THE GREAT PLANNING SCANDAL

THE HEALTH PLANNING "MOVEMENT," THE MOST RECENT ATTEMPT TO BRING REASON AND LIGHT TO AMERICA'S 19TH CENTURY MEDICAL MARKETPLACE, IS ALREADY SHOWING SIGNS OF AGE AND DISILLUSIONMENT. AS HOSPITAL COSTS SPIRAL AND MEDICAL RESOURCES DRY UP, THE ONCE REVOLUTIONARY CONCEPTS OF PLANNING AND REGIONALIZATION HAVE SETTLED DOWN AS HARMLESS CLICHÉS.

The need to "rationalize" laissez faire medicine, even at the cost of long-dreaded government intervention, is now a commonplace theme for medical school graduation oratory. Government "intrusions" resulting from Kennedy/Johnson Health New Deal legislation have calmed the fears of all but the most rear-guard national health forces: The movement for planning and regionalization does not threaten to truly rationalize health services.

The need for planning became especially acute to many Federal policy-makers after the passage of two financing bills—Medicaid and Medicare. Liberal medical advisors thought it would be prudent to follow up the Federal dollars with some sense about health care organization. The results were the Comprehensive Health Planning Act (CHPA) and the Regional Medical Program (RMP). Both laws looked to the medical establishment—medical schools, voluntary hospitals and private insurance companies—for leadership towards the Brave New World of planned care. Both are failing fast.

The New York City scene exemplifies the national crisis in planning:

- Bed occupancy in the City's voluntary hospitals is 92 percent, which means that doors are often closed even to the seriously ill. One New York doctor has dropped his Blue Cross policy, explaining that if he had a heart attack he wouldn't be able to get into a hospital for three or four days anyway.
- Nursing home bed shortage is so severe that elderly patients linger on in expensive hospital beds while waiting for nursing home openings.
- With the present City budget cuts, ambulatory services will evaporate to the point where hospital admissions will be necessary for patients who stopped vital medications which were not obtainable in the outpatient clinics.
- Some sections of New York City have so few medical resources and such difficulty with access to medical facilities that they have developed "rural" health care delivery syndromes.

In New York, as in many other cities, CHPA and RMP are being destroyed by local nonfeasance and misfeasance. But right from the start, the programs had such serious "congenital defects" that there was little hope they could survive local institutional selfishness. Both are based on the long-standing tenets of American health policy—voluntarism and elitism—which add up to the naive hope that, if you give the most respectable elements of the private sector enough rope, they will eventually knit together a rational health system.

All such hopes for elite, voluntary leadership have been dashed by the New York City experience. The New York Regional Medical Program debacle is a case study of what happens to frail Federal legislation in the hands of local medical barons. [See RMP story, Page 3.] The elitist assumption that medical schools would take leadership in reorganizing medicine ignored the existing role conflicts among the "medical empires." Some were too busy building their own private regional empires to bother with the regional service networks RMP envisioned. [See April, 1969 Brave New World?]
Editorial . . .
related story, Page 6.) New York City has been hailed as the medical planning model for the nation. Yet all the problems that planning was designed to solve (maldistribution of facilities, bed shortages, etc.) have become worse in New York City despite (and sometimes because of) the 30-year-old Health and Hospital Planning Council. It would take a miracle of retroactive planning to salvage the City's health system from chaos. But the only improvement comprehensive planning is likely to bring, if it ever gets off the ground, is a cosmetic smattering of "consumer" representation in the planning process—something the Planning Council never felt worth bothering with.

There are clues that the designers of these self-stopping programs (RMP and CHPA) were not very serious about planning and regionalization in the first place. In the Health New Deal of the mid-60's, financial reforms (Medicare and Medicaid) are carefully segregated from organizational reforms (RMP and CHPA). This separation automatically renders any form of planning impotent. Without the financial clout to change existing patterns of service, no new organizational forms (such as team practice) can be encouraged. This amounts to making planning a process of changing relationships between given institutions without significantly altering the services offered by those institutions.

Reorganization of American medicine through RMP and CHPA has or will clearly fail. But Federal sanction of regionalization and planning has resulted in two major changes. First, planning has been elevated to the status of a new "science" in the armamentarium of health skills. Previously, planning was not only considered unnecessary, it was counter to the spirit of a free society. Some may still look with apprehension on schools, insurance executives, etc.). RMP and CHPA have done that health planning as a science will become a new mask for the new health "planning" technicians. The real danger is that health planning as a science will become a new mask for the current elite health planning, shielding real decision making from the public view behind a fog of "science" of planning as a basis for decision-making. But there is little substance to this fear. The actual health planners (hospital directors, deans of medical schools, insurance executives, etc.) are not about to surrender any of their power to the new health "planning" technicians. The real danger is that health planning as a science will become a new mask for the current elite health planning, shielding real decision making still further from the public view behind a fog of jargon and professionalism.

Second, the Federal sanction of regionalization and planning is another symptom of the decline of the entrepreneurial doctor-dominated forces in medicine and the rise of the new corporate managers (hospital directors, deans of medical schools, insurance executives, etc.). RMP and CHPA have done little so far by way of direct subsidy, but they have provided a flutter of Federal flag-waving for the corporate consolidation efforts. "Regionalization" is a nicer word than "empire building;" and "planning" sounds less arbitrary than "deciding." In fact, from Washington, D.C., a tightly-run medical empire probably looks much more "rational" than an open market of private practitioners—just because there are fewer actors on the scene. But these more consolidated enterprises are no more rational in the delivery of health services than the fee-seeking solo practitioner. The corporate forces have their own narrow institutional priorities, which seldom include the delivery of comprehensive personal health care to the patient. Both regionalization and planning have become tools in the hands of these corporate forces for further mystification of the decision-making process.

But it is clear, that in its misguided and hesitant way, the Federal government is inviting somebody to do something about the chaotic health industry. The invitations are still out on the table. Nobody has picked up the challenge. RMP and CHPA have shown there is an absolute vacuum of concern for improving health services for all the people. It is time for the new consumer and health worker forces to take leadership that no one else seems to want. Planning and regionalization must serve as technical adjuncts for the consumer to reorganize the system from the bottom up.

