EXPROPRIATING THE PUBLIC’S HEALTH

THE HEADY WINE OF “HEALTH AS A RIGHT FOR ALL” HAS BEEN CRUELLY AND FINALLY EVAPORATED WITH THE LATEST STATE MEDICAID CUTS. APPARENTLY GONE WITH IT, AS THE RECENT CITY HEALTH BUDGET CUTBACKS SHOW, ARE PAST PROMISES OF UNIFIED PUBLIC LEADERSHIP IN HEALTH AND COMPREHENSIVE REFORM OF THE MUNICIPAL HOSPITALS.

The expropriation of the public sector is almost complete. If the City budget cuts go through, some City hospitals may be closed and vital paramedical staffs may be cut at many others. Preventive, ambulatory, and emergency services at many City institutions will be the first to go. Many people will literally be pushed into the streets at the very time voluntary hospitals will be cutting back their services because of Medicaid cuts.

Many of the causes of this tragic collapsing of the “Health New Deal” and the breaking of the “health bank” in New York City must be traced to Albany, Washington, Saigon, and the inflationary and unproductive contradictions of the health private enterprise system in America. Nationally we are in a period of expanding war expenditure, ABM as well as Vietnam, and of domestic social welfare cutbacks. The “War on the City” just conducted by the recent backlash session of the State Assembly will be showing up in the social cost accounting for years.

The State/Federal Medicaid package may have been full of holes, but much could have been salvaged from it before all the funds ran out. Health and hospitals officials have not spent the past three years reorganizing City regulatory structures to most effectively use and control Medicaid funds. They have not worked to capture Medicaid funds to strengthen local public sector hospital and health service capacities. The City not only lost opportunities through top level inaction on Medicaid; it lost ground. Three years of concerted neglect of the City hospitals and casual management of the Medicaid funds set the stage for this spring’s full-scale fiscal disaster.

The latest, deepest State Medical cuts challenged the City to rise to the occasion and assume responsibility for its people’s health. At the very least, the City could have reasserted its traditional role as the provider of “last resort.” But the City opted to retreat still further from an already-shrinking responsibility. Faced with the immediate prospect that private hospitals will be dumping Medicaid-ineligibles into the streets, the City cut into the heart of Municipal hospital appropriations. In fact, this year’s $400 million City hospital appropriation represents an effective decrease of 10 percent compared to last year’s budget. At the same time, the City has set aside an implausible 40 percent increase in Medicaid-tied funds for private providers. In the politics of health budgeting, the private medical establishment takes clear priority over the disenfranchised constituency of the Municipal hospitals.

The Municipal hospitals found no defenders downtown. Looking forward to the tightest year yet, Department of Hospitals’ officials were unconcerned about the cuts—if not actively in collusion with the budget cutters. Not only did the Hospital Department fail to rally opposition to the cuts, it rebuffed the health-defense forces which did emerge. Rather than joining with the medical boards, house staffs, hospital workers and community residents to fight the cuts as literally life and death matters, City hospital administrators quietly worked out their plans for reducing services. With shouts of protest ringing in Municipal hospitals around the City, hospital officials met to decide which hospitals could be closed, which services could be reduced, and how much paramedical staff could be suspended.

After all, the City hospital officials had other things on their minds when the cuts hit. Over the last two years,
City officials have been busy, honing and hustling their plan for wrapping City hospitals with a "public benefit" corporation. Shamlessly, they used the financial crisis this spring as fanfare for the unveiling of this latest public authority. When the Municipal hospitals' lay boards met to consider the budget crisis, the Hospital Commissioner attempted to twist the occasion into a public endorsement of the Corporation. But when community residents and workers at one City hospital rallied to protest the Corporation as well as the budget cuts, they were threatened by the hospital administrator with police intervention. Thanks to the Hospitals Department's excellent selling job, the Corporation and the budget cuts are linked in consumers' minds as the spring's twin health law-and-order measures.

The Corporation and the budget cuts are only the most recent, and most painful, evidence of the City health system's fiscal and administrative bankruptcy. Most of the promises of the mid-60's Health New Deal have ebbed into oblivion in the wake of diminishing public funds and public commitment. The Health Services Administration (HSA), the City super-agency which was to unite the central health agencies into a common thrust, is atrophying through disuse and disability. Plans for a city-wide comprehensive health planning agency have skidded to a dead halt. An ambitious program for a city-wide network of neighborhood health centers has been forgotten by all but a few still-hopeful community groups.

A mood of increasingly sophisticated frustration—knowing where it's not at—is rising among consumers and health workers. At a recent Harlem health conference, the audience heard out the official apologists for the drain of money, institutional resources and planning initiative from the City government. When it was over, a woman in the audience demanded of the City officials, "So what do we need you for?"

The credibility of any kind of public leadership in health in the City is now on the line. The public knows it cannot expect the private medical empires to yield academic and professional prerogatives even in the face of overwhelming public need. And the public knows too, not to count on the public health officials going to bat for the public in the struggle for limited health resources. It was in this spirit of growing impatience with public non-leadership that Harlem chose to take a chance for a breakaway corporation of its own—rather than wait for any stirring of life "downtown." More and more, people realize that who controls public budget totals, priorities and channeling is not a side-issue. Community-worker control is not a luxury of participation but a self-defense necessity.

What emerged in the recent budget showdown is the advance guard of a massive, city-wide, community and worker health constituency. Roughly aligned over the single issue of defense of the public health resources, these forces now face the necessity for real community control over allocation of murderousclosc public health care funds. Basic imperatives are becoming clear:

- Maintenance, not closing, of vital City hospitals and health services, the last and often the only resort for the medically neediest;
- Expansion, not folding, of basic preventive, ambulatory and emergency services in hospitals;
- Adding vital paramedical workers, not cutting them out simply to maintain physicians' incomes and income increases;
- Acceleration, not cutting back, of more convenient, comprehensive ambulatory care centers and services in the neediest neighborhoods;
- Reorganization of City hospitals into more effective and responsible service delivery patterns, rather than haphazard physician-chasing;
- An end to loosely channeling the heart of public funds to private institutions without assuring absolute continuity, convenience, and quality of service for all;
- An end to arbitrary dumping by the voluntary hospitals and private professionals of the medically indigent.

