budget Bureau quickly scoops up the savings. (Thus there is little incentive to save.) If the administrator does *not* manage to save—the usual case—the Bureau of the Budget often helps him out by levying an "enforced saving." (In the fiscal year 1968, these practices cost the Department of Hospitals \$37 million out of an original appropriation of \$246 million.)

The Lindsay administration tackled these "bureaucratic roadblocks" one-by-one. There were "crash" programs for hospital construction, and there was "PPBS," Rand Corporation's recipe for budget reform. Hospital administrators were given a pay boost and a pep talk. But none of these attempts seemed to have any impact on front-line conditions. Demoralization of City hospital employees (and users) increased, and some top officials began to hint that the hospitals were beyond saving.

There were some levers of change that the City never thought of pulling, or never dared to pull. The City talked about closing down some Municipal hospitals to concentrate on improving the others. It never mentioned the more economical option of demanding improved care for Medicaid and Medicare patients in the voluntaries, in order to unburden the Municipals at least long enough for renovations. In late 1967, hospital workers and a large contingent of community groups urged the Mayor to empower HSA to control *all* health services, private and public. But the City was not about to use its new financial muscles if there was any danger of stepping on private toes.

Although publicly contemptuous of the threat of public regulation ("The City can't run its *own* hospitals!") the private sector was far from complacent. With tax support of voluntary hospitals zooming past 50 percent, there was a real possibility of eventual demands for accountability. This possibility actually increased as the municipal hospital system deteriorated. The Municipal hospital system had always been a kind of shield, or filter, between the voluntaries and the indigent hordes, who, by the mid-60's, were even getting militant about medical care. Alarmed by the failure of Lindsay's hospital reforms, many private medical leaders were ready to pitch in and help shore up the Municipal system.

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# TAKING CARE

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They agreed in principle with the reform approach taken by the City so far: It confined itself to the problem of the municipal hospitals in the framework of *City government*, rather than in the context of the *total hospital system*. It focussed on the relationship between the Municipal hospitals and the *overhead agencies*, rather than on their relationship to the *voluntaries*. The trouble with this approach was, it was just *too slow*. Lindsay and the Health Services Administrator had been trying to cut the strands of red tape one-by-one. There was a way to cut them all in one fell swoop: by creating an authority or corporation to run the hospitals. ("Authority" and "Corporation" seem to have been used interchangeably.)

## Trial Balloons

In one form or another, the authority idea had been around for years. In 1961, Dr. Willard Rappleye, who had been a leading promoter of the affiliation program, proposed an authority embracing both public and private hospitals. When Medicaid forced the hospital issue again in the late sixties, liberal medical leaders, such as the New York Academy of Medicine, revived the idea of an all-hospital authority. Dr. Cherkasky later suggested starting out with an experimental authority for the Bronx only: "Something like a modified Transit Authority . . . with perhaps more chance for public participation."

Meanwhile, other private leaders were thinking along the lines of a Municipal-only authority. In 1967, Dean Lewis Thomas set up a staff committee to study alternative frameworks of organization for the Municipal hospitals. The "alternative framework" of choice seems almost to have been a foregone conclusion, for NYU soon obtained a foundation grant to study what would be required to cut only Bellevue loose as "Bellevue, Inc." If the City came up with an authority proposal on its own, the foundation money was to be spent studying the City legislation, and "informing the public about it."

In May, 1967, Thomas surfaced with a public proposal for a Municipal hospital corporation. The line of reasoning was, briefly: What with Medicaid, medical schools will increasingly be held accountable for patient care. Medical schools don't want to be accountable for patient care, especially in Municipal hospitals where the school has little control over the hospital's physical operation, etc. The only mechanism which could run the municipal hospitals while shielding the medical school from the public is a Corporation:

"We, as medical schools, cannot and should not run the City hospitals; the City cannot do it either and must not be allowed to continue its feckless, damaging efforts. We are in need of a third party, a buffer state, a Corporation, an Authority, a new kind of quasi-government, quasi-academic institution to relieve us both of this turbulent task, and enable us to get on with doing what we are good at doing."

Echoes were soon heard from HSA. Administrator Brown threatened to turn the hospitals over to private operation by a nonprofit corporation if he wasn't given enough freedom to make improvements within the system [May, 1967]. "But I want to make it very clear that I am not suggesting turning over the City hospitals to the voluntary hospitals," he added.

Historically, authorities have usually been set up to give continuity, business efficiency and elastic management to the construction or operation of a self-supporting or revenue-producing public enterprise [Gulick, 1947]. With Medicaid, the hospitals were on their way to being self-supporting enterprises and deserved the freedom of the corporate form.

