HEALTH IS THE CITY'S BUSINESS

THE AFFILIATION PLAN FOR NEW YORK CITY HOSPITALS HAS BEEN EXPOSED AS A DISASTER—COSTLY IN DOLLARS AND LIVES. THE PRIVATE HEALTH ESTABLISHMENT THAT CREATED IT HAS FAILED. THOSE PERSONS WHO DESPERATELY NEED HEALTH SERVICES ARE TURNING TO CITY GOVERNMENT FOR DISASTER RELIEF.

This health crisis must be solved by positive government and community action. Hospitals and health centers are public business. These most precious resources of public facilities and funding for health must not be given away through affiliations or organizational fronts that leave all real operating and planning power in private health establishment hands.

The City must establish new public accountability, not sell out the little that remains. The city must not "get out of the hospital business."

Hospitals here will be threatened by the fires next time, as they have been in Newark, Detroit, Philadelphia, and elsewhere, unless the picture changes dramatically. It is time for Mayor Lindsay to go beyond symbolic visits to the burning streets and the calling of hand-holding task forces. It is the crumbling community service institutions and growing community alienation as a result that cause the fires.

A year ago our report on New York City's municipal hospitals,* an unofficial, un-established, and independent analysis of the so-called affiliation plan for 19 City hospitals and numerous City health centers, was publicly released. Our conclusion: that loosely spent public dollars through affiliation contracts were a backward step from positive public and community leadership for a health services system that serves all persons equally well and excellently.

We found Private Health Establishment leaders were essentially concerned with expanding the financing, institutional economies of scale, patient population control, and faculty-staffing teaching and research opportunities of the private medical centers and private voluntary teaching hospitals. They were facing capital shortages and fading control of charity patient populations with the advent of Medicare and Medicaid. Thus, they acted to bring under private institutional control the potentially competitive resources of municipal hospital financing, facilities, professional staffs and (Continued Page 2)

A Political Coalition That's Bad Medicine

A HANDMAIDEN TO the State Medicaid cutback is Governor Rockefeller's proposed compulsory health insurance plan. It is advertised as a device to cover the working poor and the medically needy lost in the Medicaid cutback and as a guarantee of medical coverage for all (with more incentives than Medicaid for efficiency of utilization and of services administration.) However, critics have called it an administratively unworkable payoff to the private and non-profit insurance plans that would cost more, as well as tax the poor for a service that should be theirs by right.

The plan is given little chance of passage this year and is seen by many observers as a Rockefeller flag for national attention in this election year, rather than as the most humane and efficient policy for New York State. Governor Rockefeller proposed such a plan on a national basis in testimony before Senator Ribicoff's Committee in Washington in late April as the key point of what was called his major Presidential campaign policy position on health.

That this kind of medicine might be better for the Republican political coalition than for the patient is perhaps evidenced by the following statement from the special assistant to Governor Ronald Reagan (R-Calif.) in response to an inquiry from HEALTH-PAC:

"Governor Reagan . . . is in agreement with Governor Rockefeller's Plan to assess charges against the medically indigent with small incomes in order that costs may be minimized under the government-sponsored program . . . ."
unionized hospital employees. There were only a few professional leaders concerned with an independent, first-class municipal hospital system, and these few were essentially powerless in the face of the Establishment assault endorsed by the Mayor, as well as City Hospitals and Health officials—some of whom were conveniently on loan from the private hospital and medical center sector.

New York's health service elements are increasingly observable as part of baronial domains loosely aggregated under the purview of large medical centers and private voluntary teaching hospitals with their own elite trustees, administrators, and medical staffs and their own private plans and priorities. They hardly form a system of service that provides all people with what they desperately need medically, let alone that is closely related to positive general community development to meet basic human needs.