What role is left for New York City's discredited central health officialdom in this new environment of harsh budgetary realism and even harsher health needs? If they are to regain public confidence lost during the spring crisis, in fact, if they are even any longer to be called "public"—they will have to accept the presence and the power of the growing public health constituency. They will have to work with this new constituency, and for it, on dramatic new initiatives:

First, to pull together a positive continuing role for the City hospitals and health services, now that it is so widely understood that the fickle and discriminatory private institutions cannot be counted on to serve the neediest public effectively; in fact, in the face of overwhelming public health constituency. They will have to work with this new constituency, and for it, on dramatic new initiatives:

Second, to crack down on existing permissive public subsidy of private institutions through Medicaid and affiliations. If the City's public health officialdom is not ready to take such initiatives, many communities will see no choice but to withdraw, in anger, from an increasingly empty "social contract" with the City government. But when the City government is ready to stand up to private medical interests and demand public medicine, when it is ready to stand up to the Federal government and demand funds for urban services, then perhaps it might be ready to lead. That might just be the day when the acknowledgement rings out from even the most bitter islands in the City: "We need each other!"
MEDICAID BEGAN IN 1966 just as the war in Viet Nam hit full stride. Medicaid began to die two years (and $100 billion of war effort) later. For a few months in between, for a couple of million New Yorkers, health care was free. Health care—if you could find it—was a right. Teeth were filled, glasses were fitted, hearts were checked in a long, long overdue medical shopping spree. It's all, or almost all, over now and time to take a hard, cold look at Medicaid: What did it buy? How much did it cost? Would we do it again if we had the money?

The answers echoing from the frontlines are bitter. “Medicaid set health care in New York City back 30 years,” says one veteran hospital physician, “Now, we're just picking up the pieces.” Starting in late 1966, Medicaid hit New York City's medical marketplace like a flash flood. What's left is an altogether new game:

The stakes are higher. Uncontrolled medical inflation was the price of Medicaid's meagre benefits to the poor. Medicaid-inflated costs shoved millions of New Yorkers into medical indigency and onto the brink of welfare.

The rules are different. The City government's historic role was the provision of care for both the indigent and the “medically indigent”—those too rich for welfare and too poor for health care. Now the City's commitment extends not a penny past Albany's 19th century definitions of poverty. What's more, the City's ability to guarantee care, as opposed to just money for care, has deteriorated. Municipal hospital budgets have been starved to feed the rising cost of private sector care.

There are fewer players. Squeezed between rising costs of care and sinking definitions of medical indigency, thousands of consumers have vanished from the medical care scene.

Medicaid Hits NYC

There were no “good old days” in the city's health history, but the old days were not that bad, either. Before Medicaid New York City's commitment to health care for the poor was heavier than that of any other city in the country. The City held itself medically responsible for all welfare recipients, all victims of TB, and all the “medically indigent.” Although the State reimbursed the City for the care of families earning less than $5200, the City defined medical indigency flexibly, case by case. As it worked out, people in families earning less than about $6000 a year were likely to qualify for free City care. To care for all these people the City operated 21 Municipal hospitals, whose clinics were free to anyone who couldn’t afford to pay. In addition, the City paid (at low, fixed rates) for “its people” in voluntary hospital wards and outpatient departments (OPD's). Still, the City's “welfare medicine” was a poorly integrated patchwork of often shoddy material.

Because of its already “high” standards, New York City was the pace-setter (and eventually the bank-buster) for Medicaid nationally. New York State set its income eligibility limit at $6000 a year for a family of four, compared to the runner-up, California with $3900. For the eligible, there was a full range of services, twice as many as mandated by Federal law. Rich as this program later seemed to many conservative congressmen, it was not quantitatively much different from what New York City had offered before.

Medicaid was different, though, in two important ways. For the poor, Medicaid meant not just guaranteed health care but a free choice of the source of care. For the City, Medicaid meant an initially unlimited amount of State and Federal matching money for health expenses. Except for AMA-oriented professionals, everyone agreed that these two features of Medicaid guaranteed an end to charity care, and the beginning of an age in which everyone would enjoy the “mainstream of modern medicine.” Everyone did not agree, however, on how this would all come about. Many private medical leaders [see Winter BULLETIN on the Corporation] saw the change occurring as people exercised their free choice, “obviously” opting for private, rather than City facilities. Gradually the City hospitals would empty out, and the City would have no choice but to turn the buildings over to the private sector.

Officials in the newly organized Health Services Administration (HSA) sized up the situation somewhat differently. HSA's former chief, Dr. Howard Brown, focussed on the financial aspect of Medicaid. He saw that the new State and Federal money could be used to upgrade Municipal facilities, by renovating City hospitals and creating a host of new “Neighborhood Family Care Centers” along the lines of the Governor Ambulatory Care Unit. At the same time, the immense new quantities of money could be used as a lever on the private sector—to raise the standards of private hospital and physician care, and to ensure that all doors would be open to the sick poor.

For all these good intentions, Medicaid hit the City government almost wholly unprepared. “We didn’t know what we were getting into,” says one former Medicaid official—how much would it cost, how many people would participate and what it would take to administer the program. Administration was shared, ungraciously, by the Department of Health and the Department of Social Services (Welfare). With less than a million a year for staff, the Health Department people embarked on a heroic effort to monitor the private practitioners participating in Medicaid. [See BOX, Page 5]. Meanwhile, the Department of Social Services applied $20 million worth of its bureaucracy to policing patient eligibility and validating doctors' claims.

(Continued Page 4)
Cutting Up Care . . .

May, 1966: New York State Medicaid program begins. The nation's richest, it featured:

ELIGIBILITY: The only criterion was income—less than $6000 for a family of four. Ownership of a home, a car and assets up to $1000 per family member did not affect eligibility.

PEOPLE COVERED: An estimated 3 million New Yorkers of whom about 50 percent were not on welfare.

April, 1968: Federal Medicaid cutbacks sparked State cutbacks, leaving:

ELIGIBILITY: The upper income limit was cut from $6000 to $5300 for a family of four. All people between the ages of 21 and 65 were excluded except: (1) welfare recipients, (2) the blind or disabled, (3) pregnant women starting from the fourth month and continuing to the sixth week after delivery, (4) the "catastrophically" ill, i.e., those whose inpatient costs exceed 25 percent of their income.

PEOPLE COVERED: At the time of the cutback, 2.2 million New Yorkers were enrolled. 700,000 were cut off: 100,000 people of all ages because of the new income criterion, and 600,000 non-welfare recipients between the ages of 21 and 65. This left 1.5 million people enrolled in Medicaid, and an estimated 500,000 more eligible but not yet enrolled. About 40 percent of the city's Medicaid eligibles were now non-welfare recipients.