Heal Thyself . . .
FOR PERHAPS THE FIRST TIME, this June medical students handed the Deans a document in exchange for their diplomas at several medical school graduations. Following is the statement given to the Deans by students concerned about their profession and its future:
"As we enter the medical profession, we look ahead to working within a health care system primarily consisting of private physicians, private hospitals, drug companies, and health insurance companies governed by the profit motive in a society that makes disease, itself, a commodity. We ask ourselves whether we can work meaningfully within a society whose health system has low social priority and dehumanizes members of all classes. Where can we work so that the medical care we provide is not just a series of Band-Aids on immense social ills?
Seventy billion dollars of our public tax money supports private industry and the military in its production of weapons for war. Health, education, and welfare (the purpose of taxes?) are allotted less than 10% of the national budget. These figures articulate our national priorities. Will the priorities shift without basic social change?
We must turn our attention not only toward the "health system," but also toward the system that maintains people in poor health, psychologically as well as physically. But our union, the AMA, fights for doctors, not for better health. It has helped maintain control of the number of physicians, of the class from which they come (one third from the upper 3%), and of medical knowledge, which must be spread, not preserved behind the status screen of "professionalism."
We five recognize that we do not represent the majority of our colleagues. But our numbers are increasing, and we are beginning to reach out to other health workers and to politically radical organizations. We will take our knowledge and skills out to the people, so that they may better challenge the society as a whole.
In a country where the provision and availability of social services are still a political instrument, medicine is also used politically: in Vietnam to support the destruction of a country struggling for its very existence, and at home to pacify the colonized poor. We therefore conclude that medical service must relate to a political movement to eliminate the causes of ill-health—poor housing, poor nutrition, poor schooling, and the political impotence of poor people. Only then can we physicians practice meaningful medicine for all people."

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The ANATOMY OF A MUDDLE

THE REGIONAL MEDICAL PROGRAM in New York City has been a disaster. There is almost nothing to show for the $2 million dollars that the medical schools have spent for “planning” in the past two years. The record of the New York Metropolitan Regional Medical Program (NYM-RMP) at a glance reveals:

- Only two projects have been approved and funded. One, the pediatric pulmonary center at Babies Hospital at Columbia is a failure. The other, the Mobile Coronary Care Unit at St. Vincent’s is a poorly conceived demonstration.
- No plan or set of priorities has been established for the metropolitan region. What data have been collected on the needs of the region are meager and superficial.
- During the last year, almost all the central staff has left the program. The Associate Director was the first to go. He was soon followed by the Director, the Director of Program Development, the Director of Administration and Organization, and finally by the Director of Research and Evaluation.

In New York City, the attitude of the medical schools doomed RMP from the start. For openers, the Deans of the New York City medical schools met and decided that they were not going to participate in the Program. RMP did not really offer them much: There were no funds for new construction; nor was there any opportunity to take over and staff hospitals. Instead, they were supposed to strengthen community hospitals by cooperating with them. In many cases, the hospitals, that they were supposed to aid were in competition with the medical schools for staff, research money and new facilities. Now the medical schools were to associate not only with strong hospitals but also with the weak hospitals and the lowest level of practitioners—groups which they had systematically excluded in their drive to build “centers of excellence.”

Turf-Fighting

Curiously enough, it was the isolationist Cornell Medical College which was one of the first medical schools in the city to change its mind and apply to plan a Regional Medical Program. Part of the reason was that Memorial Hospital for Cancer, which is closely affiliated with Cornell, felt that it could get some money from RMP for some of its already existing programs. It looked to nearby Cornell as the medical school with which to form a Regional Medical Program. Downstate Medical School also applied to organize a Regional Medical Program at the urging of some of its affiliated hospitals. Subsequently several other medical schools also began writing applications for their own RMP.

Washington, however, insisted that in keeping with Congressional intent, “there should not be a region for each medical school.” (See Box, Page 4.) This decision was made in part to avoid the fragmentation of a natural region, New York City, and in part to avoid the political problem of deciding how to parcel Manhattan among its five medical schools. So the medical schools and the New York Academy of Medicine formed a corporation, the Associated Medical Schools of Greater New York, Inc., which was awarded a two-year planning grant for the New York Metropolitan Regional Medical Program. Cornell Dean, John Deitrick, was chosen to be President for the first year of planning.

The Deans, although not enthusiastic about the Program, were determined to control it through their new corporation. Of the various agencies other than medical schools that expressed interest in becoming trustees of the corporation, only the prestigious New York Academy of Medicine had enough political clout to get a seat. Health and Hospital Planning Council [See Council story, Page 6.] and the City’s Health Services Administration were relegated to the back seats. They were only given representation on the advisory committee along with the medical societies.

“Closed Shop”

Under the national RMP Guidelines this advisory committee was supposed to be a broadly representative group with considerable power to prevent the Program from neglecting the consumer and provider interests of the region. It was to have had the responsibility for approving all applications for operational grants. But the Deans made it a subversive group. As a recent Federal audit declared, the Deans “were in a position to dictate the decisions and evaluations required of the advisory committee.”

As of 1968, 17 members of the 45-member advisory committee were connected to medical schools or to their affiliates. The remainder of the committee was hardly representative of the community. The “public” representatives were mostly Wall Street businessmen and philanthropists. Also listed as a “public representative” was the vice president of the Health and Hospital Planning Council. Medicine’s own out-groups were excluded from membership. There were no unaffiliated physicians on the committee and there were no representatives from the smaller voluntary hospitals or the proprietors. As if all these safeguards’s against unwelcome “advice” were not enough, the Deans kept for themselves the powers of choosing a chairman for the advisory committee and changing its by-laws.

Having emasculated the advisory committee, the Deans next turned to weaken the program’s central staff, which, according to their own grant proposal, was supposed to be “responsible for coordinating the activities carried on by the staff located at the medical schools and for the proper allocation and reallocation of resources within the project.” Instead, the Deans set up a decentralized structure, resting heavily on staff located in the various medical schools. They gave their appointed central director no say in the selection of the local staff. Each school (and the Academy too) simply took $45,000 each year to pay for whatever local RMP staff it wanted. One of the coordinators was not even seen by the Director during the year he was there. The Deans also decided that the coordinators were actually their representatives as well as staff of the project. So the coordinators often substituted for the Deans at the meetings of the Trustees. The Director often found his “staff” acting as his boss.