Despite certain improvements in professional staffing status, as the City Hospitals budget has more than doubled during the last six-year period with more than $100 million spent on affiliation, city hospitals—the hospitals of last resort and the family physician for many of New York's medically needy—are becoming private utilities, reflecting the private research and financial priorities of private and academic institutions. The result has been increased dumping of academically "uninteresting" or "socially difficult" patients, increased threats to vital hospitals in low-income areas unwanted by the medical establishment, increased alienation between in-hospital and out-community physicians in a hopelessly scattered professional services market, increased fiscal starving and operational deterioration of public hospitals, and the creation of neighborhood health centers as "satellites" of the private elite medical centers rather than as consumer-controlled, multi-service cooperatives.

The evidence of crisis has mounted even as the declaration of new intent in high places has escalated. The crisis is most visible in person at the bottom: A $300 million State Medicaid cutback cruelly punishing all and literally giving the death sentence to some persons among the more than 500,000 medically needy New Yorkers cut off the rolls; critical staff shortages (more than half of the City hospital registered nurse positions are not filled and more staff cuts will result from Medicaid cutbacks); threatened City hospital closings; continued City hospital operational deterioration and construction and renovation stalls; neighborhood health center delays and indifference to community demands; and sky rocketing medical fees.

New York is graced with mayoral sensitivity and perspective in the person of John V. Lindsay, reflected in his estimate of health services policy a year ago that "... for a program conceived today to be progressive in 25 years, it must verge on the revolutionary." Unfortunately, this awareness does not appear to be matched with the political commitment, the administrative resourcefulness, and the public fiscal capacity to be more than another source of frustration.

1967 was the year of reacting to revelations about the failures of loose city hospital affiliations and about the tragic unmet health needs in the City, as well as the first stream of the Federal "finance revolution" of Medicare, Medicaid and comprehensive health planning and program funds. Announced were crash programs to renovate city hospitals and to "tighten" affiliation contracts. Launched was a program of comprehensive neighborhood health centers. Released in December was the report of the Mayor's Commission on the Delivery of Personal Health Services [See "Piel Report," Page 5] calling for a total, new approach to public leadership for health.

1968, however, at least thus far, has been a year of passivity, paralysis, and rollback. Regressiveness concerning health in Albany has been complemented by drift in New York City. Despite the formal passage of the Health Services Administration (authorized by the City Charter late in 1967), much of its potential machinery of reorganization and public accountability has not been utilized. Neither the HSA Advisory Board calling for a consumer majority nor the provisions for comprehensive planning capacity in the office of the Health Services Administrator have been acted upon.

Dr. Bernard Bucove, the new Health Services Administrator, has assumed his difficult job with apparent open-mindedness and concern for administrative rationality, such as making the Community Mental Health Board more publicly accountable. But most top City health officials appear to style themselves as powerless, neutral arbitrators, presiding loosely over the dissolution of an unwanted and outmoded government empire, rather than as the public servants charged with the most important leadership in the total health system and with responsibility for the vital remnant of public service institutions that mean the difference between life and death for the medically needy.

The public paralysis and drift must end. There is no lack of plans for at least a coherent and comprehensive beginning. There is new creative energy emerging from new forces; neighborhood organizations demanding decent health services...
WHAT IS HEALTH-PAC?

HEALTH-PAC is the Health Policy Advisory Center of the Institute for Policy Studies. It is an independent, non-government center for the public which serves as:

- Advisory Center and Independent "Health Ombudsman" for the general public, as well as in relation to the professional community, with regular HEALTH-PAC BULLETINS and other special reports to help assess the most important directions in health policy and institutional change.
- Data Center, including a Neighborhood Health Information Service, to gather relevant information about health standards, problems, institutions, power forces, and policy and institutional alternatives, as seen particularly in the diverse New York City context but with awareness of developments elsewhere in the nation and world.
- Social Analysis Laboratory and Development Center in community health affairs, with emphasis on the policy and institutional trends of the metropolitan New York City setting, to encourage promising research and analytical reporting.
- Technical Assistance Center for both citizen and professional groups, including direct training and project assistance with emphasis on the development of community-controlled comprehensive health centers, health service programs, and health planning processes.
- Communications Center for health professionals, administrators, and workers, program and policy analysts, community organizers, and concerned citizens who meet to develop together programs and proposals to achieve the most healthful community environment and the most advanced, equitable and accountable health services.