April, 1969: Further Federal cutbacks touch off further State cutbacks, leaving:

ELIGIBILITY: The upper income level has been cut from $5300 to $5000 for a family of four. In addition, allowable assets have been reduced from $1000 to $500 per person, with a maximum of $200 per family. This means that a family must spend its own money on medical care until it is left with only $2000. Non-welfare Medicaid recipients must now pay the first 20 percent of their outpatient bills themselves.

PEOPLE COVERED: The new income criterion will cut off approximately 206,000 people. This will leave about 1.8 million people on Medicaid, of whom only 33 percent are working people.

FIVE STEPS

(From Page 3)

In spite of the enormous weight of the administrative machinery brought to bear on Medicaid, no one sat on top, watching where the money was going and who was getting what for it. Medicaid was handled like any other welfare program—the Department of Social Services stamped the forms and the Controller signed the checks. The City agency which stood by and drifted off to the private sector.

To attract Medicaid-eligibles. Perhaps the Department of Hospitals was waiting to see if all the City patients would eventually drift off to the private sector.

Most of the people never made it to the private sector. Utilization of the Municipal hospitals has declined since Medicaid began, but far less than was initially expected. Comparing the years 1966 and 1968, one finds that the City hospitals experienced an 8 percent decline in inpatient-days, a 16 percent decline in OPD visits and an 8 percent decline in emergency room visits. (These are city-wide averages. There was considerable variation from hospital to hospital and between services within hospitals.) Today the City hospitals are still overcrowded in terms of their manpower capacity, and are still the major provider of medical care for the poor.

The interesting question is not, "How many people did the City hospitals lose?" but "What did people who left them gain?" Where did they go and what services did they find there? The answers could be pieced together from the reams of Medicaid bills and enrollment forms stacked in the Department of Social Services—and before the City embarks on another experiment in medical financing, it is essential that this be done. For the time being, though, the only hard data we have are the changes in Municipal hospital utilization. The story they tell about Medicaid is not an altogether happy one.

The decline in inpatient utilization (general care only): People began deserting City beds when the Medicare program began and continued when Medicaid started. At the same time, voluntary and proprietary hospitals reported gains in utilization. The exodus from the City to the private sector stopped, though, in October 1967, when the City had experienced only a 4 percent decline in patient days. At this point the private hospitals apparently achieved near maximum occupancy rates, and stopped crowding in Medicaid and Medicare patients. Comparing 1966 and 1967, voluntary occupancy rates rose from 84 to 86 percent, proprietary rates rose from 79 to 85 percent, and Municipal rates fell from 77 to 75 percent.

This pattern of occupancy rates has been economically unhealthy for the City hospital system. Empty beds are almost as expensive to maintain as full beds, and of course, empty beds don't bring in any Medicaid or Medicare money. Still, hospitals have to leave some beds empty in case of emergencies. In effect, the Municipal hospital system now serves as the "safety margin" for the entire private sector: Voluntary hospitals have let their occupancy rates soar over 90 percent, knowing that the Municipal hospitals can absorb any occasional overflows.

Another disturbing feature of the 1966/1967 shifts in inpatient utilization was the sudden boom in proprietary hospitals. Unlike the voluntaries, proprietaries do not have to preserve a "charitable" facade. They steer clear of unprofitable activities, such as outpatient care, emergency care, and often even maternal care. And of course, prior to Medicaid, they did not serve any medically indigent patients. While they may have offered the Medicaid patients many amenities lacking in the wards of nonprofit hospitals, proprietaries are notoriously casual about technical standards of care. In fact, proprietaries did not become eligible for the receipt of public funds for the care of the poor until Medicaid and Medicare came along. The new public money did not bring higher quality, however. According to a recent medical audit, only a small percentage of New York's proprietaries live up to the City's Proprietary Hospital Code.

The decline in Municipal OPD utilization: It was in outpatient services that the greatest decline in utilization was expected, since over 90 percent of the OPD visitors were Medicaid eligible in 1967, hence free to find their own family physicians. Some planners in HSA optimistically expected that Medicaid would "decompress" the Municipal OPD's to such a
The People's Choice?

One thing is clear: People did not rush out of the Municipal OPD's to exercise their right to a "free choice" of medical care. They left rather sluggishly, prodded by the $8, then $11 fees. "Ignorance and apathy"—the stock explanations of the health habits of the poor—cannot take the blame. Most people would have preferred something better than clinic care. For instance, a 1965 survey of Municipal OPD users (the Lerner study) found that, if money were not a problem, 38 percent of the patients would have preferred a private doctor, and 17 percent would have preferred some other hospital. Thus, up to 60 percent of the OPD users might have been expected to leave in 1967. However, the same survey showed that only 18 percent of the OPD users had recently used a private doctor. Another 33 percent had no source of care except the City hospital OPD they were interviewed in. This is not surprising. Even though New York has more doctors per capita than any other city in the nation, some of its ghetto areas have fewer than 10 practicing GP's per 100,000 people—a doctor density rivalling that of rural Mississippi. Furthermore, 60 percent of the New York City general practitioners chose not to treat Medicaid patients.

Who benefited from the "free choice" offered by Medicaid? No doubt thousands of people were able to use a doctor's office in their neighborhood, rather than a distant Municipal OPD. But for many more people, the only "free choice" was whether to get care in the Municipal OPD—or not to get care at all. Park Avenue aside, New York simply doesn't have a wealth of ambulatory care resources to choose from. One government official, a veteran Medicaid administrator said, "Free choice meant free choice for the provider, not for the patient. . . . The biggest thing wrong with Medicaid was 'free choice.'"

It was no surprise, then, when the 1968 Medicaid cutback came and no one rioted. The poor were not interested in medical care—they were unimpressed by Medicaid. In many respects, it was the private providers, far more than the consumers, who benefited from Medicaid funds, and it was the providers who raised the loudest protest at the cutback. In fact, the Health and Hospital Planning Council, the mouthpiece of the City's private medical establishment, was so moved by the impending 50 percent cutback in Medicaid reimbursements that it actually called (from its posh East Side offices) for public demonstrations.

The Good Guys . . .