Regional Medical Specialization

When the central staff did try to take initiative to broaden the interest of the program, their efforts were obstructed by the Deans. For instance, the Deans objected to the involvement of the central staff with the Model Cities Program. When the staff member who was the liaison between the programs left RMP, the involvement with Model Cities was quietly forgotten. The Deans also frowned upon the attempts of the Director
A House Divided: View From The Top

THE "HEALTH NEW DEAL" of the Johnson Administration was more than just Medicare and Medicaid. The medical liberals who helped shape the 89th Congress’ health policy believed that it was not enough just to finance medical care for the indigent—the best in medical care had to be made available to all. President Johnson’s Commission on Heart Disease, Cancer and Stroke had stated, “a significant number of Americans with heart disease, cancer, stroke and related diseases die or are disabled because the benefits of present knowledge in the medical sciences are not uniformly available throughout the country.” So the Regional Medical Program (RMP, Public Law 89-239, October 6, 1965) was enacted “to afford to the medical profession and the medical institutions of the Nation the opportunity of making available to their patients the latest advances in the diagnosis and treatment of heart disease, cancer, stroke and related diseases.”

The Commission wanted to provide the best in medical care by establishing a national medical system, at least for the killer diseases. They envisioned establishing regional research centers, diagnostic and treatment stations in teaching hospitals, and a network to link the centers, stations and community hospitals. However, Congress replaced the Commission’s blueprint with the vague concept of “regional cooperative arrangements” among the existing health resources for research, training and demonstrations of patient care.

But who was to plan and implement the “regional cooperative arrangements”? Who was to have the responsibility of making sure that the best in medical care was made available to all? Although the law does not specify this, it was clearly the intent of Congress that the medical schools should have this responsibility. Congress saw RMP “extending the influence of the medical teaching center beyond the confines of the university.” With RMP, Congress threw out a loose, open invitation to the medical schools for leadership. Strangely enough, the American Association of Medical Colleges (AAMC) was not unanimously enthused about RMP. AAMC is divided into two main camps: the ivory tower patricians, and the more expansionary, service-oriented liberals. The former view is summed up in a 1953 AAMC report co-authored by John Dietrick. Dietrick and Berson warned against “building up large empires which serve as welfare and semicharitable institutions, steadily spreading their influence and control over many segments of health care.” The expansionary view, summed up in the Coggeshall Report of 1965 declared that the medical schools “should be appraising the needs of society for health care and health personnel” and “developing and implementing plans to meet those needs.” Dietrick and Berson were worried about the effects of “expansionist policies” upon the medical schools. “[The] already enormous and rapid growth of the service activities of the medical schools is a drain on the time and energy of the faculties and on the finances of many schools. The extension of service activities beyond those needed to support a medical school’s educational program already threatens the education of the medical student.” The Coggeshall Report was worried about what would happen if the medical schools didn’t expand their responsibility: “Failure to do so will damage the standing of the profession and educational institution and will invite—even make necessary less desirable approaches,” such as the direct “intervention of the government.” Dietrick and Berson wanted to preserve the traditional role of the medical school, the role of excellence in research and education. The Coggeshall Report was concerned with preserving the entire voluntary free enterprise medical system.

Thus, on the national level, it was with much hesitation and even passive resistance that the medical schools embarked on the Regional Medical venture.

ANATOMY

(From Page 3)

to fund a Student Health Project in New York. Although the Student Health Project was finally funded by RMP, it was not by the metropolitan program, but by Washington directly.

When the central staff suggested to the Deans that the medical schools become more involved in the continuing education of the unaffiliated physicians, they met vigorous resistance and even resentment. Dietrick, who was then president of the board of trustees, suggested that “the larger voluntary hospitals might undertake a program to upgrade medical education by providing better training for house and attending staffs and allied health personnel.” The medical schools were thought not to have a role and the unaffiliated doctors were to be ignored.

Last October, the Director was finally fired for being too independent of the Deans. Most of the central staff have since left the program.

The New York Metropolitan RMP is now undergoing a reorganization which promises, if anything, to strengthen the control of the medical schools. The advisory committee is being made more representative. Its membership has been increased from 45 to 87 and will probably be increased to two hundred. A new Director was appointed in March and the central staff will have been fully restored by July. However, the medical schools are still in control. An advisory committee of over two hundred members will probably be little more than a rubber stamp for its steering committee, which will be just as dominated by the medical schools as was the old advisory committee and steering committee.

Business As Usual

Although the medical schools control RMP, they have neglected it. The Deans thwarted the attempts of leadership by the central staff, yet provided no leadership of their own. The Deans declared that they were responsible for the policy determination for RMP, that they would set the priorities, determine the program direction, and the philosophy of the local RMP. But, they haven’t. They had doubts about RMP from the beginning and these doubts have not given way to enthusiasm. One Dean is quoted as saying, “Sometimes when I go to bed at night, I hope that when I wake up in the morning, RMP will have disappeared.” As a result of the lack of leadership, priorities were never established and very little planning was done.

The annual report of New York RMP suggests that the medical schools spent what little energy they could spare for RMP dividing up the turf. Downstate Medical Center got Brooklyn; Einstein, the Bronx; Columbia took upper Manhattan; Mount Sinai and New York Medical College shared East Harlem and part of Queens; Cornell got Westchester and the rest of Queens. Actually, of course, the medical schools did
not develop borough-wide or regional responsibilities just because of RMP. The medical school RMP coordinators, whose function was supposedly to stimulate grant applications in their entire region, rarely bothered to look outside their own institutions and affiliates. In New York City, then, RMP served to strengthen the existing medical empires. [See December, 1968 BULLETIN.]

Rich Get Richer

Unaffiliated hospitals, which fall between the city's empires, have been effectively shut out of RMP. When it comes to grant writing, it's hard enough for a small hospital to compete with a granted-padded major medical center. But it's virtually impossible to compete with major medical centers which have special relations to RMP staff and leadership. RMP staff were not very sympathetic to the requests of small hospitals for more help in writing grants. In an editorial in the RMP newsletter, the RMP Director wondered disdainfully: "If the applicants have neither the time nor talent to describe clearly what will be done by the project, will they have the ability to conduct it?" Once a grant is written, it faces a volunteer review committee composed largely of experts from the major teaching hospitals, who have tended to fund their own institutions. One doctor was actually a member of the committee which reviewed his own grant application. A pulmonary center was awarded to Columbia rather than to a small hospital in Queens because of Columbia's "proven ability." Thus the rich get richer.