How did HEALTH-PAC develop? Following publication by the Institute for Policy Studies of the Burlage Report on New York City’s Municipal hospitals in mid-1967, a strong interest was expressed by an important cross-section of persons in New York City concerned about urban health affairs that this work continue. The development of new streams of analysis about metropolitan health service systems should be continued in New York City, they said, as part of an advisory and technical assistance center for the general public and for all groups concerned about a more advanced and publicly accountable health services system.

HEALTH-PAC is the first urban research and advisory center established by the Institute, as an independent, non-profit research and educational organization based in Washington, D.C. Robb K. Burlage, a Fellow of the Institute, is Director, and Maxine Kenny, a former state War on Poverty program developer and former director of the Committee of the Professions in New York City, is Assistant.

The Samuel Rubin Foundation, which supported the Institute inquiry that resulted in the Burlage Report, has generously provided a grant for support of the Center. The Center is to operate independently of all government and private organizations according to the policy direction of the HEALTH-PAC staff and advisory committees. Its commitment is to the basic principles and over-all social analysis articulated in the Burlage Report, with eyes open to the revolutionary changes being demanded in the urban services and environmental setting today.

Editorial . . .

(From Page 2)

and a say in that service; health worker organizations demanding not only better wages and better hospital and health center working conditions for the benefit of the patient but a totally new career opportunity and training system, especially in the largest employer of low-income and minority group people in the city, the municipal hospitals; and health science students seeking alliance with community people to change the system. There are new Federal financial and administrative resources for tackling hard-core health problems, although, of course, mouthily unhealthy priorities of military counter-insurgency in Viet Nam exist which preemp public expenditure to help the neglected and exploited at home.

Community hospitals and health institutions must be revitalized, strengthened, and made accountable to their communities of service from the bottom to the top. Now is the time for Mayor Lindsay and Health Services Administrator Bucove to do the following:

(1) Order a comprehensive, coherent program of thorough reorganization and revitalization, beyond empty administrative boxes and slogans, of public sector leadership, facilities, and services that emphasizes public planning, flexible institutional administration, comprehensive regulation guaranteeing excellent services for all, and demonstration of new modes of service delivery and new programs of social commitment;

(2) Lead all citizens actively in demanding that the Governor and State Assembly restore Medicaid funds to prevent the needless deaths that will surely result from such an unconscionable rollback, assuring no City hospital closings, no hospital give-aways, no medical turn-aways, and no further deterioration in service, and in demanding the provision of adequate public monies for the overall operation of health services to serve all citizens decently and equally;

(3) Encourage directly more action by neighborhood residents in shaping the decisions of community health institutions that affect their lives by (a) establishing broad-based, consumer-controlled community health boards in all areas of the City to develop comprehensive plans and to make basic program decisions as part of a public comprehensive health planning and HSA administrative regulation process, and (b) by creating broad-based, consumer-controlled boards with real policy and program powers for municipal hospitals and health centers, as well as requiring that all public-fund-receiving private health institutions and agencies (this means practically all of them) must be directed by broad-based community boards reflecting a membership of those persons actually served.

—Robb K. Burlage

1967 WAS THE YEAR of reports and revelations about City health services.

In May, 1967 in the midst of exposés concerning the failures and unaccountabilities of the affiliation plan for municipal hospitals the Burlage Report was issued. It presented an analysis of previous policy failures and a comprehensive proposal for a totally new structure and stance for City health officials, administrators, and planners in relation to the total health services pattern.

In December, 1967, in response to a request from Mayor Lindsay to deal with the current crisis, the Piel Report of the blue-ribbon Commission on the Delivery of Personal Health Services was issued. While defending the basic trend of policy and action of the existing “Health Establishment,” including defense of the affiliation plan as an “interim step toward the objective of making City hospitals...first-class,” it calls for “the redesign and systematic reconstruction of the relationship between public authority and community initiative in the delivery of personal health services.”

