DO WE HEAR FOOTSTEPS?

Steps — halting, unpublicized — are apparently now being taken by Mayor John Lindsay, through his aides and through his Health Services Administration, to exert some leadership, to induce agonizing reappraisals, and to avoid certain narrow courses of City policy with regard to the health services crisis. There are recurrent signs, according to knowledgeable sources, of the following:

1. City determination, led by the Mayor, to achieve Federal-State designation of a primarily Mayor-appointed, consumer-oriented City agency for Comprehensive Health Planning Authority (P.L. 89-749). A Mayoral showdown is scheduled soon with Health and Hospital Planning Council officials. (However, the present City proposal calls only for a City coordinating agency with limited or no professional planning staff. This would probably leave most of the actual planning and data-gathering process to the private, voluntary hospital establishment-oriented Planning Council.)

An open door is being left for the creation of neighborhood health boards as part of such an agency and its advisory council, but there is not a firm commitment about whether, when, where and how these would be created.

2. Pressure from the Mayor’s Office, reflected in slashed Health Services budget requests (blamed on State Medicaid and Federal grant cut-backs and overall City fiscal tightness), for firmer program planning and clearer priority setting. As one Mayoral aide puts it: “We want to see some clear sense of direction from Health Services before we can turn on the spending.”

3. Mayoral snubbing, reflected in a loud silence, of proposals for a Health Services Corporation or Authority “carved out” of the Health Services Administration for independent or privately contracted operation of City-owned hospitals and health facilities.

But There’s A Long Way to Go...

The fiscal, administrative, and political realities of New York City’s health services still run against the latest limited City leadership efforts at the top:

1. So long as the scarce public funds for health leak away to loose funding of private institutions and services, needed public action, for example, for neighborhood health centers, will be stymied. The City’s overall municipal hospitals budget for 1968-69 shows an actual decrease over the previous year, blamed primarily on the Medicaid cutbacks. But specific affiliation contracts with voluntary hospitals and medical schools within the budget, though so widely condemned, are being increased $13.4 million.

2. Few signs are being shown of specific new City administrative leadership in the nitty-gritty functions of (a) regulating private sector use of public funds, beyond certain Medicaid quality audits, and (b) expediting specific municipal institutional reforms, beyond scattered city hospital “crash programs.” As the recent detailed report of the State Investigating Commission, critical of City Hospital affiliations on the most elementary level of administrative procedures and performance, demands: “It is time for the Department of Hospitals to direct and not to ‘suggest.’ It is time for action, not words.”

3. The most dynamic and potentially progressive energy in the health services system is frequently at the “bottom,” among the most neglected health workers and among consumers of health service at the low-income neighborhood level. Hospital employee organizations (such as Local 1199 and District Council 37 of AFSCME) are winning more new career training and upgrading and a direct role in institutional change as well.

The insurgent actions of neighborhood organizations are challenging many of the assumptions of the smugly over-centralized, privatized, and narrowly professionalized existing health establishment. The question is no longer so passive as whether the people can find government leaders responsive to their needs. Can government leaders catch up with the new demands and interest being expressed by these new worker and community forces? Can they be credible as coordinator, planner, ombudsman, and expediter, and agent of change in the most pressing public interest?

—Robb K. Burlage
Director, Health Policy Advisory Center
Can the citizens of one of the most politically active and organized low-income neighborhoods in the nation make health services accountable to their needs and open to their policy-making participation? This is the challenge in the Lower East Side—South (Manhattan).

(1) It successfully mobilized almost a decade ago to prevent City closing of Gouverneur City Hospital without building a model community hospital in its place. Today residents are still pushing for rapid construction of such a facility. The project is almost still at ground-zero and there have even been reports that a chronic care facility would be substituted, although community residents say they would fight such a proposal to the death.

(2) The Gouverneur service area was targeted for one of the first national Office of Economic Opportunity neighborhood health services programs. It is based on the old Gouverneur facility, co-funded by the City, and operated by Beth Israel Medical Center. (Beth Israel, a private voluntary hospital, member of the Federation of Jewish Philanthropies and affiliated with the new Mt. Sinai Medical College, serves primarily as a community hospital for the lower East Side area with a wide array of public subsidies for providing service in this area.) The Gouverneur program, now in its third year, is reportedly lacking in certain aspects of services coordination and outreach for the whole area and, even though a neighborhood health council exits, especially in meaningful community participation in the direction of the program and in the development of new program plans.