Considering the lack of leadership in the program, it is not surprising that only 51 applications were submitted in the two years of planning. Half of these were from Downstate where there was leadership by the local coordinator. This low number of applications reflects also the lack of interest of the medical school faculties in community projects. For example, NYU School of Medicine's Dean Thomas can not find anyone in his faculty to write a grant for an urban health institute, an institute that he has been pushing for the last year as his medical school's contribution to the solution of the urban medical care crisis.

More disturbing than the paucity of grant applications is the quality of the applications. While most have scientific merit, very few are relevant to the intent of RMP to improve patient care. Most represent narrow institutional interests cloaked in the new rhetoric of the Regional Medical Program. Of the 51 applications received in the last two years, only seven have been approved by the advisory committee (two have been funded so far), 16 have been rejected or withdrawn and the rest are either being reviewed, revised or developed.

Counter-Demonstration Projects

The two projects which have been funded after all this are little more than a mockery both of the planning process which is supposed to be part of RMP and of the purpose of the program. One of these, the application for the Pediatric Pulmonary Center at Babies Hospital at Columbia, was quickly solicited and pushed through the advisory committee. It appears that Central RMP in Washington was given some money earmarked for pulmonary centers that had to be spent within a month. Washington asked the RMP in New York to quickly dig up a pulmonary center. The other funded project, the Mobile Coronary Care Unit at St. Vincent's Hospital, was planned long before RMP was established in New York. When the Heart Association didn't fund it, it was submitted to RMP.

In its application, Babies Hospital proposed a pediatric pulmonary center that appeared to be exactly the kind of integration and extension of services the RMP was supposed to encourage. Babies proposed to extend the use of specialized procedures in the diagnosis and management of chronic respiratory diseases by fusing a number of existing clinics and laboratories into a single pediatric pulmonary disease center and tightening its existing affiliation arrangements with six metropolitan hospitals. However, a federal audit has shown that Babies Hospital has done little to implement its proposal. It took the money, hired a few more researchers and continued functioning as usual.

The Mobile Coronary Care Unit, a specially equipped ambulance, at St. Vincent's, will probably never benefit anyone but the community served by St. Vincent's. It provides on the spot emergency treatment to heart attack victims. This is an expensive and therefore hard to imitate demonstration project. It is basically a luxury. The money could have been better spent upgrading the training of ambulance attendants throughout the city or improving the existing inadequate arrangements among hospitals for the acceptance of ambulance patients.

The one other project in New York that is funded by RMP is the Study of the Care of Cancer Patients at Memorial Hospital. This did not have to bother with advisory committee review and approval, however. Washington made funding the Memorial project, which was begun long before RMP started, part of the original RMP planning grant.

Surveys, Not Service

Of the five grants that have been approved and have just been sent to Washington for review, one is for a continuing education project at Downstate, the rest are surveys and registries. A tumor registry has been proposed by Downstate; a hemiplegia registry, by Grasslands Hospital; (associated with New York Medical College); a survey of acute cerebrovascular disease, by Kings County (Brooklyn); and a study of facilities and services for respiratory diseases, by a TB association. The best that RMP can offer New York City after two years of planning and two million dollars seems to be just more surveys.

The Regional Medical Program was conceived as a bold new departure in which, through planning, advances in medical science could be rapidly parlayed into improvements in patient care. In New York, the program was destroyed by the very institutions it aimed to enlist. The medical schools failed to lead RMP and failed to use it for anything beyond their own narrow institutional interests. Much the same story appears to be true elsewhere in the nation. Congress and the Nixon Administration have acknowledged the failure of RMP by sharp cutbacks in funds. It is almost a truism now that the American medical system must be reorganized. Who is going to lead the task of coordinating and organizing a patient-centered American medical system? The failure of RMP shows that we cannot look to the medical schools for leadership.

—Mills Matheson
DURING THE LAST YEAR, the Health and Hospital Planning Council (HHPC) has lost some of its delusions of grandeur. For 20 years or more it was essentially the only regional health planning agency. A year ago it faced a rosy future as the best qualified group to be the local comprehensive health planning agency under the Federal Comprehensive Health Planning Act of 1966. It saw itself, in the words of its annual report, “free from the pressures of political expediency yet sensitive to the needs and desires of local groups,” possessing “wisdom and courage in making the hard planning decisions,” taking “strong stands in recommending against narrowly conceived or inadequate proposals by hospitals.”

But now the HHPC is fearful for its very existence. It seems probable that comprehensive health planning powers will be given to a new planning agency, with strong municipal and community representation. This will make HHPC ineligible for direct federal assistance (which currently amounts to half of HHPC’s budget) unless it can contract with the new comprehensive planning agency to do part of the health facilities planning. But if the community has any power in the new agency, few contracts are likely to come HHPC’s way. Despite its self-image as an even-handed arbiter of the health needs of the city, HHPC has repeatedly been discredited as a tool of the voluntary hospitals and of Blue Cross.

Health and Hospital Planning Council, like Blue Cross, was a child of the Depression. The Depression brought financial disaster to the voluntary hospitals as the poor crowded into the Municipal hospitals, leaving thousands of empty private beds in the voluntaries. In its search to ensure the economic wellbeing of the voluntaries, the United Hospital Fund, then as now the leading institution of the voluntary medical establishment, formed the Hospital Council (which has since become HHPC) and a local Blue Cross plan. Blue Cross was to ensure that there were enough paying patients. The Hospital Council was to ensure that there weren’t too many beds.

Despite the Depression there was a 6.6 percent increase in hospital beds in New York City between 1930 and 1935. This terrified most of the voluntaries; they had visions of losing their increasingly rare paying patients to the hospitals with newer facilities. They were also terrified that the Municipal hospitals with an occupancy rate of 97.2 percent (compared to 68.8 percent for the voluntaries) would expand and further draw patients away from the voluntary system. So the Hospital Council was formed in 1934 as an unincorporated voluntary association “to develop a coordinated hospital program for the City”. The Council took it upon itself to review all proposals for hospital construction with the criteria that no hospital project “be launched unless it can be shown to be necessary, timely, reasonably assured of support and wisely located.”