Both reports call for a total restructuring of the City Health Services Administration, in the words of the Piel Report, “to promote the coordination and integration of public and private resources in the development of comprehensive community health services.” That the new Federal-State comprehensive health planning authority should be a City government agency is urged by both reports, although the Burlage Report emphasizes granting broad public authority over primary health programs and front-line institutions to decentralized, consumer-controlled boards.

The Burlage Report proposes unified, comprehensive public Metropolitan Health Authority over the total health services pattern, including both direct control over publicly-owned and operated facilities and planning control over publicly-purchased and supported facilities and services that are privately owned. A mayor-appointed Health Services Commission and Health Services Administrator are proposed. Emphasis in the Burlage Report is on decentralization of operating responsibility to District Health Service Administrators and a decentralization of planning and policy-making authority to District and Neighborhood Health Planning and Review Councils. The Piel Report calls for a dual City structure of a single Health Services Administration for planning, regulation and overview and a newly-created, independent, non-profit Health Services Corporation as a management structure for City hospital and health center operation, construction and financing.

The Piel Report seeks to place municipal hospitals and health centers more under the “unitary trusteeship and management” of the large, autonomous medical centers and voluntary hospitals. The Burlage Report stresses more independent public sector control of public institutions with only contractually specified, regionalized, back-up medical and academic supervision and services from these large centers.

The Reports differ with regard to the form of City government and community institution structural reorganization, and also in their estimates of the goals and actions of the existing “Health Establishment,” of the desired role and direct government accountability of publicly-owned and operated health facilities and services, and of the relative importance of community and health worker organizations in the transformation of the health system.

*COMMISSION ON THE DELIVERY OF PERSONAL HEALTH SERVICES, Gerard Piel, Chairman, Comprehensive Community Health Services for New York City, December, 1967; 60 pages with supplement.

Friendly Exceptions To Piel Report

WHILE AGREEING WITH MANY basic findings and recommendations of the Piel Report, three notes of criticism or extension have been notable:

In a special statement included with the Piel Report, Piel Commission member Dr. Eveline M. Burns, social services legislation consultant, formerly of the Columbia Graduate School of Social Work, makes some of the following comments:

“...There is urgent need for the assignment, to some central authority representative of the public interest, of responsibility for assessing the effectiveness of the system as a whole in providing appropriate personal health services. No one part of the present complex of health agencies, institutions, and professional practitioners can be entrusted with this task.

“...The experience of the public system has served as a screen to protect the voluntary hospital system as a whole (there are obvious exceptions) from the public criticism that would otherwise have been directed...the voluntary system, [is] answerable only to its own trustees and [is] governed primarily by what is best for the individual hospital as a research and teaching institution...the Health and Hospital Planning Council...is overly representative of the voluntary hospital establishment...

“...The task of the future is to determine which functions in relation to the delivery of personal health services must necessarily be undertaken by a major teaching and research institution and are of such vital importance that their performance cannot be left solely to the decision of the individual institution.

“...The modern hospital is a social utility and is accountable to the community for the use it makes of the resources that the community entrusts to it.”
NEW YORK CITY ANALYSIS:

(1) The affiliation plan for 19 City hospitals and numerous City health centers is basically wrong in public policy terms because of a lack of City planning and administrative controls and because it represents an essential abandonment of a positive, direct public sector for health services. It also has resulted in tragically lost dollars and opportunities desperately needed to improve services from the more than doubled City hospitals' budget in five years. Affiliated City hospitals, such as Harlem, function as research-ward spillover institutions, rather than as effective community hospitals. The neediest citizens suffer the consequences. More needy patients are being dumped and basic hospital conditions continue to deteriorate. Community physicians have lost appointments in the affiliated City hospitals.

(2) New health services domains around affiliated medical center networks are developing in each borough, using public tax funds and public planning and administrative authority to achieve elite private control, according to their own narrow financial, institutional, and research priorities, over the total health services pattern. The present private regional hospital planning council uses the power of philanthropic and insurance organizations behind these domains to assure elite private control. Attempts have been made to close desperately needed hospitals in the ghetto, such as Gouverneur and St. Francis, because these are unwanted by elite centers. These domains are not publicly accountable in any meaningful way. The constraints are overwhelming to independent neighborhood development and control of health services program and facilities. Although upwards of one billion dollars annually in public tax funds is spent for health and mental health services through City health agencies, this is probably the least community-accountable area of social and personal services.