Talking about hospital "authorities" was especially easy since no one had a very clear idea how one would look or act. Powers of authorities are not generally defined; they are defined for each individual case. As one student of public administration put it: "A corporation may be designed to suit most any situation." In general, service-providing authorities differ from service-providing government agencies in that they have a good deal of freedom from government overhead agencies. Authorities, or corporations, often have a self-contained employee system, outside of civil service. They may be empowered to make their own purchases, to administer their own budget and to contract directly for construction. Some even have the power to float their own bonds in order to raise money for construction.

The authority idea—vague as it was—was attractive on at least two counts. First, an authority would undoubtedly be more efficient than the Hospital Department. Second, and perhaps equally appealing, authorities had been used before to line the chafed interface between the public and the private sectors. An authority would be a sort of neutral ground where conflicts could be resolved in a business-like fashion. In fact, many saw the hospital authority as the eventual setting for some kind of unification of the sectors, on terms which would not have to be spelled out for quite a while.

No doubt Brown saw a corporation as a last ditch remedy for the City hospitals, but a remedy nonetheless. It is also possible that he was under a certain amount of pressure to see it that way. In the summer of 1967, NYU initiated a series of informal meeting with Hospital Department officials at the deputy commissioner level, to chat about "alternative frameworks."

Brown apparently preferred to do things more openly. He requested the Deputy Mayor's office to make a full study of alternative frameworks of organization for the Municipal hospitals. The report, released in September, 1967, was to be followed up by public hearings. Unfortunately Brown resigned before any hearings took place and the report found its way to a final resting place in the Health Department library. There is no other document that presents the full array of options that the City had in 1967, and *still* has. These are: (1) turning the Municipals over to State Control, (2) improving the Municipal system within the framework of City government, (3) extending affiliations to cover all aspects of hospital management, (4) leasing all Municipal hospitals to voluntaries, (5) converting each Municipal hospital to a voluntary, directed by a board of community people, (6) [described as a "theoretical alternative"] placing all hospitals under public control, and (7) forming a public corporation to run the Municipal hospitals. In general, the report was quite uneasy about the idea of a corporation for health services. Experience with public corporations in other service areas such as housing and transportation had not been entirely happy.

It took the Piel Commission to make the idea of a health services corporation respectable.

The Commission was assembled in early 1967 by science-statesman Gerald Piel (publisher of *Scientific American*) and charged by the Mayor with the task of coming up with a solution to the hospital problem. Between its seven members, the Commission represented the usual "blue ribbon" ingredients for health panels: major voluntary hospitals, Blue Cross, the major health philanthropies, and the systems industry (which has been moving into the "health industry" with growing enthusiasm). In addition, the Piel Commission heavily represented the business and financial community. These are the men who, through bank loans and charitable donations, support the voluntary hospital system, and, through taxes and the purchase of City bonds, support the Municipal hospital system. Since they straddle the sectors, they could be counted on to represent the broader interests of the whole community, or at least the business community.

### Good Housekeeping Seal

The final report of the Commission, released in December, 1967, did not confine itself to the municipal hospitals; it dealt with all health services, public and private. Its goal had a sweep and grandeur rare to studies of New York City's hospitals: "... the transformation of the present dual system of public and private hospitals into a single regionalized and decentralized comprehensive health care system." The "system" copiously detailed in charts, was a system of regional networks of service, each centered on a medical school. Radiating from the medical schools would be the community hospitals, and from them, the neighborhood health centers. Medical schools would retain their cherished right to select "interesting" patients, but all other facilities would be open to all. Facilities in a regional network would be linked by formal affiliations, and by a network of computers, forming a single region-wide information system.

And how was this to come about? What the Piel Commission proposed was a "Health Services Corporation," a private, nonprofit corporation set up to operate all Municipal health services. Only a corporation would have the administrative freedom to do the job of recasting the scores of facilities

and forging the vast regional networks. But, the Piel Commission acknowledged, there are perils to the corporate forms. Corporations tend to become unresponsive, uncontrollable and unaccountable. To safeguard against these dangers they recommended that HSA control the corporation. HSA would plan, set standards and regulate health services. It would contract to the Corporation for the provision of services. In turn the Corporation would either directly provide services, or contract with the private sector for them.

Strangely enough, there is no mention in the Piel Report of how the corporation would accomplish its major task—that of integrating the dual system. One close associate of the Commission explained that this omission was deliberate. No one could predict how the relationship between the sectors would evolve once the Corporation got going. Presumably the City's bargaining position with respect to the voluntaries would change drastically as the Municipal hospitals began to shape up. It is more likely, though, that internal divisions on the Commission dictated silence on this point. The two non-business members, Eveline Burns and Piel, seem to have leaned towards a strong public role, and eventually a strong community role in the management of all hospitals. Since the others didn't agree, the central issue in the hospital problem—that of relation between the sectors—was left hanging.