In 1937, the Hospital Survey, a study initiated by the United Hospital Fund, recommended that a “permanent, representative, and authoritative” central planning and coordinating body be established to save the community from the “extravagance and waste in hospital building and maintenance.” Its prestige enhanced by the recommendations of the Hospital Survey, the Hospital Council incorporated in 1938. Its only power to enforce its planning decisions was its ability to persuade benefactors of hospitals to withhold financial support from unapproved programs. In 1947 it got considerably more power when, as the regional agent for the Federal Hill-Burton Program hospital construction funds, it became itself a hospital benefactor. Between 1948 and 1963 it determined how over $21 million of hospital construction funds were spent in the City.

The financial distress of Blue Cross in the late fifties gave the planning movement in general and HHPC in particular a big boost. Increases in the cost of hospital care and in the utilization of hospitals threatened to bankrupt Blue Cross and its dependents, the voluntary hospitals. Up until the late 50’s Blue Cross had been able to pass its cost increases on to its subscribers. Between 1945 and 1963 Blue Cross in New York State increased its group rates for family coverage by 453 to 708 percent. By the late 50’s state insurance officials charged with regulating Blue Cross began to resist approving Blue Cross’s never-ending applications for rate increases, in some cases actually refusing them. Caught in the bind between increasing costs and the increasing resistance of state officials and threatened by competitive private insurance companies who offered cash benefits rather than service benefits, Blue Cross turned to regional planning as a way to control its costs.

But regional health planning meant little more to Blue Cross than stopping the construction of any new hospital beds or better still, reducing the number of beds. If there are fewer beds, fewer people can be filling them, and Blue Cross’s maximum liability is reduced. Restricting the number of beds also would lead to more optimal occupancy rates for the hospitals, so, by and large, their interests were met, too.

In some states such as Michigan, Blue Cross moved to enforce its planning by refusing to reimburse hospitals that had been constructed without its approval. However, this has proven to be a too blatantly selfish use of power and has been challenged (unsuccessfully) in the courts. In New York, Blue Cross lobbied successfully for laws that gave authority to regional planning agencies to review all hospital construction and renovation. The Hospital Council, more fashionably renamed the Hospital Review and Planning Council (and still later, the Health and Hospital Planning Council), was given this authority in 1954 for the New York City area. Although final authority to approve or disapprove hospital construction rests in the State Department of Health, the State rarely reverses the Council’s decisions.

To ensure that the Council had enough money to function “properly” under the new laws, Blue Cross (the Associated Hospital Service of New York) increased its annual support of the Council from $10,000 to $100,000. In 1968 the Council received over two thirds of its private (nongovernment) support from Blue Cross, the United Hospital Fund and the Greater New York Fund (whose health donations are distributed by the United Hospital Fund). Support from religious and labor groups amounted to less than 10 percent of the amount given by Blue Cross and the United Hospital Fund. Altogether, the private support makes up only about a quarter of the total budget; the rest comes from the State and Federal government.

Even within the HHPC, some have questioned the role of Blue Cross in health planning agencies. George Baehr, who is on the Board of Directors of the Health and Hospital Planning Council, has warned: “At the instigation of the Blue Cross plans, Hospital Review and Planning Councils in several states are now endeavoring to persuade state and local governmental...
authorities to deny approval for the construction of any additional hospital beds so that the number in their area may be kept to an irreducible minimum, and thereby "put the squeeze" on the medical profession. The existence of an excessive number of hospital beds in a community unquestionably encourages over-utilization. On the other hand, if controls are carried too far in an effort to keep down Blue Cross insurance rates through the device of bed scarcity, a serious public health hazard may be created."

In New York City, the Council's policy of limiting hospital construction has been quite successful: It has already produced a public health hazard. The New York Times has recently reported that the voluntary hospitals are crowded to the crisis point. They are now operating at an occupancy rate of 92 percent, far in excess of the 80 to 85 percent occupancy rate that most administrators consider wise. A man in imminent danger of losing his life usually can get a bed somewhere but often it is a second- or third-rate hospital instead of the well equipped, well staffed one where he would have the best chance of survival. It is probably the proprietary (profit-making) hospitals which have benefited the most from the Council's bed-limiting policy. They are now operating at 86 percent of capacity whereas they were operating as recently as 1960 at 71 percent of capacity.

The Council has also contributed to the critical shortage of ambulatory services and nursing home beds. Although the Council has given lip service to the need for these facilities, it often conveniently forgets about them when justifying its policies. In the last decade the number of nursing home beds in the City has fallen increasingly behind needs. There were fewer nursing home beds in 1966 than in 1960. Medicare and a State loan program for nursing home construction spurred a dramatic increase in nursing home construction but the need is still largely unmet. As of January 1968 there were 18,482 nursing home beds, just 1,450 more than in 1960 when the Council stated that there was a need of 13,000 more beds.

The Council has done its best to keep down the number of nursing home beds. Using its 1962 pre-Medicare estimates of nursing home bed needs, the Council announced in February of 1967 that they had already approved enough applications for nursing home construction to eliminate all the need. They then stopped processing applications, letting a huge backlog pile up. The next year they reconsidered and decided that 3,000 more beds were actually needed.

HHPC has stopped pretending to do objective health planning and has openly become the voluntary hospitals' apologists. [See Box, this page.] According to some observers the Council has been so busy developing the art of apology that it has lost the technical expertise which has been its main advertisement. For instance, the Council recently failed to live up to a contract to deliver data. Late in 1967 the New York Metropolitan Regional Medical Program (RMP) made a sweetheart contract with the Council to supply RMP [see RMP story, Page 3] with statistical data, mainly data on the city's unaffiliated physicians. Compiling this data was essentially a mechanical job which, according to some RMP staff, could have been done in two weeks by two clerks. The Council got $250,000 and 20 weeks. But data promised for May 31, 1968, wasn't delivered until May, 1969—a year late, and then only after Federal auditors had urged RMP to get its money back.

If HHPC dies, as expected, with the birth of a New York City Comprehensive Health Planning Agency, there will be few mourners. Community groups have long since recognized HHPC as the chief front-man for death-dealing hospital reduction decisions. Other planning agencies, municipal health planners as well as RMP, know better than to count on HHPC for routine data, much less longterm planning considerations. Even HHPC's voluntary hospital and philanthropic member agencies, who have long benefited from HHPC's permissive "planning", would probably not go out of their way to defend the discredited Council. (The new Comprehensive Health Planning Agency might well serve as a more plausible front anyway.) Understandably, HHPC refuses to recognize the depth of the dissatisfaction it has aroused. Instead, it feels done in by politicians, bureaucrats and irresponsible agitators. It refuses to acknowledge that there are hundreds of thousands of health service consumers, beating on the doors, demanding to be let in on the planning process.