What Is HEALTH-PAC?

...an independent, non-government center for the public, serving as a Health Ombudsman, Health Information Service, Social Analysis Laboratory, and Technical Assistance and Communications Center.

It monitors public policy in this monthly BULLETIN and in other publications. It conducts workshops for neighborhood, health worker, and community-oriented professional leaders on organization for improved community services. It assists research and reporting about the problems, issues and power forces, particularly in the changing metropolitan New York health services setting.

Its commitment is to the basic principles and overall social analysis articulated in the Institute for Policy Study's report on New York City's Municipal Hospitals (the Burlage Report) in 1967, with eyes open to the revolutionary changes being demanded in the urban services and environmental setting today.

HEALTH-PAC aims for the redirection of health services as part of general community social change toward a true public accountability and excellence for all citizens.

HEALTH-PAC is an urban research and advisory center of the Institute for Policy Studies (a non-profit, research and education organization based in Washington, D.C.) with a supporting project grant from the Samuel Rubin Foundation, operating according to the policy direction of the HEALTH-PAC staff and advisory committee.

GROUPS SEEK MAJOR ROLE

(3) The Lower East Side is now the scene of plans, involving variously Beth Israel Medical Center, the City Health Services Administration, and Mobilization for Youth (a) to create a unified City Health District, based in Gouverneur-Beth Israel; and (b) to create a neighborhood multi-service referral system for the entire area, based in Beth Israel, with Federal funding. Neighborhood groups insist, however, that any such comprehensive services coordination should be accountable, responsive to, and controlled by a broad-based community coalition.

A major force in the drive to improve community control over health affairs in this area is the Lower Eastside Neighborhoods Association (LENA). LENA actually lost private health establishment-associated foundation grant funds in recent years for its tenacious fight, along with many other neighborhood groups, to win a new Gouverneur Hospital. This fight was against the wishes of the Hospital Review and Planning Council (now the Health and Hospital Planning Council), the voluntary hospital leadership, and even the then-City Commissioner of Hospitals.

More recently, LENA has devoted the time of staff organizers to assist the Lower East Side Neighborhood Health Council—South, which also serves as the community health council for the Gouverneur Neighborhood Health Services Program. An immediate goal of the Health Council with regard to the Gouverneur program is to strengthen participation of recipients of service in the area (generally south of Houston Street and east of Third Avenue) in the policymaking and control of the program. Negotiations are now under way with Beth Israel and the Office of Economic Opportunity for an independent grant for a staff person, hired directly by the Council, for community organization and health education. The Council has also discussed seeking community representation on the Board of Trustees of Beth Israel.

Beth Israel has launched a proposal to lodge powers and jurisdiction of the District Health Officer of the City in the Gouverneur-Beth Israel facility to serve under the general direction of Beth Israel in cooperation with the City Health Services Administration. A goal discussed by some neighborhood groups is that the District Health Officer should have strong public administrative powers and independent staff to serve as, in effect, an Assistant Health Services Administrator for the district, rather than being, in effect, a ward of the private medical center. With this position he would be able to carry out and to induce in all the health facilities and services of the area the plans and program priorities of a broadly-based, consumer-controlled Neighborhood Health Board.

Another Beth Israel-launched proposal, for a "Neighborhood Multi-Service Center" program, in cooperation with Mobilization for Youth, is also probably to be based at Beth Israel. It is also being challenged by the Health Council, LENA, the North East Neighborhoods Association (NENA), and other neighborhood groups. They are demanding that such a program be related to a broad-based community coalition of groups and be administered directly by community-based organizations, not to be essentially the administrative ward of the externally owned and controlled private hospital.
NENA to Open Health Center

When a small boy almost died because he could not get to Bellevue Hospital during the 1966 transit strike, Lower East-side mothers protested vehemently and petitioned Mayor Lindsay. Last month the Federal Public Health Service funded the first community-owned, comprehensive health center in a low income neighborhood in the nation.

The North East Neighborhood Association (NENA) health center was not a quick response from the City Administration, however. In fact, according to the co-chairman of the NENA Intergroup Health Committee, the community coalition sponsoring the project, Mrs. Gloria Martinez, "As an answer [to the petition] we were referred from one office to another without getting anywhere."