(3) Loose and superficial reorganization efforts under Mayor Lindsay's Health Services Administration have shown little capacity for stopping the drain of the positive public service leadership role in relation to these narrow private domains. Under the rhetoric of crash programs and agonizing reappraisals about public accountability, the sell-out of public health services capacity has continued. Without direct public program and institutional capacities, City health officials are essentially impotent and cannot recruit effective professional staffing for planning and regulatory functions. The necessary restructuring of public facilities and services to use scarce medical resources most effectively and meet the most pressing community health needs—e.g., maternal and infant, elderly nursing, early diagnosis and prevention—has not taken place.

BASIC RECOMMENDATIONS:

(1) All health facilities and services, as public utilities, should be under general City government planning, regulatory, and administrative direction with direct City government capacity for efficient operation, construction, and capital financ-

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PIEL REPORT

(1) "The affiliation contracts have substantially accomplished the particular purpose for which they were written . . . Quite apart from the City's failure to deliver on its commitments under the affiliation contracts, the divided management and disparities in staff salaries and other benefits . . . tend to inhibit and stifle initiative on both sides . . . it requires the devoted leadership of a unitary trusteeship and management and the support of a staff with high morale. . . . In providing inadequate and substandard health services and in serving only the indigent population through its own clinics and hospitals, the City is perpetuating a dual system of medical care with a built-in invidious double standard of private and welfare medicine. The system is demeaning to all concerned and wasteful of the community's medical resources.

(2) "...Should encourage the organization of . . . communities of affiliation on a formal and systematic basis. With seven medical schools in the City and a score of teaching hospitals, it should be possible to organize a 'regional' system for each borough . . . Voluntary initiative has played a central role in the development of this country's medical institutions. . . . Among them [in New York City] are several of the greatest institutions of their kind in the world. . . . There is here a reservoir of experience and devotion . . . to help with the physical and administrative rehabilitation of the City hospitals and their integration into a unified health delivery system. This development could also provide an important link between the City hospitals and the communities they serve. Other equally important channels of communication to the community must also be developed. Between the people of middle-class background who operate the medical institutions and the low-income and otherwise disadvantaged groups of the City there is a significant 'cultural gap.'

(3) "The City is fortunate at this moment in its history to have an Administration committed to fortifying the capacity of local government. . . . The health officials of the present Administration have made considerable progress toward the important goal of unifying and coordinating the work of their agencies in a single Health Services Administration . . . In order to secure for the Health Services Administration the authority and flexibility it requires, the City Administration must continue its efforts to restructure the City's governmental machinery. . . . The separation of the responsibility for operating health facilities from the planning and regulation of them is a desirable end in itself. . . . Freed of the task of operations, the Health Services Administration should be able to acquire its regulatory responsibilities in a better fashion."
Comparison of Reports

BURLAGE REPORT

BASIC RECOMMENDATIONS:

ing of hospitals and health facilities. A public-interest ap­
proach to the development of comprehensive community
health services should be led by a City Health Administration,
or "Metropolitan Health Authority," empowered by a consumer-
majority, comprehensive policy-making and planning bodies, a
consolidated Health Services Commission and a City Health
Planning and Review Council in the City government. A Fed­
erally funded and State-designated comprehensive health plan­
n ring authority for New York City should be vested in a City
agency with a broad-based consumer majority board and with
decentralization of much planning authority to district and
neighborhood boards.

(2) To achieve such public-interest leverage over primary
health programs and front-line institutions, decentralized,
consumer-majority neighborhood and district health planning
and policy-making boards should be created. Empowered dis­

(3) Medical research and teaching institutions must relate
their overall efforts to a framework of public and community
planning, policy-making, and direction for those community
health services. They must re-shape their own priorities to
meet the comprehensive, basic needs of their individual pa­
tients and of their total surrounding service communities. All
patient dumping and unnecessary fragmentation of services
must be ended. These institutions must open their education
and training to allow all persons full opportunity to advance
their skills and to enter health careers.