The least advertised and potentially most revolutionary feature of Medicaid is not the money, but the power that comes with it. According to Dr. Lowell Bellin of the New York City Health Department, the real challenge of Medicaid is to fulfill "the heady tasks of standard-setting, surveillance, and enforcement of quality in every aspect and every locus of publicly funded, personal health care." So far, the State Health Department has done its best to prevent the City from actually using this mandate—by limiting the City's standard-setting powers and by cutting City Health Department funds for Medicaid quality control operation. So far the only "locus of publicly funded personal health care" which the State conceives to its surveillance is the private practitioner's office. A City-drawn code for hospital clinic care, which would have forced humanizing changes in OPD care, has been blocked in Albany because it sets higher standards than the State's code. But in the limited arena of private practice, the City Health Department has undertaken a pioneering program of quality control.

With the help of the Health Department, teams composed of general practitioners, dentists, pharmacists, etc., each drew up standards for their own specialty. These "peer group" standards enable the Health Department to detect any glaring abnormalities among the bills submitted by the doctors. Unusually high bills, peculiar uniformities of diagnosis or treatment, or even consumer complaints, are enough to set the Health-men out on an on-site investigation. The errant practitioner is first urged to conform, then threatened with expulsion from the Medicaid program.

Nation-wide, most observers agree that the City Medicaid monitoring program has been of historic importance. It set a precedent for direct public regulation, with on-site intervention. It will probably have a lasting effect on the quality of care offered by many of the City's solo practitioners.

So, if the local Medicaid-monitoring program goes out of business soon, it won't be because tough public health regulation is politically impossible. It will be because the State doesn't think it's worthwhile. Last year the whole program ran on $600,000 (almost entirely State money), and this year it will have to trim down to a $500,000 budget. Something like three times as much would be required to "really do the job right," according to one top official. Compare these sums with the $20 million a year spent by the Department of Social Services to process Medicaid bills and applications: Apparently the City and the State are more concerned about not paying for "undeserving patients" than they are about not paying undeserving practitioners.
Five Steps
(From Page 5)

Hospitals were dropping too, so no new shift was underway.

The “mystery” of the disappearing patients was finally cleared up by interns and residents at Jacobi Hospital’s pedi-

atrlic clinic: Patients were not coming to the Municipal clinics because they couldn’t afford the fee, which had by this time soared to $16. In an unprecedented patients-rights protest, Jacobi house staff publicly told their patients not to pay, and to mail the bills to Hospitals Commissioner Terenzio. In re-

sponse to the protest, clinic fees were re-set on a scale which slides from $2 to $16. Even with these “nominal” fees, many clinic doctors are alarmed at continuing declines in clinic utilization. People are “saving” by skipping vital preventive

services such as prenatal check-ups.

The Department of Hospitals, however, is remaining calm. In its 1968 Annual Report, released in April, 1969, hospital com-

missioner Terenzio observes cryptically:

“Since many factors influence the choice pa-

tients make in the procurement of medical care, it is difficult to positively document the correlation between the Medicaid cutback and decreased utilization of (municipal) hospital services. Nonetheless the substantial reduc-
tion of Medicaid financial support may well have a bearing on the declining in-patient census, as well as the decrease in the number of outpatients.”

Where The Money Went

Medicaid brought hundreds of millions of State and Federal health dollars into New York City. In the three years since Medicaid began, the City’s total health bill (including State and Federal funds) has leaped from under $500 million to over $1 billion. Three quarters of this money flows, willy-nilly, through the City Medicaid program. $750 million is not small change— it represents about 15 percent of the City’s total budget. Yet no governmental official can give a clear accounting of how this money is spent. Some rough impressions, pieced together from the City budget and Health Department figures, are:

- About 80 percent goes to hospitals. Less than 7 percent goes to “family doctors.” The rest is for dentists, drugs, x-rays, etc.
- Less than a third (somewhat over $200 million) goes to the City hospitals (although they cost about $400 mil-

lion per year to run.
- More than a third goes to private hospitals and proprietary hospitals.
- Altogether, about a third goes for items and services which are sold at a profit: drugs, nursing home and proprietary hospital care.

The peculiar thing about Medicaid money is that the more you spend, the less it’s worth. In the first year of the Medicaid (and Medicare) program, doctors’ fees rose 2.4 times as fast as the overall cost of living. Hospital costs rose 5 times as fast as the cost of living. One private hospital is charging Medicaid $37 per clinic visit! (See “Before and After” Box Page 3.) A reasonable increase in hospital prices should have been expected in the late ’60’s— because of higher wages for nonprofessionals, the high costs of new life-saving equipment, etc. But costs never would have risen so high, so fast without Medicaid and Medicare. According to law, Med-

icaid must pay each hospital exactly what that hospital claims as its cost for rendering a service. Thus, each year, the private

hospitals tell the State and City what they expect their costs to be. The City not only has to give them the required amount in advance, it has to set aside a sum (about $20 million) to cover any cost increases that may occur in the course of the year!

(One of the 1969 amendments to the New York State Med-

caid law would freeze the amounts at which hospitals can be reimbursed. Chances are, though, that this amendment will be ruled illegal by HEW.)

The trouble with reimbursing hospitals at their “costs” is not only that it’s expensive, but that it’s uncontrollably ex-
pensive. As a former administrator of the City’s Medicaid pro-

gram, Ray Alexander, pointed out: Under Medicaid, there’s no incentive for a hospital to be efficient. In fact, the incentive is to be inefficient. It was because of the wildly and irrespon-
sibly escalating hospital costs—not because of “abuse” by patients or fee-hustling by private doctors—that Congress slashed Medicaid in 1968.

Policy Impact of Medicaid

Initially, Medicaid was seen as easing the City’s load in an already heavy commitment to health spending. But because of unexpectedly high costs, Medicaid turned out to be a major new drain on the City tax dollar. The City found itself committed to paying 30 percent of the bill—a bill which rose higher every month. Most of the money did not return to City facilities; it flowed out to the private sector through an open-ended account. As the Mayor pointed out in this year’s budget message, 71 percent of all the State and Federal funds brought into the City by Medicaid since 1966 went to the private sector. Only 29 percent went to City hospitals.

Why did the City hospitals, which still care for over half of the medically indigent, gain so little from Medicaid? Much of the blame lies with the Department of Hospitals itself. For many months after Medicaid began, the City hospitals were extremely lax about enrolling their patients. While many voluntary hospitals took on the responsibility of seeing that Medicaid application forms were correctly filled out by their patients, the City hospitals left this task to the welfare bureaucrats. By July 1967, only 60 percent of Municipal OPD users were enrolled in Medicaid, at an estimated loss to the City of about $15 million. Additional, unknown sums were lost to the City hospitals through what amounts to theft. In some City OPD’s, the name of the City hospital’s voluntary affiliate was listed on patients’ Medicaid forms as the recipient for the Medicaid reimbursement.