### The Silent Spring

The *NY Times* greeted the Piel Report with a front page story and a rave review. The Mayor, however, was cool. (He has still not publicly thanked the Commission or acknowledged their report.) According to then-Health Services Administrator Brown, Lindsay had expected something quite different from the Piel Commission. Since taking office, he had felt that a stronger public role in planning, and regulating *all* health services was essential. What he wanted from Piel and his powerful colleagues was a political endorsement of the new public role which he hoped to shape. What he got, the "Health Services Corporation," would be privately dominated, only distantly accountable through HSA, and seemed unlikely to solve the real problems. Be that as it may, mayors think in terms of two-or-three-year time spans: maybe enough time to replaster an operating room but hardly enough to build utopian systems of information flow. And, one of the Mayor's closest advisors was insisting that major improvements *could* be accomplished within the City system, within a reasonable time—if either HSA or the Bureau of the Budget were willing to try.

But, in a sense, the Piel Commission had already accomplished its mission. The idea of a Health Services, Inc., was out on the table, and a number of forces, which could collectively outweigh the Mayor, were rallying to it. All agreed within the broad outlines of the Piel Report—that the Municipal hospitals should be carved out of City government as a corporation. The major forces lining up behind the corporation proposal in the spring of 1968 were: (1) The voluntary hospital and medical school elite, (2) The Department of Hospitals, and (3) The Bureau of the Budget. While this formidable tripartite was getting itself together, a series of spring events dramatized the hospital crisis:

A NYC Health Construction Fund, proposed by the Mayor to finance and speed up health facility construction, was killed in Albany.

## Why No Giveaway?

**THE PUBLIC VIEW:** "You cannot, however, get out of the hospital business altogether. . . . The most important reason is that we have not yet come to the position where we can convince ourselves or anyone else that the private system, even if supported by Government money, would really look to the needs of the poor. It simply does not happen, and that is the danger."

Mayor John Lindsay, before a U.S. Senate subcommittee, July, 1968

\* \* \*

**THE PRIVATE VIEW:** "I believe we will still need institutions with the special role of our Municipal hospitals. . . . To give up, at this time when public funds [Medicaid and Medicare] seem at long last to be available for supporting the venture, the great tradition of teaching students and young physicians in our Municipal hospitals, is absolutely unthinkable. It is our obligation to society to figure out successful ways to retain, and to use with intelligence and imagination, this great resource. Dean Lewis Thomas of NYU, speaking on the meaning of Medicaid, May, 1967

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## *The Linebackers...*

**THE VOLUNTARY HOSPITAL AND MEDICAL SCHOOL ELITE** had been split on the issue of whether a corporation should include only Municipal hospitals, or all hospitals. Consensus around a Piel-like corporation was achieved during the course of the Piel Commission's studies," which featured a series of small dinner parties with the various private medical moguls. No doubt these informal gatherings carried over after the Report had been released, dealing then with the problems of implementation. By mid-spring of '68 notables such as Cherkasky, Thomas, Trussell and Glazier, were sitting down with other voluntary leaders and City officials to talk about the form that the corporation should take.

**THE DEPARTMENT OF HOSPITALS'** Commissioner Terenzio had been agitating for a corporation for close to a year. Even before the Piel Report was released, he had drawn up his own proposal for a corporation and circulated it within the City government. In late March, Terenzio testified before a State Committee investigating hospitals that, as Commissioner, he was powerless to do anything about the hospitals. The implication was, that given the freedom of a Robert Moses, he would be able to work miracles.

**THE BUREAU OF THE BUDGET** traditionally has little brief for corporations or any other devices to diminish its power over City money, but Lindsay's Budget Director, Fred Hayes, was not a traditional Budget Director. He had been largely responsible for importing Rand and program budgeting to NYC, a move which would have been violently resisted by past generations of Budgeteers. Perhaps systems-oriented Hayes was simply attracted by the neat lines of the corporate form. More to the point, rising wages for policemen, sanit-men, teachers, etc., combined with skyrocketing welfare rolls, were throwing the budget off balance. It was hard to be sympathetic to the Hospitals Dept., whose costs rose at 15 percent a year while the service declined even faster. If the hospitals were incorporated, the City might eventually reduce its share of their financing. A corporation couldn't come whining to the Budget Bureau as often as the Department of Hospitals does—it would just have to increase its revenues (fees) or reduce its costs. At any rate, Hayes made his endorsement of the Piel Report well known to the Mayor.

motors were quietly waiting for their cue. In the few months since the Piel Report release, they had already done a considerable amount of homework. They had managed to enlist the interest of Victor Gottbaum, leader of Council 37 of the Municipal hospitals workers' union AFSCME (American Federation of State, County and Municipal Employees), which had been the only possible source of organized opposition to a corporation. Apparently Gottbaum had been convinced that anything which might prop up the Municipal system was worth a try.