(4) A complete network of neighborhood health and mental
health centers and services should be developed as prime en­
try points to the health services system to fill the critical
gaps of personalized primary, diagnostic, and preventive ser­

(5) The marshalling by public leadership of all institutional
and professional resources will be necessary to carry out the
total new health mission. Technological and social forces out­
side the usually defined health systems will be crucial to
demanding and achieving necessary changes. New organiza­
tional forces of health workers unions, low-income neighbor­
hood consumer groups, community-service-oriented health
science students and new professionals will be central in ex­
p10sing present inadequacies, in developing new visions of
what a positive health system in a decent community environ­
ment could be, and in calling for new alliances to achieve
such goals.

through planning, financing, and regulating. . . . The statutory
Boards of Health and Hospitals will play integral roles in
policy-making . . . . The Community Mental Health Board .
will continue to promote the development of mental health
services and facilities . . .

"The City should initiate the creation of a non-profit Health
Services Corporation . . . governed by a board of outstanding,
independent citizens . . . appointed by the Mayor . . . [who will] ap­
point the chief executive officers of the Corporation with
the concurrence of the Mayor . . . [to] operate the City hos­
pitals and health centers . . . undertake . . . physical and admin­
istrative repair . . . develop and operate system-wide . . . ser-

(2) "For each hospital or other facility under its management
the [Health Services] Corporation will initiate the organization
of a Community Advisory Board made up of the local com­

(3) "One important objective to be achieved is the resolu­
tion of the clash of mission—between service on the one hand
and teaching and research on the other . . . The community hos­
ital should be obliged to receive and care for anyone in the
community who requires its service. The medical school and
medical center on the other hand, must be permitted reason­
able selectivity in the admission of patients. This require­
ment is satisfied when the medical school and its hospital, with
command of the rarer specialties and more exotic instrumen­
tation and equipment, serve as a regional medical center and
backstop to the community hospitals in the region.

(4) "A fully comprehensive system of health services lays as
much emphasis upon preventive, supportive, and positive
health measures as upon treatment for illness and injury . . . To
bring physician services into these [low-income neigh­

(5) " . . . The Health Services Administration . . . must provide
leadership to the other elements in the health services system.
As [one analyst] has emphasized: 'The needed balance of in­
terests depends upon the conscious and systematic coopera­
tion of the four groups concerned with the giving and getting
of medical care: consumers, arrangers, providers, and payers.'"

(NOTE: All bold emphasis and arranging and re-
ordering of content is ours.)
Who Plans for New Yorkers' Health?

THE DECISION ABOUT WHO PLANS for New Yorkers' hospitals and health services is, officially at least, still up for grabs. What began as a loose bargain between the private health establishment and City officials behind closed doors may turn into a most explosive public issue. Community groups are placing great pressure on Mayor Lindsay to come up with a strong City government planning agency proposal oriented more to consumer and neighborhood policy-making power.

Source of this struggle is the Federal Comprehensive Health Planning legislation (Public Law 89-749), which provides Federal funds and authorization for a single comprehensive health planning agency designated by State governments for each large region of health services, in this case New York City. Federal legislation calls for the designated agency to be concerned with physical facilities, program, manpower, and social planning for personal and environmental health on a unified regional basis. Federal administrative requirements call for a single regional agency with a majority of consumer representatives either on the board or the advisory council of the agency.

The present voluntary planning agency, representing primarily the private health and hospitals industry, in New York City is the Health and Hospital Planning Council of Southern New York, Inc. Traditionally it has functioned as the technical hospital planning agency to develop standards and specifications to prevent costly overexpansion of hospital beds and duplication of costly equipment and services for hospitals. Its chief financial support through the years has come from Blue Cross, United Hospital Fund, Catholic Charities, Jewish Philanthropies, and a few union-management health plans. Its organizational and policy-making base has been drawn primarily from private hospital administrators, business executives who are private hospital trustees, physicians, and Blue Cross and private hospital philanthropy executives. A few City health officials have been ex-officio board members. City health facility plans in recent years have been shaped to fit this private agency's plans and standards. The Council has exerted strong pressure both for expansion of City hospital affiliations with private voluntary hospitals and for the closing of some City hospitals.