—Mills Matheson
Who Prints The Blueprints?

A HIGH-LEVEL DECISION to build, or rebuild, a City hospital is just the beginning of the process leading to actual construction. The two major steps on the road to a completed facility are functional architectural programming and, a recent addition, master planning.

The architectural programming for all New York City hospitals is done by the Health Services Administration's (HSA's) programming and planning unit, Health-SPACE (Space, Planning, Architecture, Construction and Equipment). Created only two years ago, Health-SPACE was the City's major attempt to solve the tremendous bottlenecks in coordination and construction of City health facilities.

SPACE's first job was to coordinate construction and development of all facilities run by the Departments of Health and Hospitals and the Community Mental Health Board and expedite purchasing of equipment. In its first months, SPACE was fully occupied assembling information on the various City health facilities, the equipment needs, the administrative procedures for purchasing, etc. Once that data had been collected and mechanisms created for keeping it up to date, Health-SPACE took on the more ambitious role of functional programmer for City health and mental health facilities.

Functional programming translates health programs into staff and space requirements. From the space requirements, the size of site and the costs of construction can be estimated; a site can be chosen and a building designed.

As SPACE functional programmers set to work, they quickly discovered a need to know more about health care itself. In the case of community mental health centers (SPACE reviews plans submitted by hospitals which intend to run the mental health center programs), SPACE people needed a set of standards. After reviewing reams of literature and many examples of mental health centers, they found they couldn't do the job without learning a great deal about psychiatry, mental health, and treatment of mental "illness." Since experience and intuition provide the only clues to the relationship of floor-space and staff specifications to functions, functional programmers found themselves on shaky ground—making non-technical judgments in order to come up with usable programs. Thus some feel that good functional programming requires the kind of understanding of the local situation that only local groups can provide.

Consumer involvement in the translation of health needs into health facilities, to the extent it exists at all, has been rather remote from the functional programmers. For instance, when there is a question or problem about a particular hospital, the Hospitals Commissioner or the administrator of that hospital deals with the community. Lloyd Siegel, the head of SPACE, believes that since SPACE serves as the technical arm of the HSA, the proper relationship of SPACE to the communities is through the administrators of the local City hospitals—on the assumption that local administrators are in constant touch with their communities.

While functional planning was conceptually a great leap forward, it did not itself get facilities built. And while expediting construction seems to be helping get facilities built, it did not help to integrate health care and health facilities with one another and with other community needs. Something which could integrate functional programs into a total health care strategy seemed necessary.

The hospital "master planning" program was designed to fill this need. The master plan lays out a long-term strategy for the development of a hospital center. It fills the inevitable time lag between the decision to build and the opening of a complete facility, stressing the need for flexibility, the ability to respond to changing community needs and health care practices, and the relationships of health facilities and other community facilities such as housing.

Master plans are prepared by architectural consultants. Because the health facilities process is fragmented (construction divided between City and State and perhaps soon to be handled by new City Health and Hospitals Corporation), the contracts for hospital master plans are held by several different agencies. For example, Chapman and Garber's plan for Harlem Hospital Center was prepared for the Department of Public Works, while Russo and Sonder's plan for Metropolitan Hospital Center will be done for Health-SPACE. Health-SPACE, however, is supervising all of the master planning, regardless of which agency actually contracts with the architects. [See Box, this page.]

There is general agreement among the SPACE and consultant architects that "master plan" is something of a misnomer, implying more integration with planning for other community needs than actually exists. Ideally, master planning would integrate information on excellent health care with structural plans for delivering that care—a combination of functional programming with a strategy for building. It would integrate community judgment of needs and priorities with plans for providing health care—both in the functional programming and in the strategy for getting things done. And it would integrate plans for health care facilities with plans for the total development of an area—its housing, its schools, its environmental quality.

It is unlikely that the present hospital master planning

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**Plans & Planners**

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(8)
COMMUNITY PARTICIPATION IN PLANNING, up until now, has almost always taken the form of stopping someone else's plans. Since most public and private health planning is well insulated from public view, particularly in the early stages, communities often learn of the existence of a plan only when their houses are slated for demolition or ground is broken. Little wonder then that community action is directed at halting the plans. There is no alternative. The following two case studies are examples of community groups that got in on the act of planning earlier, but not early enough. Both communities valiantly struggled to define positive roles for themselves in the planning process. But the establishment's response turned these attempts into negative results, so that building was delayed in one instance, and programs were removed without replacement in the other.

FORDHAM CITY HOSPITAL, BRONX—The case of the Hospital Community Advisory Board vs. public planning officials:
In October 1968, Fordham Hospital's administrator announced to the Community Advisory Board that the hospital would be moved to a different location within the area served by the hospital. Out of seven possible sites, one or two had been selected for presentation to the City's Site Selection Board. The Community Advisory Board objected strenuously. Why hadn't it been consulted earlier in the planning process? How could it form an intelligent opinion without access to information on all the sites?

The Community Advisory Board decided to take action. First, it needed all the information necessary to make a reasoned judgement about site location. Second, and more important, it wanted to establish the principle of community participation in the planning process. To accomplish the first aim, the board obtained its own planning advisor, who was assigned to collect information and report back to the advisory board.

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process in New York will achieve these goals. Since each hospital's master plan is prepared separately, the master plans cannot deal with citywide health needs or distribution of health facilities. "Areawide planning," Mr. Siegel points out, "is something quite different." Functional programmers and master planners are finding, after intensive research, that no one really knows what good health care really is. Those technic "are aware of the areas they are planning, (2) they want to see plans implemented and good care provided, and (3) they regard community involvement as essential to developing a good plan and to implementing the plan. They are therefore anxious to meet with community groups—for ideas and review of ideas and to enlist support for the resulting proposals. Architects do seek out community groups but must do so rather randomly. It seems likely that they will wind up working with those groups they feel comfortable with and who feel comfortable with them. And, whether or not that happens, no one can be sure they are getting any substantial representation of community views.