The City hospitals not only failed to profit from Medicaid, they have probably suffered a net loss. Under Medicaid, the City could do little—that is, little which would not have in-

volved stepping on politically sensitive toes—to check the flow of funds to the private sector. The only politically safe way of controlling the costs of the Medicaid program was to clamp down on funds for the Municipal hospitals. This was done, in part, by withholding Medicaid funds which were due to the City hospitals. State Senator Seymour Thaler estimates that the City Budget Bureau has been “saving” about $100 million City hospital Medicaid dollars a year. Through this and other forms of fiscal sleight of hand, the City has been able to reduce its share of the City hospital budget substantially, thanks to Medicaid. [See Box, Page 3.]

This year’s City Budget brings out the inequities in health spending more sharply than ever. The City hospital budget has been increased by only 3 percent. Since inflation is running
UAW Be-Labors Health Insurance Plan

THE UNITED AUTO WORKERS, like most of us, are fed up with the health system. They see their hard-earned wage increases subsidizing built-in waste and inefficiency in an obsolete, non-workable non-system. They see that even with the best available insurance, they can't get comprehensive quality care. They see that their health care is getting worse. So now, they are mobilizing support for reform.

Walter Reuther is convinced that a national health insurance program must precede any basic changes in the health system. He sees national health insurance providing the economic leverage needed to create change. Hence, late last year, he formed the Committee for National Health Insurance (CNHI). CNHI now has over 40 members including many of the well know corporate liberals of medicine as well as business and labor liberals. It's uncertain whether this alliance will hold together long enough to get legislation through Congress: Labor wants decent medical care at a reasonable cost. Business wants to make sure that the cost is reasonable. And the medical corporate liberals want new money to finance their tottering empires.

Since its formation, CNHI has been organizing around a set of basic principles that everyone is to be covered and that the coverage is to be comprehensive. The program will provide for "the entire range of services required for the maintenance of personal health, for care and treatment of illness, and for medical rehabilitation." This will be quite a boon for the 30 million Americans under 65 who now don't have any health insurance, as well as the rest of America which is insured for only 35 percent of sickness costs.

However, CNHI's principles evade several key issues. For example, they don't say who is going to pay for the program. CNHI states that the program will be financed by contributions from employers, employees, self employed persons and Federal general tax revenues. But they do not indicate how much of the financing will come from each of these sources. That part of the financing coming from regressive payroll taxes could mean a heavy burden for poorly paid unorganized labor and marginal employers.

CNHI calls for "a proper and proportionate voice for the consumer on the advisory councils assisting in administer-

ing the program" and for "full public accountability for the financial activities of the program." But it stops short of calling for public administration of the program. Who CNHI wants to administer the program is not clear.

Blue Cross and the private insurance companies will all be after a piece of any new national insurance program. Being the carrier, the middleman between the government and the providers, is a nice safe cost-plus business, the next best thing to a defense contract. For Blue Cross it's a matter of life and death. If it doesn't get a large piece of a new national health insurance program, it may have to fold. If it does get a piece of the program, we may as well forget about a consumer voice and public accountability. Blue Cross is so dominated by provider interests that it could never be responsive to the public interest. Even its trademark is owned by the American Hospital Association.

Buried in CNHI's liberal rhetoric are several statements that may in the future be used to justify a program that falls short of comprehensive quality care. For example, "personal health care services should be provided under arrangements that are acceptable to the people to be served and to those who provide the services." Since present arrangements already please most of the providers, it's hard to be sure what CNHI wants.

There is considerable danger in Reuther's strategy of first financing and then reforming the system. On its journey through Congress, national health insurance may, like Medicare, adapt to the existing medical institutions and customs. Then national health insurance would provide money to strengthen the forces which are most opposed to rational reform. Essentially, it would provide semi-rational financing for an irrational system.

Actually, economic leverage to change the health system does not hinge on a new nationally financed health program. The sad fact is that the Federal government is not willing to use the economic leverage it does have through Medicaid and Medicare. It would rather save costs by cutting services than by changing such sacred medical customs as fee-for-service.

—Mills Matheson

at about 15 percent a year, this represents a hospital budget cut of about 10 percent. At the same time, appropriations for private providers (chiefly Medicaid funds), have been increased by a whopping 40 percent. There is a self-reinforcing quality to the City hospital budget cuts: Reduced funds mean reduced services which mean reduced utilization. Reduced utilization can then be used to justify the next year's cuts.

What is happening, then, is a far-reaching change in the City's entire pattern of health spending. In 1966, less than 25 percent of the City's health dollar went to private providers. Now the figure is up to 40 percent, and if amounts spent on affiliation contracts were included, one would find that over half the City health dollar goes to the private sector. The problem is not that this money is handed over to the private sector, but that it is handed over with virtually no guarantees to private providers. Now the figure is up to 40 percent, and if amounts spent on affiliation contracts were included, one would find that over half the City health dollar goes to the private sector.

The residue of Medicaid, now that it has been cut to a near-meaningless level, is the wreckage of the City's 40-year-old public health and hospital system. The City has less to offer, to fewer people and at greater cost, than at any other time since the Depression.

—Barbara Ehrenreich
WHAT GOES UP, COMES DOWN

GREAT EXPECTATIONS were raised by Medicare (Title 19) of the Social Security Act, the “sleeper amendment” adopted by Congress together with Medicare (Title 18) in 1965. Medicaid promised to bring the poor into the “mainstream” of American medical care—not only the welfare poor, but also the working poor (medically indigent) for whom illness often spells financial disaster. Medicaid was projected by many—including the news media—as the medical “savior” of the medically indigent. But these expectations were shortlived. Once it realized the costs involved, Congress began to pare down the Medicaid program. First it cut people off by reducing income-level eligibility almost to the level of eligibility for welfare. Now it is reducing the number of services for which Medicaid will pay.

But these cuts should be no big surprise. Congress never intended Medicaid to be more than “welfare medicine.” If it had, Congress would have designed Medicaid to cover ALL the medically indigent—that is, all those people who cannot afford medical services after paying for food, clothing and shelter because their income is too low. Instead, Congress chose to base Medicaid on the existing welfare structure. This structure distinguishes two groups of welfare recipients: those that qualify for Federal welfare assistance and those that do not. Only certain categories, such as the blind and disabled, families with dependent children, and the aged over 65 years old qualify for Federal welfare assistance. All other welfare recipients are covered by State, County and City welfare programs. This latter group includes all welfare recipients between the ages of 21 and 65 who are not blind, disabled or the parent of a dependent child.