In recent years subsequent State legislation sanctioning such voluntary planning under a State Hospital Review and Planning Council has increased the flow of State and Federal grants to the Regional Council's burgeoning budget. The Council recently added the word "Health" to its name, expanded its stated definition of purpose beyond technical hospital planning, and added a few new board members in hopes that it could hold on to its public tax funding by gaining Federal-State planning agency endorsement without too much organizational change.

A year ago this bid by the Council appeared to be on a collision course with Dr. Howard Brown, then City Health Services Administrator, who was insisting that the new agency be a City government agency with broad consumer representation. The Piel Commission report in December, 1967, reinforced this position that comprehensive health planning was a City government responsibility accountable to the general public.

Widespread and intensive criticism of the Council has cumulated over a period of years among community organization leaders who consider it a rigid and narrowly technical private agency "front group" for the wishes of the private hospital establishments, unresponsive to the needs of low-income people.

The Council is blamed by angry Lower East Side community residents for putting pressure on the City early in the 1960's to close Gouverneur Hospital. The community won the fight for a new Gouverneur Hospital and an interim Ambulatory Care Unit in the old building. But there is an enduring resentment against the agency.

Representatives of neighborhood groups from throughout the city picketed the Health and Hospital Planning Council's offices at 3 East 54th St. in late February, 1968, in opposition to the Council's bid to be the Federal-State designated agency and in opposition to the secret negotiations then going on between Council representatives and City health officials.

Alternate Planning Recommendations

Public Agency:
Several prominent individuals in the health and welfare field, including staff members of the Community Council, several of its member organizations, and other city-wide citizens groups, are pressing for another alternative — the "Densen Plan." Proposed by Dr. Paul Densen, former HSA Deputy for research and development, the plan calls for the creation of a City health planning agency directly answerable to the Mayor. Under the plan, the agency would be directed by a board of 19 consisting of the Health Services Administrator, nine additional City government officials concerned with community health, and nine non-government representatives, including two from the existing Health and Hospital Planning Council and Regional Medical Program, and two voluntary health agency representatives appointed by the Mayor. Five persons would be selected by an Advisory Council, one of whom is to be from the Coordinating Council of the Medical Society. The Advisory Council would have 45 members, all appointed by the Mayor: 23 to represent consumers, 12 from health professional organizations and medical school nominations, and 10 from voluntary health agency nominations.

Neighborhood Boards:
Numerous neighborhood groups concerned about health services from throughout the city, as part of an ad hoc group called the Special Committee for Comprehensive Health Planning* have been gathering grass roots organizational endorsement for a planning agency proposal emphasizing "neighborhood health boards." These consumer-oriented neighborhood health boards would cover all health districts of the city with decentralized planning authority and staffing and would have direct representation on a consumer-majority board for a strong City health planning agency. These groups in a public statement have strongly opposed the designated agency being "a private agency, or a paper front group for an existing private agency," specifically opposing the Health and Hospital Planning Council proposal.

* c/o LENA, 119 Suffolk St., New York, N. Y.
Who Plans

(From Page 7)

Despite these strident criticisms of the Council, City health officials claim that State officials insist that, to get their approval, they must work out some kind of "partnership" with the existing Council. With the departure of Dr. Brown from the City HSA post early in 1968, obstacles were apparently removed for such a City partnership essentially on the terms of the Council.

City health officials and Council President Dr. Jack Haldeman were revealed in early March to have developed a "tentative proposal" for a "new agency" essentially along the lines the Council had been publicly demanding since last summer. This proposal is described as merely a reorganization of the existing private Council and its staff as the "Health Planning Council of New York City, Inc." as a public, non-profit corporation. "Corporate membership" of the Council would be expanded to include the City of New York, with seven votes for each of seven health-concerned City officials: the Health Services Administrator; Commissioners of Health, Hospitals, Mental Health; Human Resources Administrator; Environmental Protection Administrator; and the Chairman of the City Planning Commission.