An informal task force, consisting of Gottbaum, Piel, William Glazier (an associate dean of Einstein) Cherkasky and Trussell, plus ranking staff from the Budget Bureau and Hospitals Department managed to hammer out their major differences in a series of spring meetings. Gradually the general outlines of a lowest-common-denominator corporation began to emerge: (1) It would not infringe on the private sector. If the voluntary system was ever to merge with the Municipal system, it would do so on its own terms. (2) The corporation would not infringe on AFSCME's turf; corporation employees would remain public employees. (3) the status and power of present HSA leaders would be preserved in the corporation. The minute the beleaguered Mayor showed the first flicker of interest in a Hospital Corporation, the corporation promoters were ready to go. Piel advocated starting with a round of public hearings on his Commission's report, but no one else felt ready to risk public exposure at a point when their own alliance was still fragile. So they decided not to go public until the enabling legislation for the corporation had been written and submitted to the State legislature. Naturally, City staff—Budget and Hospitals—would do the actual drafting.

### **The City's Bid**

The City staff then proceeded to closet themselves for a few months of "in-house" efforts. No one can be sure exactly how insulated from private medical advice they were while the corporation gestated. It is clear that they had many internal differences to work out somehow. For at least three years, there had been no love lost between the Hospitals Department and the Budget Bureau, and all during the drafting, each party suspected the other of being about to dash off to the Mayor (in the case of Budget) or to the voluntary leadership (in the case of Hospitals), with a version of their own.

At last, in January, 1969, the Lent-Thaler Committee of the State legislature received the City's final product: 50 pages of legislation to enable the City to establish a public benefit corporation, the NYC Health and Hospitals Corporation. In broad outline, the structure proposed is very similar to Piel's "Health Services Corporation." The Corporation would operate health facilities under contract to HSA. HSA, in turn, would plan and set policies. Compared to the present HSA, the Corporation would have a good deal of freedom from overhead agency bureaucracy. [See Box, Page 2]

Of course the corporation will not be really free—after all, the City will still control the purse strings. The Corporation's operating funds, like HSA's now, will come from Medicaid, Medicare, fees, Blue Cross, etc. and City appropriations, which are usually scaled to just make up the difference between the income from other sources and the costs of operation. Similarly, when the City contracts with the Corporation for services, the City would promise to pay the estimated deficit after Medicaid, etc. According to a member of the Budget Bureau staff, the larger that deficit and the greater the

## TAKING CARE

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The State Medicaid cutback unexpectedly reduced NYC's Medicaid program to an almost meaningless level. The cutback should have given the corporation-promoters second thoughts about whether health services were really a revenue-producing activity, hence "suitable" for incorporation. But by this time the corporation plan had an irrational momentum of its own, and the cutback only fanned the panic to do something about the hospitals and do it fast.

An ultimatum on the Municipal hospitals from the State Investigation Committee in April: "If it [the City] can't [correct the inadequacies of the hospitals] then the City should get out and turn the municipal hospitals over to an authority or some other private body." The City was given "a few months" to shape up.

Meanwhile, behind the scenes, the allied corporation pro-

City share, the more power the Budget Bureau will have over the Corporation. Formally, City power over the Corporation will be exerted in two ways: the Corporation's budget will be reviewed every year by the Budget Bureau (without a public hearing) and its books will be audited at least every five years by the City Controller.

As should be apparent, the legislation is remarkably vague. It is *enabling* legislation. It doesn't say that anything has to happen, or that anything will happen. If the legislation is passed, the Corporation *may* be set up. If it is set up, the City *may* give it some hospitals to operate. The City may give it one hospital to operate, all the hospitals to operate, or all the hospitals plus all other City health facilities. According to a knowledgeable City official, *all the hospitals is what is intended. But if this were spelled out, with a timetable for the transfer of the hospitals to the Corporation, the bill would become a home rule issue, requiring passage by the City Council and Board of Estimate. The State legislature was thought to be friendlier.*

The legislation is also remarkably uninteresting. It says nothing about the relations between the Corporation and the private sector. It says nothing about the scope of the public commitment to health care: how many or what kinds of people it is the Corporation's mission to serve. Nowhere is there a word about quality or standard setting; contracts for services will undoubtedly be as casual about patient care as they are now. Some Hospital Department officials contend that these matters may not be spelled out, but they are what the Corporation is really all about. As the Corporate machine begins to whir, high quality care, a unified hospital system, a massive commitment, etc.—will automatically spin off. Other officials, notably Budget staff, warn not to expect too much from the Corporation. The legislation, they say, deals simply with "management problems." Solving these problems will not necessarily ensure any improvements in the hospitals as far as patient care goes.