When the NENA Health Center opens in January, 1969, at 290 East 3rd Street, New York (Manhattan), its policies will be set by a board of neighborhood residents—the traditional "receivers" of services. Because the Committee is a cross-section of the community (although a breadth of income and educational levels are represented), low-income residents are the dominant force on the Committee and have been central to all the action—from program and facility planning to finding (and persuading) sources of private as well as public funding to recruiting a highly qualified staff. During the struggle an unusually strong partnership between professional and lay leadership developed.

The neighborhood of 60,000 persons which stretches from 14th Street to Houston Street and from Avenue A to the East River is predominantly Puerto Rican (55-60 per cent) and Negro (20-25 per cent). Even though the area is primarily low-income, the center will be open to all residents from all income levels. It will initially save 25,000 persons.

Ana O. Dumois, project organizer, says the committee is presently designing a plan for reimbursement which will assure all residents the use of the center, as well as control cost, provide quality care and motivate people to use the services properly.

The doctors hired for the Center will be paid competitive salaries, but their attitudes toward the poor will be carefully scrutinized by the lay board. Dr. David Zimmerman, graduate of Albert Einstein College of Medicine in the Bronx and a doctor of internal medicine at New York University Medical Center, will head the medical team and has already begun recruiting the seven doctors and four nurses who will initially staff the center. In addition, more than 40 neighborhood people will enter para-professional health careers at the center.

The New York Infirmary, a small voluntary hospital in the area, will serve as the primary backup facility. All NENA group practice physicians will be allowed to admit patients and follow the patients while hospitalized, providing a real continuity of care. In cases where required services are not available at the Infirmary, New York University Medical Center will provide backup.

Principles for operation of the health center are the opposite of the traditional pattern of urban health services in low-income areas, whether in hospital clinics or in "satellite" health care clinics which are hospital-sponsored. The NENA center will provide comprehensive medical care by appointment. All adults in one family will be seen by the same internist and all children by the same pediatrician. Specialty clinics will be eliminated and specialists at the center will see patients only on a referral by the family doctor. Two special emphases of the NENA plan are to:

1. "Provide local residents with the chance, through training programs and job opportunities, to enter into careers in the health professions and... to solve the manpower shortage in the health profession by a careful downward transfer of functions;"

2. "Make the facility more responsive to the community and, as such, capable of having a more positive impact on the health of the community residents, by involving the local residents in the planning and operation of the health center."

Almost three years of determined struggle for the health center on the part of the community residents were preceded by many years of discontent with the inadequate health care in the neighborhood. David Cook, Committee co-chairman, described the following scenes at Bellevue: A patient being operated on for the wrong ailment because of a mixup of records; a patient dying in the waiting room; or, waiting for hours in line at a clinic (there are over 200 clinics at Bellevue and the patient must literally diagnose himself) only to find he must start all over again because he guessed wrong.

Bellevue Hospital, though not far away in actual distance, is to many virtually inaccessible. There are seldom taxis in the neighborhood. The only transportation is the city bus, which runs approximately once each half hour during the day and stops running at midnight. Clinics are run only during the day, on a first come—first served basis, and a day spent at Bellevue means a day lost from work or family.

It is not surprising the situation reached critical proportions during the transit strike of 1966. When the 500 mothers who petitioned the Mayor got no results, they told their story at a public hearing in the neighborhood, where NENA first heard of their frustrated efforts and offered staff services to contact and coordinate other interested groups. [NENA is a neighborhood association, organized six years ago by the Lower Eastside Neighborhood Association (LENA), which gained its autonomy last year.] The NENA Intergroup Health Committee grew from this effort and now includes the support of 62 neighborhood organizations.

"We never had difficulty getting community participation. They came to our meetings because they came to develop the plans for a health center, not to discuss the plans that had been developed "downtown,"" says Miss Dumois.
Unrest in the Columbia Domain . . .

HARLEM DEMANDS POWERFUL BOARD

A “Committee of 100,” spearheaded by Harlem CORE and including representatives of HARYOU ACT, the Harlem Neighborhood Association (HNA), Harlem Hospital employee unions, and Harlem community physicians and hospital staff, is developing a program to demand that prime public authority be delegated for the creation of a “Harlem Community Health Board.” The prime target is control of Harlem City Hospital Center where widespread community unrest has been created by agonizing construction lags on the long-heralded new hospital building, jammed job opportunities, and a crisis of medical service confidence.