Under this proposal the traditional corporate membership forming the Council would be expanded slightly but the heart of the membership base would continue to be Blue Cross and seven private voluntary hospital funding and promotion agencies (United Hospital Fund, Catholic Charities, Federation of Jewish Philanthropies, etc.) Included also are the Private Hospitals Association, the Nursing Home Association, the Medical Society Coordinating Council, the New York Academy of Medicine, the Metropolitan Regional Medical Program (primarily medical school representatives), and the Public Health Association. The list also includes the Central Labor Council, Teamsters Joint Council No. 16, the Commerce and Industry Association, State Communities Aid Association, and the Community Council.

Mayor Lindsay has criticized the narrowness of this Council proposal and has urged a proposal be made which is more directly in the public sector and is more consumer-oriented. Dr. Bernard Bucove, new HSA Administrator, before officially taking office in mid-March, was quoted as being pleased with the next year's budget to pave the way for City leadership for such an agency. It is also reliably reported that City officials continue to meet secretly with the Council regarding its proposal.

Dr. James Kimmey, regional director of the U.S. Public Health Service, has said that to receive Federal funding approval at least 51% of the governing board or advisory council of the planning agency must be consumers of health services, not providers. Under the Council's proposal many of the non-health-professional members of the Council board would essentially represent health provider organizations.

As the deadline for Federal funding for planning grants under the current fiscal year nears and as discussions continue between City health officials and the private Council representatives, many community leaders fear either a drag-out costly to everyone or a final quiet City bow to the essential Council proposal. However, the crescendo of demand for positive action by the Mayor and Dr. Bucove steadily increases.

Friendly Exceptions

(From Page 4)

A special statement from the Citizens' Committee for Children of New York, Inc., includes the following:

"Citizens' Committee for Children does not believe that a Health Services, Corporation should be established . . . Throughout the [Piel] Report there is discussion of 'one hospital system', but the report does not make explicit that the voluntary sector is to take over the municipal hospitals once they are rehabilitated by the Corporation . . . "The structure recommended is an 'administrative nightmare,' with the Health Services Administration checking on the Corporation . . . Planning would, in part, be separated from implementation, which would create a natural atmosphere for quarrelling and buck passing. The Health Services Administration, which would be charged with reviewing budgets and programs of the Corporation would, in fact, become impotent, since most of the basic resources for review, such as data processing, planning, etc. will be in the Corporation.

"We are not willing to accept the premise that City government cannot work and that it must contract out vital functions!"

A letter written originally for the New York Times from Ana Dumois, community organizer with the North East Neighborhood Association, and Victor Gothbaum, Director of District 37, American Federation of State, County, and Municipal Employees (including City hospital employees) said:

"We . . . support the minority report of Dr. Eveline M. Burns which calls for the power to compel the private sector to meet the most progressive standards of health care . . . "New ways to utilize professional and non-professional health manpower, and new ways to organize care, are important needs which the Report tends to neglect, because it gives to the existing institutions more credit for knowing and doing what is best than they deserve.

"We also believe that the proposed Health Services Corporation in effect would replace one centralized institution with another one. What is needed is more decentralization, with strong and representative community health boards, equipped with competent professional staffs, given the power to organize the network of services within each of several rationally drawn health districts. These boards should represent the consumers of health services and the health workers, as well as the providers of health services.

The Health and Hospital Council—as a narrow negative planning force—is analysed by Peter Rothstein, of Albert Einstein Medical College, in his study "The Closing of St. Francis Hospital: A case Study of the Politics of Health Planning." In describing the closing of this Bronx hospital in late 1966, Rothstein focuses on the unaccountable shuttering of planning decisions between the Catholic Archdiocese and Catholic Charities leaders, with positive funding power, and the Hospital Council, with negative planning power. Though neither acknowledged their responsibility, both coordinated their efforts to close St. Francis. (Copies are now available from the HEALTH-PAC office.)