### January Draft Under Fire

It is not easy to know how to react to a proposal which is held up simultaneously as a panacea and as a minor technical repair. What little overt reaction there has been to the January draft has been almost unanimously hostile. The legislation, which was meant to please everyone, in the end seems to satisfy only the actual draftors (and they appear to be falling out over certain issues now too).

First, there is the business and financial community, which had been so amply represented on the Piel Commission. They are said to be annoyed by the Corporation's power to float bonds, a power which was pointedly denied Piel's corporation. The Piel Report said (and this was undoubtedly the bankers in the group speaking) that the City's present borrowing power is sufficient to finance health construction. It would be bad for the City's own credit to create an additional debt-creating authority within the City. Furthermore, bankers have made clear that they are not very excited about "health bonds" in the first place. For bankers as well as poor people, health is a risky business, and they would insist on high interest rates to cover any bonds they did buy. If the Corporation's interest rates were higher than the City's, then it would be grossly wasteful for it to borrow money on its own. There are indications that the legislation's failure to require tighter contracts is also unpopular. Some of the City's super-taxpayers are tired of seeing tax money pouring out through

## The Experts Say...

*"The irony of the greatest city in the world [New York] being unable to support services that special authorities, lacking powers of taxation and police powers, are capable of financing has begun to generate puzzlement and dubiety. The skewing of governmental resources . . . away from service functions that do not pay their way and toward enterprises that make money has also engendered anxiety. And the more rapidly the authorities grow, and the more self-directing they appear, the more profound are the uncertainties and anxieties about their position."*

Wallace Sayre and Herbert Kaufman in their book *Governing New York City* (1960)

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*" . . . It should be noted that in forming a public authority the DESIRE is to achieve the efficiency of business and the public interest of government; the DANGER is that one may achieve the 'inefficiency' of government and the private interest of business."*

Luther Gulick, former president of the Institute of Public Administration (1947)

cost-plus affiliation contracts which say nothing about what service are to be provided. With the corporation, a whole new layer of seive-like contracts—those between the City and the Corporation—would be superimposed on the affiliation contracts. They feel that if the Hospital Department wants to emulate private business, it should start by writing business-like contracts, not by turning itself into a corporation.

Then there are the leaders of the major voluntaries and medical schools. All of those interviewed seemed to be miffed by the City's high-handed independence during the drafting of the legislation. One thing some would have insisted on, if they had been consulted more intimately, is a private board. As drafted, the board would be dominated by HSA officials. More alarming though, is the City's failure to promise to "maintain its effort," i.e., not to diminish the City tax levy share of health financing. In fact, they point out, the City might not just neglect the hospitals, it might steal from them. The Corporation is "empowered" to collect Medicaid money, but it is not *mandated* to do so. Thus the City could collect Medicaid reimbursement and stash it off in the general fund—as it has done for the last two years. The legislation, they feel, shows the clear imprint of the Budget Director's grasping fingers. One spokesman for a major medical school described the legislation as "incredibly cynical"—a plan to amputate and abandon the City hospital system. (However, the same medical school sent staffmen to Albany, to work on redrafting the bill and to lobby for their version.)

Then there is the State legislature. What little news has drifted down from Albany does not bode well for the Corporation. First, they see the bond-floating power as unnecessary. Can't the newly created State Health and Mental Hygiene Facilities Construction Fund build faster and cheaper than any City corporation? Second, conservatives are nervous about the decentralization provision. Although there is nothing in the legislation to suggest that community control (or even participation) was intended, the conservatives are not about to fool around with "another Ocean-Hill Brownsville."

Finally there is Senator Thaler, whose reactions are in tune

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## A GRIM FAIRY TALE:

# Once Upon A Time, There Was A Plan

*"You can't put a rat, a cat and a dog in one room and expect them to come out agreeing . . ."*

—Vic Solomon, Harlem CORE,  
Commenting on Comprehensive  
Health Planning, December 1968

THE HEALTH AND HOSPITAL Planning Council (HHPC) threw a rewritten proposal for a private comprehensive health planning agency back into the State hopper for approval late in February. Meanwhile, the City Health Services Administration (HSA) and the City-Wide Health and Mental Health Council are debating consumer representation for a rewritten public agency plan to meet the April 5 application deadline.