A key element in this demand is community resentment of the domination of Harlem Hospital by the Columbia University College of Physicians and Surgeons and Columbia-Presbyterian Medical Center. This fiscal year they are receiving about $13.5 million, almost half of the City hospital’s total budget, under a City affiliation contract for provision of professional services. This includes upwards of $1 million accruing directly to Columbia for “managerial overhead” under this contract essentially to assist in the recruitment of physicians.

This movement of community organizations comes in the wake of protest, joined by striking Columbia University students late this spring, against Columbia University’s use of City park turf adjoining Harlem for a college gymnasium, and of well-publicized charges by Congressman Adam Clayton Powell that black Harlem physicians have been ousted to make way for whites under the Harlem Hospital affiliation. Although Columbia hospital affiliation officials claim that there are more Negro directors at Harlem Hospital now then at any time in its history, leaders of black physician groups in Harlem contend that the most important positions in the hospital have, in fact, gone the other way and that there is widespread bitterness among black community physicians about being slighted.

Says Dr. Arthur Davidson, a long-time member of the Harlem staff and of the Mid-Manhattan Medical Society: “When Columbia came into Harlem in the early Sixties, black physicians were promised by Columbia that they would have full access not only to a revitalized Harlem Hospital but to full opportunities for themselves and their patients at Presbyterian, St. Luke’s and at all medical facilities in the Columbia ‘medical family.’ However, these promises have not been kept, and these physicians are now demanding more ‘black power’ or community control over what is rightfully the community’s, because false promises of integration in the general system have not been met.”

Victor Solomon, of Harlem CORE, notes that the Medicaid cutbacks are forcing Harlem residents again to rely primarily on Harlem Hospital because many have lost their coverage in more “integrated” private hospitals. Erunan Yoba, an organizer for Local 1199, Hospital and Drug Workers Union, which covers “Columbia-affiliated” technical, clerical, and service employees at Harlem Hospital, says that those who work in the heart of the Hospital know best how neglected it has been by both the City and Columbia and how new community power is needed to make positive changes.

A memorandum calling for the creation of a Harlem Health Board states that a majority should be “lay members of the Harlem communities.” The Board would essentially control “all of the medical and mental health services and whatever such facilities exist in Harlem.” It also states that “any affiliation of any hospital would take place on the basis of contractual relation with the community . . .”

NENA

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In June, 1966, the group approached the New York University Medical Center to ask that a “satellite” clinic of Bellevue be established in the neighborhood. Some officials there were receptive to the idea and suggested the use of mobile trailer units until the health center could be equipped and opened around October, 1967. With this assurance, the Committee began the arduous task of preparing an application for a Federal grant.

The group suffered a major setback, when they learned in May, 1967, that NYU had deferred the entire project, unilaterally, and without consultation with the community. One member of NENA voiced the despair of the group: “We realized for the first time that the primary interest of the Medical School is to teach students, and not to service the patients whom they use.”

By summer of 1967, the Committee overcame this blow and began making contact with interested social scientists, with Federal agencies, with political figures, and with City officials. Talks began with the New York Infirmary. The Committee finished a working draft of a proposal to be used as a base and guideline for development of a final proposal.

Many who worked closely with NENA Intergroup Health Committee during their struggle see this experiment in health care as an historic step. It is perhaps the first time a group of low-income people, the traditional recipients of clinic services, have taken the full initiative and leadership in direct planning for medical care and mobilized themselves to involve a major medical institution in their plans. Though they were not professionals, they agreed to a set of principles upon which to build the center which were not unlike those advocated by many progressive health professionals. It is unique similarly in the politics involved—it is community controlled.

The Public Health Service of the U.S. Department of Health, Education and Welfare is providing the operating grant of $559,282 for the first six months and $1,108,382 for the first year. The grant application was prepared with a six-month planning grant from the Carnegie Foundation. An investment by the Samuel Rubin Foundation allowed the purchase and renovation of the building, which the community will pay back in rent-like payments, and within a few years the community organization will own the health center facility.

—Maxine Kenny