By designing Medicaid to fit the existing welfare structure Congress refused to give one penny for the medical care of poor people who did not qualify for Federal categorical assistance. Unless a medically indigent person were blind, disabled or the parent of a dependent child, no Federal matching funds were given to the State for Medicaid to cover him. Thus, the States were given no financial incentives through matching funds to cover a substantial portion of the population.

New York State was one of several states that included this 21-65 age group in their program, even though the State had to foot the entire bill for these people. This amounted to about 20 percent of the total Medicaid budget in New York State in November, 1967. But the size of the group was considerably larger—44 percent of those who received Medicaid payments. Though Medicaid seemed to promise that everyone who needed medical care would be able to pay for it, the States were not eager to enact the necessary programs without Federal financial incentive. Congress issued all the promises, but didn’t kick in money to cover all the people.

Medicaid’s “welfare medicine” aspects became more explicit in the 1967 amendments to Title 19. These amendments placed a ceiling on the family incomes above which Federal matching funds would not be available. States would no longer receive Federal reimbursement for those people whose incomes were greater than 133 1/3 percent of the standard State welfare payment. If this amounted to $3000 for a family of four, then any family of four with an income greater than $4000 was not officially medically indigent. If a State were willing to offer Medicaid to poor people whose incomes were greater than this ceiling, it would have to pick up the entire bill. In New York State prior to 1967 this income ceiling was set at $6000 for a family of four. Because of the 1967 amendments, New York has cut back its income eligibility to $5000, cutting off all those families with higher incomes.

With such halfhearted Federal commitment, it is no surprise that State participation was minimal. Only 38 states had operative programs by Spring 1968, and although several states have initiated programs since then, at least one (New Mexico) has dropped out. This patchwork participation was to be evened out by the Medicaid requirement that states “furnish comprehensive care and services to substantially all persons meeting the eligibility standards for needy and medically needy set forth in individual State plans by 1975.” As a threat to back up this requirement, Congress mandated each State to initiate a Medicaid plan by January 1, 1970 or else lose all future Federal assistance for medical care of the poor. It is clear that several states will be “unprepared” to meet this deadline. Already recommendations have been made to change the law so that no state will be labelled an outlaw. Medicaid expectations will be shattered once again.

It is obvious that Medicaid is far from a “national” program. Not only are eligibility standards different in each State,
to the level of a welfare program; now services are being cut. Anticipates saving another $238 million in reduced Federal charges the prevailing "lowest" Blue Shield rates.

The verbal brickbats flying between New York City and Albany this spring had an all too familiar ring, and citizens began to question whether the "crisis" was a camouflage. Curiously enough, the hospital cuts were announced before the City budget was written and before the State budget had even been approved. Suspicion heightened as the City Bureau of the Budget told their hospital administrators to whittle $8.8 million from their current operating budgets. As a result, Harlem Hospital temporarily closed down. Within weeks, Hospitals Commissioner Terenzio directed the City hospitals to cut $60 to $75 million from their projected 1969-1970 budgets, or (in the case of nine hospitals) to prepare to close. In most instances the administrators followed their leader's lead. To save their institutions, it was the medical boards' and doctors' turn to scream "crisis" and to begin lining up support from organized labor and the community.

The Bureau of the Budget axe struck a particularly cruel blow to the City hospitals this year. Each year the hospitals need at least 15 percent increase in funds just to meet salary and wage increases in an inflationary and competitive health industry, but this year the Hospitals Department received only a 4 percent increase, i.e., an effective cut of about 10 percent. This cut will be reflected in an actual decrease of services to people.

[Author's Note: As this BULLETIN went to press, Mayor Lindsay "found" $14 million for the hospitals. This is less than one third of the sum which would be required even to keep the hospitals running at last year's level.]

In New York City, where an apparently greater effort is made to find money after year to begin to meet the demands of policemen, firemen, sanitationmen and teachers, Mayor Lindsay and his administration proposed a moratorium on health care. The Mayor suggested three possibilities for belt tightening: (1) across the board cuts in the non-acute ambulatory services and outpatient and rehabilitation services; (2) the closing of selected hospitals; and (3) no longer taking responsibility for psychiatric or tubercular patients, with the hope the State would provide for that patient load; or a combination of the above. The threat of closing hospitals was not a new one. Last year the City suggested closing five hospitals to meet a $25 million budget gap.

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Postmortem
(From Page 9)

tion bill. It almost seemed as if the budget "crisis" were being used to drown any possible opposition to a corporation which would rid the City of the pesky task of dealing openly with a dying City hospital system.

In response to a threatened $8.8 million cut in the current (1968-1969) budget, Commissioner Terenzio slapped a "job freeze" on hiring of clinical personnel in the City hospitals. The nurses in the intensive care unit and the recovery room "froze" on hiring of clinical personnel in the City hospitals.

As the City budget hearing opened in early May, he said: "I don't think there's any chance of getting more money for the hospitals. As far as I'm concerned, the budget matter is closed!" But, is it closed? Other forces, intimately concerned with the continuation of City hospital service, say not.

Commissioner Terenzio was not particularly concerned about finding money to meet the 1969-1970 hospital crisis, however. As the City budget hearing opened in early May, he said: "I don't think there's any chance of getting more money for the hospitals. As far as I'm concerned, the budget matter is closed!" But, is it closed? Other forces, intimately concerned with the continuation of City hospital service, say not.

Public Officials: Before the City budget hearings (and while the State Legislature was still in session) politicians placed blame and passed the nonexistent buck. So far, of those who are running for office in the fall, none have chosen to give health and hospitals priority in their campaign platforms.

Among the more creative suggestions for meeting the crisis, Congressman Adam Clayton Powell called on Mayor Lindsay to close Gracie Mansion and suspend limousine service for City officials in order to keep Harlem Hospital open. He also called for a contribution from City officials to the tune of 5 percent of their salaries. State Senator Seymour Thaler and Manhattan Borough President Percy Sutton called for a State takeover of Municipal hospitals. Sutton stressed the necessity of strong community-worker boards if such a plan were implemented. Other Harlem politicos called for investigations of the use of Medicaid funds by the City. The Democratic City Council president suggested the Republican administration call on President Nixon for an emergency transfusion of Federal dollars.