Since last October when the State Health Planning Commission turned down proposals from both HSA and HHPC, a third force—City-Wide Health and Mental Health Council [representing such groups as the Washington Heights Health and Mental Health Council and the Peoples' Health Center of the South Bronx]—has emerged with its own plan. A task-force composed primarily of militant blacks and Puerto Ricans from local health councils plans to negotiate with HSA for strong consumer participation in health planning through a decentralized neighborhood board structure. City-Wide maintains it will take its proposal for a public agency directly to the State if it is not satisfied with HSA's design for effective community participation.

The fact that HHPC is back in the running at all, perhaps even in the lead (informed sources say that the State's only objection to the rewritten HHPC plan is that it lacks City endorsement) is pointed to by angered community groups as evidence that the City was never really in the race. The private-versus-public health planning issue appeared to be virtually settled a year ago when Mayor Lindsay, under pressure from community and citizen groups, confronted HHPC (which is dominated by elite, private, voluntary hospital

related doctors, administrators and trustees, and private health insurance executives) and declared that his administration would fight for a public agency with a majority of consumers setting policy.

The press announced the "fight" for public accountability, but it never took place. Instead, the Mayor's referee, HSA Commissioner Bernard Bucove, set up a consensus arena. With rejected plan in hand (it was designed hastily by a Florida planning consultant) he called together a committee of consumers, providers (including HHPC representatives) and public officials, and busied himself designing a task force which would reapply to the State. This would be not for designation as the planning agency, but for a two-year organizational development grant to better *plan* a planning agency for New York City.

Militants from City-Wide, who were willing to go along with HSA while they thought there was a glimmer of hope for setting up a publically responsive agency, saw this maneuver as a final sell-out in a series which began three years ago. After the passage of the Federal Hill-Staggers Act calling for consumer participation in comprehensive health planning, the City hesitated for two years before taking on HHPC at all. With this history, the militants say, there is little hope that Republican Mayor Lindsay or his administration will do anything to anger the rich and powerful private sector in an election year.

The moderates, members of consumer-based civic organizations [such as the Community Council of Greater New York], support the HSA plan, pinning their hopes for local planning and participation on the section of the rewritten document which says that during the two-year organizational

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## TAKING CARE

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with those of health-minded groups such as the Community Council and the Citizen's Committee for Children. He sees the Corporation as another ploy in the City's long struggle to divest itself of the Municipal hospitals. He foresees the actual give-away taking place at the subsidiary corporation level, spawning a chain-store of "Einstein, Inc.," "Catholic Health Industries, Inc.," etc. For the time being, though, Thaler agrees with the voluntary leaders that the Corporation is primarily a Budget Bureau plot to starve the hospitals. He too is dissatisfied with the composition of the Board of Directors. How can the HSA officials both regulate the Corporation (as HSA officials) and run it (as Board members)? They will be no more successful at regulating their own activities in the Corporation than they have been at regulating their own activities in HSA.

Whatever differences the financial community, the private medical community, the Bureau of the Budget, the Department of Hospitals and the legislators may have about the Corporation will eventually be worked out, this year or the next. They will not be aired in the press or at public hearings. They will be settled in committee rooms at Albany, in faculty clubs of medical schools, in the stark offices of the Budget

Bureau, in restaurants and private clubs. And not a single person that the NYC Health Hospitals Corporation is designed to serve will be consulted.

And why should they be? The legislation deals with no issues of life or death interest to them. It says nothing about whether we will continue to have a two-class hospital system in which a dying person can be turned away by an elite institution, or neglected in an understaffed second-class institution. It says nothing about the tens of thousands of babies who die each year in the wards, or survive to eat lead, or be eaten by rats. It says nothing about "community participation": the right of the people in their own defense to help structure and control a service that their lives depend on. Finally it says nothing at all about the right of people to medical care and to health, and how the City intends to guarantee this right.

The Health and Hospitals Corporation is a bag—that is, a structure created to contain (and to hide) problems which the City and the private medical leadership cannot or will not face. Hospitals can go into the bag; health centers can go in; anything can go in. Whether they will be better or the worse for it, not even the Corporation's promoters will say.

—Barbara Ehrenreich

period the HSA task force will review proposals from neighborhood groups for local health planning. The HSA task force will make recommendations to the Federal government (under the same legislation) for funding such demonstrations. While the militants are angered by his "consensus fantasies," the moderates are irritated by Commissioner Bucove's "fiscal fantasies." If the HSA grant is approved by the State, the City task force will be eligible for up to \$500,000 of Federal money on a 50-50 matching basis. HSA has set aside \$250,000 in its budget to supply 25 percent of the matching money, and Commissioner Bucove hopes that the task force itself will be able to raise the remaining quarter of a million dollars. (At a charity ball? Keep the faith, Barney . . .)