For the architects, the operational question vis-a-vis community involvement is whom to talk to and how to set up an ongoing, productive dialogue. (Chapman and Garber have even written into their master plan for Harlem a proposal for a hospital board including community people—other than recommending it to the City, they have no way to help create a public process for community involvement.)

For the communities, the question is basically whether or not talking to the architects is going to be worth the time, since hospital master plans are at best only a series of recommendations for City strategy with respect to City health services. The first completed master plan document is just now being submitted by Chapman and Garber. It remains to be seen whether master plans will have any effect or whether decisions will continue to be made the same old way—with the voluntary affiliates determining what happens on the basis of their own priorities.

—Ruth Glick
THE LOWER EAST SIDE NEIGHBORHOOD HEALTH COUNCIL—South, GOUVERNEUR HOSPITAL—The case of the Lower East Side Neighborhood Health Council-South vs. Beth Israel Medical Center:

Some critics of community participation in planning argue that, while it is relatively easy to arouse a community about a hospital site (which threatens their housing), it is very difficult to mobilize people about program. The reason, they feel, is that community groups lack the expertise and overview necessary to understand the complexities of medical programs. The Lower East Side Neighborhood Health Council South's (LESNHC-So) attempt to influence Gouverneur Hospital’s health services disproves this cynical view of the community.

The LSNH-So has developed an increasingly sophisticated approach to program priorities. When Beth Israel (the affiliating hospital for the Gouverneur Health Services) turned over its 175 page plus proposal for OEO funds to the Health Council, as mandated by OEO regulations, few thought the Health Council would be able to master the document. To Beth Israel’s surprise and consternation, the Health Council’s review of the proposal included a thorough analysis and some severe criticism of the hospital’s program priorities with an explicit statement of the Council’s own priorities and appropriate justification. The health council acknowledged that the basic program of the Gouverneur Health Services should remain the provision of comprehensive health care delivered through family health units (team practice) with emphasis on prevention and continuity. They vetoed a “cognitive testing” program to be carried out by the Department of Behavioral Sciences at Gouverneur, an obviously research rather than service oriented endeavor. Also, they succeeded in replacing the ameliorative “patient guide” program suggested by Beth Israel with a “health advocate” program to be sponsored by the health council. This latter program had the potential for establishing a patients’ grievance mechanism at Gouverneur. However, they argued, certain additional programs were essential to meeting community health needs. These were: (1) a narcotics treatment and outreach program; (2) an employees training and career ladder program; (3) a Saturday clinic and improved transportation facilities for patients; (4) a lead poisoning detection program.

The value of community priority-setting is in terms of the community’s perception of need. Often, this perception is more sophisticated than the expert’s understanding, and it always expresses a greater sense of urgency. For instance, Beth Israel is dubious that lead poisoning is a problem on the Lower East Side, since it has treated fewer than one case of acute intoxication per year. Though aware of the problem, the Health Council had a real sense of urgency about the problem. A recent survey at Bellevue Hospital (on the Lower East Side) seems to validate the community’s concern. Bellevue’s patients come from housing similar to the housing of Gouverneur’s patients. Since Bellevue has become more sensitive to the lead problem and adopted new screening tests, four cases of lead intoxication have been hospitalized in one month.

The Health Council had taken its role seriously, but Beth Israel had not. All the effort at detailed review of the Beth Israel proposal brought only negative results. Beth Israel ignored the community’s positive program suggestions, omitting the narcotics program, training program, and lead poisoning detection program from the proposal they sent to OEO. OEO then slapped the Health Council in the face by cutting its meager budget from $32,000 per year to $1,500 per year. This eliminated the health advocacy program and left only enough money to pay transportation for health council members to council meetings, a minimum requirement to meet OEO guidelines vis-a-vis community participation. Thus the changes wrought by the Council’s program planning efforts turned out to be largely exclusionary. Perhaps the real problems were that the health council was polite and that it had only advisory powers. It may be true that new programs can be mandated only by communities that really control the planning process.

—Ruth Glick
Oliver Fein, M.D.
Behind Closed Doors

The New York City Health and Hospitals Corporation act was no sooner signed into law than it went underground for weeks of secret, top-level planning. The job of setting up the Corporation's internal management structure goes (under a fat contract) to McKinsey & Co., a private consulting firm which is also being paid to install a Defense Department-style program/planning/budgeting system (PPBS) in all City agencies. Meanwhile, all the City's miscellaneous philanthropy and hospital special interest groups are scrambling for seats on the Corporation's Board of Directors. The City Council has five seats to hand out, and will be opening them up for bids any day now. The Mayor intends to use the five seats he has to dispense to ensure elite domination of the Board, and is shopping around for individuals with a "corporate, financial or legal background." All the rhetoric about "community involvement" which preceded the Corporation bill's passage has been discretely forgotten.

Blackened Blue Cross

Blue Cross's fading "public service" image evaporated with its latest request for rate increases. The rate increase will hit hardest at the poor, that is, blacks, Puerto Ricans and the elderly. Meanwhile, Blue Cross's own claims to poverty are being sharply challenged by the New York State Assembly Insurance Committee.

Dissection of the requested rate increases shows that Blue Cross aims for the same low-risk, low-responsibility role as its profit-making counterparts in the insurance industry. While rates for certain categories of group subscribers are untouched, direct pay rates will rise as service is cut. People on direct pay rates include the self-employed (small shopkeepers as well as rich doctors), the retired, and workers in small, often marginal establishments, such as drug stores and groceries.

Another provision of the Blue Cross proposal amounts to a set-up for future rate increases. Blue Cross wants to raise rates for "community"-rated groups, thereby forcing them to submit to "experience"-rating. Under community-rating, all groups of a given type, whether they use few or many services, pay the same rate. This means that expenses are averaged out between low-risk groups (generally those containing young, middle-income people) and high risk groups (poorer and older people). Low-risk groups have tended to opt out of community-rating to experience-rating—where their rates reflect the experience of their group alone, unblemished by the high-risk groups in the "community." What's left over in the community-rated groups is increasingly the medical bad bets. Raising their rates, while holding those of experience-rated groups steady is thus another attack on those most in need of service and least able to pay. Pressuring them to shift to experience-rating has the same effect, since it will result in eventual rate increases for these groups.