City Hospital Medical Boards: Medical boards in recent years have generally represented the sentiments of the voluntary hospital or medical school which has agreed to staff a City hospital through an affiliation contract. These boards became understandably nervous when City "cutback" policy was reiterated by hospital administrators (who, as assistant commissioners, are directly responsible to the Department of Hospitals). Medical board threats ranged from cutting out services to pulling out of affiliation agreements altogether.

Bronx Municipal Center (including Jacobi and Van Etten City Hospitals) medical board has urged all other City hospitals to end all but emergency admissions and treatment by June 1. Earlier, the professional house staff and hospital workers in Local 1199 held a rally of more than 1,000 persons from Jacobi and declared they would curtail both inpatient and outpatient services if the budget were cut.

Elmhurst City Hospital (Queens) medical board plans to close only ambulatory services. Leaflets are being distributed warning patients that outpatient clinics will be closed July 1.

Lincoln Hospital (Bronx) has threatened to "terminate all services" if any single service is cut.

Morrisania Hospital (Bronx), which passed a resolution supporting the Hospital Corporation bill before it passed, has not only refused to cut its budget, but has asked for additional operating funds. Coney Island Hospital (Brooklyn) and Metropolitan Hospital (Manhattan) are expected to follow suit.

Queens Hospital Center, a City hospital staffed by Long Island Jewish Hospital (voluntary), may lose its professional staff. If the budget cuts are enacted, Long Island Jewish has threatened to discontinue its affiliation contract as of July 1.

Professional Staff in City Hospitals: A rising number of medical students, interns, residents and directors of ambulatory care in City hospitals are aligning themselves with community and worker forces to salvage outpatient clinics and emergency care. But most organized effort falls into the category of saving the institution at the expense of the patient.

The Society of Urban Physicians (SOUP) surfaced about the time of the Harlem Hospital crisis. It was formed last fall by chiefs of services of the City hospitals (many of whom are personally affiliated and on the staffs of voluntary hospitals) and its membership now includes three quarters of all such service chiefs. SOUP was an active advocate of the Hospital Corporation. They threatened to withhold Medicare and Medicaid fees from the City's general fund. This threat coincided with the final push to get hospital administration out of the City and into a corporation. SOUP says if the City doesn't restore the cuts, as well as add more money for hiring supporting personnel, that senior physicians will begin submitting their resignations. In a poll released to the press by the Society, its 300 members' opinions reflected: (1) 75 percent backed a plan calling for the resignations of all chiefs and associate chiefs of services if the money is not found, and (2) 69 percent supported the closing of all non-emergency Municipal hospital clinics if more money is not found. Technically the doctors do not have the authority to cancel clinics, but they can do so in effect by refusing to staff or supervise them. A spokesman for the group has said, "We refuse to participate in the budget slashes, thereby preserving over the
funeral of the City hospital system. . . . Confrontation is not the way doctors usually like to act and I feel sick about most of what we are doing. . . ."

The Committee of Interns and Residents (CIR), the bargaining agent for about 1500 doctors primarily at City hospitals, opted to work quietly behind the scenes for a solution. Its leaders combed diligently through Federal welfare legislation looking for places where Feds may have stashed some money which could be diverted to New York City hospitals. They saw hope in these provisions: (1) Federal reimbursement of up to 80 percent for the employment of welfare eligible persons, (2) Federal monies for training programs for hospital workers, and (3) Federal reimbursement for "social services" provided to welfare clients up to 75 percent. It took only one day for the doctors to learn from an HEW representative (who visited the City to view the hospital disaster area at CIR's behest) that the Federal social services bank is broken.

**Hospital Workers Unions:** District Council 37, AFSCME, has threatened to close down all City hospitals, if the City attempts to close down any one of them. Hospital Workers Local 1199 went further by saying they would close down the hospitals if any services are cut.

District Council 37 executive director, Victor Gotbaum, said of the crisis: "One of every five patients who die in the City hospitals do so unnecessarily because of the lack of personnel and equipment. . . . More blacks and Puerto Ricans have died in New York City because of inadequate medical care than in Watts, Newark and Detroit put together. AFSCME represents 21,000 non-professional hospital workers.

A leader of Local 1199, representing 3,000 hospital workers in City hospitals employed by voluntaries under the affiliation agreements, said: "To protect the health and safety of the patients, we will take appropriate action to prevent the delivery of the dangerously understaffed health services should the proposed cuts be instituted. . . . We will close the hospitals down."

**Hospital Community Advisory Boards:** These boards, which were appointed by the Hospitals Department and its local assistant commissioners and have not been noted for their militancy, met in emergency session to consider the hospital crisis. (Only 13 hospitals have advisory boards, some, though authorized, were never appointed and several had not met for a number of years.) The meeting was called by the most active of the Boards, the Fordham Hospital group. In its call the Fordham Hospital Advisory Board said: "The poor cannot tolerate further abuse and degradation. They are first to suffer in war. They are first to be victimized by political conspirators guilty of inhuman health cut-backs. . . . The buck passing must end. Billions of 'defense' dollars poured away must be used to rebuild our own cities, schools and hospitals. If not, our people will be 'defense-less' against the scourge of poverty, illiteracy and disease."

**Community Residents:** Since most City hospitals serve ghetto neighborhoods, many of their patients are affected by welfare cuts as well. A preliminary injunction preventing implementation of State welfare cuts obtained by City-Wide Coordinating Council for Welfare Rights is in effect pending a test of the constitutionality of the cuts. Special Welfare allowances affecting peoples' health which were cut entirely by the State legislature include: transportation fare to see a doctor, diet grants which provided for diabetics and pregnant women, and telephones which were installed for health emergencies.

Community involvement to fight the budget cuts has been sought (or listened to) by City officials and City hospital administrators only up to the point where community voices could be useful. The East Harlem Health Council called a meeting in mid-April of over 100 residents to discuss the crisis. They were determined to fight the cuts, especially after the hospital administrator said the outpatient clinics would be the first to be cut. The administrator said they could use the hospital lobby for a rally. Three days later, when the administrator found out that the rally would protest the formation of the hospitals corporation as well as the cuts, he threatened to have the group forcibly removed from the hospital. The morning of the rally 50 hospital guards armed with nightsticks greeted more than 200 demonstrators. The guards beat a hasty retreat when they spotted several politicians and clergy in the crowd. The rally was their first stop on the way to a public hearing at City Hall where they protested the formation of the hospital corporation.