Meanwhile HHPC, which had been sitting on the HSA committee, used the opportunity to announce that this act was in no way to be construed as its endorsement of the public agency concept, and quietly (sans announcement) sent a rewritten version of its own proposal off to the State. Informed sources point out, however, that HHPC has modified its proposal by incorporating several of the HSA's consensus committee's guidelines for participation of providers and consumers.

Thus far, the State Health Planning Commission has chosen to interpret conservatively an already conservative piece of Federal legislation. The Federal Hill-Staggers Act (popularly called "Partnership for Health") says consumers, providers and government officials *must all play a role* in designing a modified plan for delivery of health services. (Both the HSA and the HHPC plans were rejected for failing to spell out these conflicting roles.) At the same time the Federal law declares that the planning shall not interfere with "existing patterns of private professional practice of medicine, dentistry and related healing arts." There are cynics who believe that the State is playing a waiting game—pitting all the local forces against each other by insisting that each have the endorsement of the others. When all fail to agree, the State will magnanimously step in and take on the planning task—along with the power of setting priorities for billions of health dollars. (The State legally could have the entire State designated as a single planning area.) If the State itself were to take over this agency function directly, not only would the positive trend toward consumer representation in New York City be undermined, but there is every indication the policy-makers would be drawn from the same private provider interests now dominating the State-sanctioned HHPC.

The planning money at stake for New York City is about a half million Federal dollars, but the stakes are much higher than the figures would indicate. Almost a decade ago the State granted veto powers over all hospital and health facilities to HHPC. And under the more recent Folsom Act, which created the State Health Planning Commission, HHPC was designated to plan and set priorities for all Federal and State money for health services.

The turmoil during the last year over who should control comprehensive health planning for the City has brought the elitist interests and policies of HHPC out into the open. Not only has it been criticized by consumer voices, but by other providers as well. In commenting upon HHPC's first plan (the one which was rejected by the State) one of its own members, Dr. George Baehr, the founder of HIP, said:

"Under the proposed plan, the Comprehensive Health Services Planning Agency would still be dominated as heretofore by hospital influences such as AHS [Associated Hospital Service, meaning Blue Cross], the Greater New York Hospital

## The Poor Pay More

What did Medicaid do for the poor? Hospital statistics confirm what front-line observers have suspected for months: The net effect of the Medicaid program has been to disenfranchise many thousands of New Yorkers from routine outpatient care. In a recently released analysis of Municipal clinics data, Hospital Department statisticians suggest that Medicaid did lead many people to seek care outside the public sector. (Whether they then found care in the private sector, no one knows. Private physician and hospital visit data is incomplete.) However, the 1967 decline in Municipal outpatient department use was much smaller than expected—in fact, a regorous statistician would be hard pressed to call it a trend.

The big surprise came with the 1968 Medicaid cutback. Municipal hospitals had been bracing themselves for an influx of ex-Medicaid eligibles, now barred from the private sector. Instead, City hospital outpatient departments saw the steepest fall-off yet: a real trend by the most nit-picking statistical standards. The reason? The Medicaid program required that facilities try to collect fees from its Medicaid-ineligible, hence potentially paying, patients. Municipal outpatient visits, historically free to all, now cost up to \$16.

[NOTE: HEALTH-PAC is now working on a full study of NYC's Medicaid program—who profited from it and who lost.]

Association, the United Hospital Fund, the Association of Private Hospitals, the Metropolitan Nursing Home Association. If AHS is a member of the Corporation and of the Board, why exclude UMS, GHI, and HIP, which provide medical services for most of the population of the City? Also, the following health agencies are not represented on the Board: the nursing profession, dental profession, public education, schools for health and social services personnel. They certainly have more to contribute to comprehensive health services planning than the Commerce and Industry Association. . . . My point is that the proposed agency [still] is . . . not representative of all essential elements in the health field. . . ."

There are, in fact, State legislators waiting in the wings to amend the Folsom Act as well as shift the veto powers over health and hospital facilities to any newly created public agency. HHPC is fighting for the survival of its bureaucracy as well as its influence. (About four years ago, the public sector outdistanced the private in the flow of money into the HHPC operating budget, which is well over \$1 million per year.) A three-year grant from U.S. Public Health Service for \$1.7 million is about to expire, and it is very likely that if a public agency should be designated health planner for the city, there would be a shift of all State and Federal funds to that agency.