Blue Cross blames the rate increases on steeply rising hospital costs. But Blue Cross itself is one of the forces behind the hospital cost explosion. Over the years, Blue Cross has made on attempt to force hospitals to operate efficiently and thriftily. It has paid the hospitals whatever they claimed as their "costs," with few questions asked. A recent president of the American Hospital Association enjoined Blue Cross not to act as a "defender of its subscribers against the hospital rather than as an agency for the prepayment of hospital care as it is determined to be by the hospitals and the doctors." Blue Cross served its masters well.

Letters to Editor

Community At Heart?

Dear HEALTH-PAC:

In Dr. Fill's [Comm., Community Mental Health Board] letter published in the June BULLETIN, he states that the CMHB is "... seeking genuine development of community input . . . in giving communities the responsibility and the funding for the planning and development of services. Where a community group becomes a legal incorporated body, we have accepted it as the responsible agent and sought funding." If Dr. Fill's relationship with the West Harlem-Washington Heights-Inwood Community Mental Health Council is any example, his remarks above appear quite disingenuous.

First of all, it is extremely difficult to get incorporation papers that provide for community-consumer control and development of any health services. The New York State Department of Social Services must approve all incorporation papers of organizations planning to relate to health services. If the community group plans to build and run a clinic, the State Department of Health must first inspect and license that clinic before the Department of Social Service will approve incorporation. However, for the community group to build the clinic, it must first receive funds and to receive funds it must first be incorporated. Thus, any community which plans to develop and control its own, new health services shouldn't hold its breath.

To avoid delay in the community's development of a clinic, it is necessary for the community group to contract out to an already existing health facility. . . . But before an institution like Columbia University will sign contracts with a community group [it] will insist that it control the administration of, and the setting of priorities for the proposed service, thereby negating the entire concept of community control. The CMHB has been pressuring the [local] Mental Health Council to turn to Columbia University as the chief provider of services in order to accelerate the community's incorporation papers. At the same time, however, they are emasculating the powers of the community and negating the principles of meaningful community participation . . .

The [local] Mental Health Council, in its attempt to become truly representative, has developed education and information committees. However, . . . they need funds to handle the preparation and mailing of notification of and minutes from Council meetings. When asked for CMHB funds for postage expenses, Dr. Fill said that if the Council wanted funds it should have cooperated with Columbia University in the first place, because it was up to Columbia to decide
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whether it wanted to share funds with the Council. When questioned whether some other institution in the catchment area might share CMHB funds with the Council, he stated he would have to take it up with the Board of Estimate. Such is Dr. Fill’s interest in the community’s development of their own services.

—Richard Kunnes, M.D.
Department of Psychiatry
Columbia University

From the Empire
Dear HEALTH-PAC:
There is much good analysis in [Einstein-Montefiore “Medical Empire” Issue]. There are many constructive insights and much justified criticism. However, I wish to point out . . . these errors [among others]:
There was indeed a threat of dismissal [of free-protesting Jacobi Pediatrics house staff] by a minor assistant administrator which was immediately counteracted by the chief administrator of Jacobi Hospital. When I, as a representative of the “Einstein affiliation” was told to prevent the house officers passing out leaflets, etc. I told the administrator in no uncertain terms that both I and the Einstein department involved supported the house officers . . . both I and Dr. Einhorn, the chief of the pediatric service at Lincoln Hospital brought the matter of ambulance service forcibly to the attention of the Commissioner of Hospitals and his assistants and were told by these people that nothing could be done and that hopefully in the future these ambulance services would be run by the Fire Department. I do not see how this is the fault of the affiliation group.
We have as much to do with ambulance service as you do. We have been fighting this problem for the last fourteen years . . .
The pediatric services, both at Jacobi and Lincoln Hospitals, have no selective admissions practices, either for teaching or for research. Children are admitted if they need medical care and are often admitted for “social” reasons . . . . The patient load this year at the Bronx Municipal Hospital Center on Pediatrics has been running close to 100 percent. We have been told by the nurses who are not affiliated that if we admit beyond 100 percent of capacity they will quit . . .
The operation of the affiliation program has much that merits criticism but it has not made things worse. In 1958, the Pediatric service at Lincoln Hospital was about to collapse. There was one part-time attending physician. There were no pediatric residents. There were a few pathetic rotating interns rotating through this service. There were many thousands of patients. The Pediatric service of the Albert Einstein College of Medicine took over this responsibility with no budget whatsoever . . . . It was not until 1961 when Commissioner Trussell took over that we had any kind of a contract to run the Pediatric service . . . . If anyone thinks that the affiliation program with the Lincoln Department of Pediatrics is worse than it was before, he just doesn’t know the situation.
Small community projects could indeed hire a few saintly, primary physicians. I assure you they will not be able to hire radiologists, anesthesiologists, surgeons, ophthalmologists and all of the other groups which are so essential in running hospitals. If you are one who feels that medical care in the South Bronx should collapse totally in order that it become a complete disaster area, then perhaps the affiliation should be stopped immediately, but if any sort of medical care is to be given to the people of the South Bronx it will have to be under the auspices of medical colleges and well-endowed voluntary hospitals. You might not like this, nor might I, but it is a fact of life . . . .
—Lewis M. Fraad, M.D.
Professor of Pediatrics
Bronx Municipal Hospital Center
Albert Einstein College of Medicine

On The Record
Dear HEALTH-PAC:
Your latest sweeping denunciation of the Affiliation record [HEALTH-PAC BULLETIN, April 1969] cannot go unchallenged, containing as it does misstatements and misinterpretations of the facts.
There is no doubt at all that there has been qualitative improvement in medical care in those of the affiliated hospitals where it had steadily declined over a 20 year period. A careful study of medical records—which you have certainly not undertaken but which I have, clearly shows this to be true. I agree that the milieu in which this care is provided has not improved significantly but remains deplorable . . . . [But] the Affiliation program should not be indicted for failures on the part of the City to match professional improvement with similar improvement in non-professional areas. It would be less than realistic to claim the Affiliations have provided ideal medical care at every level. Our out-patient and emergency care is far from what it should be but there is progress despite your disclaimers.
The solution you purpose—Community Control—will not be a panacea. You fail to recognize that establishing community control will not guarantee that good doctors will be attracted to work in such institutions. I am still naive enough to believe that good doctors are still a prerequisite for good medical care . . .
—Paul W. Spear, M.D.
Director of Medicine
President of the Medical Board,
Morrisania-Montefiore Affiliation