The following week, the East Harlem Health Council called another meeting with community people. Also attending were members of the Metropolitan Medical Board, and some white professionals. The group resolved that it would accept no cuts in service at Metropolitan. They also resolved that National Hospital Week (which Metropolitan planned to celebrate in May) should be either cancelled or renamed "Hospital Disaster Week." When the Council met with the administrator to tell him of their stand he shocked the community representatives by blowing up and walking out of the meeting. Now the medical board and the East Harlem Health Council are allied in their determination to oust the unpopular administrator.

During the public budget hearings in early May, about 50 patients from the Gouverneur Ambulatory Care Unit (Lower East Side) joined several hundred workers from Local 1199 and professional house staff in a protest at City Hall. After a circuit of the City Hall Park, demonstrators raced up the front steps of City Hall where the City Council was conducting the hearings. Stopped at the doors by policemen who said that they could not enter because the hearing room was full (several people subsequently entered), the demonstrators held a spontaneous rally on the outside steps. As the rally began, mounted police emerged from behind City Hall and the City Hall doors opened and a wall of policemen moved down the steps, forcing the demonstrators to disperse.

Only a few months ago, when Hospitals Commissioner Terenzio submitted his budget request for hospitals to the Mayor, he heralded the present hospital disaster and (unwittingly) his own department's inability to build a public constituency and to fight for life and death health services:

"Hospital care is expensive. . . . If we are to have anything approaching first or even second-class hospital care, we are going to have to pay for it. "We are going backwards in our programs to improve the availability and accessibility of health care at the very time when the medically indigent population is rising and at a time when the present legitimate demands of a society (much better informed about health care) for improved community service ought to be met."

—Maxine Kenny
Corporation Puts Harlem in Business

THE CITY COUNCIL has passed the home rule message, Albany has passed the legislation, and the New York City Health and Hospitals Corporation is now a reality. The corporation bill was passed in spite of substantial community, worker, and professional opposition. And the bill which passed was not even the bill discussed at the only public hearing ever held on the corporation proposal, a City Council committee hearing on April 14.

A proposal to transfer management from public bureaucracies to a quasi-public corporation would not at first glance seem likely to attract much public notice, let alone opposition, and the outpouring of public anger and dissatisfaction seems to have surprised corporation backers. Opposition was, in fact, generated largely by the secrecy and the timing—both of which factors might have been expected to contribute to quick and unobtrusive passage. Communities were understandably suspicious and angry when they found that City officials had been working for a year and a half on a corporation proposal, instead of improving the delivery of medical care. They were also annoyed that all that work had been carried on in virtual secrecy—particularly as the City Council review approached. Then too, the corporation came into view at about the same time as the new City budget—with its proposed drastic cuts in money for health services. While some corporation proponents may have hoped that the budget crisis would deflect the public, it appears that the budget crisis intensified public concern for the future of City health services.

Support for the corporation came mainly from City officials, the voluntary hospitals and the New York Times. Among the many groups opposing the corporation at the public hearing were District Council 37 of AFSCME, prestigious voluntary civic agencies such as the Citizens Committee for Children and the Community Council, medical professional groups such as the Physicians Forum and the Medical Committee for Human Rights and a wide range of community groups including the East Harlem Health Council, NENA, Harlem CORE, and the Puerto Rican Guidance Center.

After the public hearing, and at least partly in response to the volume of criticism voiced there, the City rewrote the corporation bill again. (According to an official of the Department of Hospitals, this was the sixth time around.) Two significant changes were made at this time, both designed to create a new image of increased concern for public participation and public accountability. First, the size was expanded and method of appointment of the Corporation's Board of Directors was changed: Five directors will now be appointed by the Mayor, five more will be appointed by the City Council (this is unprecedented), five more will be ex officio city officials, and the last (the Executive Director) will be chosen by the other fifteen. Second, instead of one community advisory board whose purview would be limited to matters brought before it by the directors, each hospital will now have its own board whose purview would be limited to matters brought before it by the directors, each hospital will now have its own community advisory board. The definition of these boards' concerns has been left vague and open.

At the last minute in Albany, Harlem CORE hit the corporation bill with a running tackle. Failing to stop the bill, they did succeed in persuading the legislature to exempt Harlem Hospital from the provision that no subsidiary corporations can be created for at least two years. Back in Harlem, CORE and other groups are already moving into the space created by the "Harlem amendment." They are working to set up their own Corporation well before the "downtown" corporation gets off the ground.

Where does the passage of the Corporation bill leave other communities which are fighting for high quality, locally controlled health services? Far from ending the struggle, passage of the corporation bill seems to have f ocussed and defined it. Up for grabs are the community advisory boards mandated by the bill. Community groups in four or five areas of the city are already working to set up their community advisory boards before the Corporation moves in and appoints its own "advisors." There is already widespread muttering, though, about having to settle for an advisory role. All over the city, people are asking: If Harlem has its own corporation, why can't we?

Meanwhile, at the Department of Hospitals, officials are too busy scrambling for top Corporation posts to pay much attention to the community voices outside. They are confident that they can clear up the "misunderstanding" in Harlem by blocking approval of the Harlem amendment or failing to recognize any insurgent Harlem Corporation Board. They hope to placate other communities by putting "a couple of real grass-roots people" on the Board of Directors of the central Corporation. These moves are likely to run into even more trouble than did the corporation bill itself.

—Ruth Glick

Letters to Editor

Dear HEALTH-PAC:

Your recent issue (May, 1969) does not reflect the NYC Community Mental Health Board's goals and commitments at the present time.

We are particularly concerned that constructive efforts toward effective development of community boards is labelled "pacification"... We are seeking genuine development of community input, not only in terms of participation in policy making, but 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.

More specifically: (1) It is a matter of public record that, as early as 1965, the Community Mental Health Board voted in favor of establishing a Department of Mental Health; (2) Regarding the issue of whom the voluntary mental health clinics are serving, the NYSDMH reporting system was not equipped to reflect the population served by a specific facility until CMBH employed the Rand Corporation to extract such data from the clinic reports...; (3) The Board has been well aware of Bedford Stuyvesant's needs and has stimulated program development for the area. We are puzzled by HEALTH-PAC's reference to a sit-in in this regard; and (4) No funds have been allocated to St. Mary's, although CMBH is most anxious to develop Ocean-Hill services.

—J. HERBERT FILL, M.D.
Commissioner, CMHB