Assuming for the moment that the State will go along with the City plan and neither give the nod to HHPC nor grab power for itself—HSA's decision to apply for an organizational grant has assured only one thing. It has assured that HHPC will continue to control all the health and hospital facilities in New York City for at least the next two years. And, at the end of the two-year planning grant period if the State Health Planning Commission doesn't like the plan for a new public agency for health planning, there are no assurances that it won't scrap the task force's entire plan.

— Maxine Kenny

## Letters to Editor

### City Foot-Dragging?

Dear HEALTH-PAC:

*I think that it is unfair to describe the role of the Health Center community advisory boards as "almost totally perfunctory." (See BULLETIN No. 3, "City Foot-Dragging.") In the negotiations which developed the new contract under which St. Johns Episcopal Hospital operates the medical and pediatric clinics in the Bedford Health Center, both the local community, through the Health Committee of the Central Brooklyn Coordinating Council, and the City's people as a whole, through the Health Department's city-wide advisory board, played a very significant role. Indeed, the contract was not finally agreed to until both groups had gone over it in detail, had had their questions satisfactorily answered and had approved it. Much of this work was done by our very patient Associate Deputy Commissioner of Health, Mary McLaughlin, M.D., and it was far from "perfunctory."*

*I would also like to say that I do not think that the "authority" idea for health services is necessarily a bad one. Maybe, with proper controls and carefully chosen personnel this would be a "change (in) government structures" which would really benefit the people of New York City. After all, the present Municipal health system, run by a popularly elected government (theoretically) leaves a lot to be desired, as we all know.*

—Steven Jonas, M.D.  
Deputy Assistant to NYC  
Commissioner of Health

### Medical Young Turks

Dear HEALTH-PAC:

*As is the case with many of the young Turks in medical education and public health, I am enormously impressed with the HEALTH-PAC BULLETIN. It speaks out in a fresh and vigorous way and in a sense, forms a liberation press which counter-balances the tired status quo media available in health.*

*It seems to me that your BULLETIN should be available to all faculty and students in the health professions, particularly to students. Is there any possibility that the BULLETIN might be made available to public health students at Yale?*

—Lowell S. Levin,  
Associate Professor, Department  
of Epidemiology and Public Health,  
Yale University School of Medicine

[Editors Note: Special bulk rates for the BULLETIN are available from the HEALTH-PAC office.]

## NEWS BRIEFS

### Out Of Site

For several months, the Department of Hospitals and the Bronx Local Area Planning Office of the Department of City Planning have argued over which of two sites near 180th Street and Third Avenue would be Better for a new Fordham Hospital. On Feb. 18, at a stormy public meeting of Community Planning Board #6, residents of both sites being considered voiced strenuous opposition to destroying any housing for a new hospital and suggested that the hospital be replaced where it is, if necessary expanding the site so that a new building can go up before the old one is torn down. In response to this suggestion, and because the city has chosen not to explore the possibilities at that location, the Community Advisory Board of Fordham Hospital recently formed its own committee to look into what could be done to keep the hospital where it is and to avoid destroying much-needed housing.

### State Cuts Up

Try not to get sick in the coming fiscal year. Cuts in State aid will leave New York City with a \$700 million deficit in operating funds. Lindsay's pre-campaign slate of priority services includes fire, police and sanitation—because these services are "vital to public health and safety" (Finance Administrator Perrotta, March 2, 1969). Hospitals and health centers, presumably less vital to health and safety, will be pillaged to meet the City's deficit. Cuts forecast for neighborhood health and mental health centers are bone-deep. As for hospitals, gloomy City budgeteers predict amputation: The City may try to close one or two Municipal hospitals in 1969.

### Source-ery?

Blue Cross Association, the organization of Blue Cross plans in the U.S., Canada and Jamaica, is showing a new side to its usual gray-flanneled personality: liberal, "concerned" and aggressively expansionary. The first sign is *Sources*, Blue Cross's recent report on the health problems of the poor. Glossy, eloquent and generously peopled with pictures of the poor, *Sources* may be obtained free of cost at any Blue Cross headquarters. Why such interest in the poor from a private company that deals primarily with those who can afford to pay its rates? Blue Cross President McNerney says, "We in Blue Cross have discovered that we know too little about the health problems of the poor." That's understandable, but why should Blue Cross publish its homework? Word is that Blue Cross is aiming for a new image as *the* health organization with the public interest at heart. Madison Avenue isn't all that stands to profit from the Blue Cross image-campaign. Blue Cross may be after administrative power over Medicaid (it has Medicare in most states), federal subsidies for its cost-squeezed policies, and eventual control of any future compulsory national health insurance program. Blue Cross plans to release veiled disclosures of its ambitions in a series of reports following *Sources*.