Health Policy Advisory Center
No. 36 December 1971

HEALTH/PAC
BULLETIN

CORPUS DELICTI:
HOSPITALS' CORP.

After sixteen months of life, the New York City Health and Hospitals Corporation enters its second winter—a season which promises to be its winter of discontent. Already the Corporation, its leadership, policies, and structure are under attack from all quarters. While criticism of the New York municipal hospital system is nothing new (see BULLETINS, Winter, 1969; April, 1970; January, 1971), the discredit which accompanies the Corporation's every move becomes newsworthy in light of current talk in health and government circles about bringing modern management techniques to the delivery of health care.

While the Health and Hospitals Corporation (which took over administration of the City's 18 municipal hospitals in June, 1970), bears few of the hallmarks of the Nixon Administration's Health Maintenance Organization (HMO) plan, they do share common philosophic roots. Both ideas are extensions of the belief that what's wrong with the health system is that it's inefficiently managed. In order to gain efficiency, Nixon, in the case of the HMO's, would turn the management over to the private sector profit-making financiers. Mayor Lindsay, in the case of the Corporation, turned management over to the cost-benefit analysis, efficiency experts of the McNamara school.

The corporation idea first started being seriously discussed in 1967, when the Commission on the Delivery of Personal Health Services (otherwise known as the Piel Commission after its chairman, Gerard Piel, editor of Scientific American) called for the replacement of the Department of Hospitals with a nonprofit health services corporation "to operate the City hospitals and health centers... undertake... physical and administrative repair... develop and operate system-wide... services... and... undertake the construction [and financing] of health facilities for operation by itself or by voluntary institutions."

When the Piel Commission and its suggestions for reform came to the fore, the municipal hospital system was going through one of its more highly publicized periods of crisis. At least half a dozen different investigations of hospital conditions had uncovered horror stories of patient neglect; deterioration of hospital plants; personnel shortages; backlogs of supplies; and multiple abuses of the affiliation program (under which private voluntary medical centers are contracted to provide professional services to the public municipal hospitals). No one could dispute the fact any longer that there were two classes of health care in New York City—public and private—and that the public was vastly inferior. In this atmosphere, the idea of a corporation or authority, as suggested in the Piel Report was seized upon. An authority, created by state enabling legislation, like the Port Authority, which would give "continuity, business efficiency and elastic management or operation of a self-supporting or revenue producing public enterprise" was just what the doctor ordered.

The Corporation's quasi-public, quasi-private nature was supposed to offer the best of both sectors, while at the same
time eliminating their evils. Hospital administrators, patients, workers, voluntary hospitals and community groups were assured—the Corporation would be all things to all people! Some of the basic claims for the Corporation included:

- Taking Health Care Out of Politics and Decentralizing Hospital Management
- Establishing the Fiscal Autonomy and Integrity of the Municipal Hospital System
- Equalizing the Two-Class Hospital System
- Speeding Up Construction of Facilities
- Insuring Public Accountability in Hospital Policy-Making

**Taking Health Care Out of Politics**

The Corporation was to lift hospital management above the vissitudes of partisan politics by being governed by an autonomous Board of Directors—empowered to choose a President for the Corporation and determine priorities and policies for the operation of the municipal hospital system. The Board consists of fifteen members—five 'public representatives' appointed by the City Council; five appointed by the Mayor; and five city agency heads who are in turn appointed to their agency jobs by the Mayor. One of these latter members, Gordon Chase, head of the Health Services Administration (a super-agency, which includes the Health Department and other city health agencies) is Chairman of the Board.

Although the Corporation gives the appearance of being governed by an autonomous Board, the Mayor is really the power behind the throne without having public accountability for its actions. He exercises this power through his appointments to the Board and through the Chairman of the Board, who in his capacity as head of the Health Services Administration, has responsibility for determining overall city health policy. If the Corporation is, as the New York Urban Coalition has stated, a 'political football', then the Mayor is the coach and Gordon Chase is the quarterback. (Chase's background and experience incidentally, typifies that of the management experts that have been brought in to run the city's health scene. He gained his credentials with the Agency for International Development, the State Department, and McGeorge Bundy's staff.)

Joseph English's job status (Corporation President) and security offer a classic illustration of the partisan political nature of the Corporation's business and the degree to which the Mayor controls even the most basic task of the Board, that of selecting a President for the Corporation. English came to the $65,000 presidency from Washington, where he had been chief psychiatrist for the Peace Corps and subsequently head of the Health Services and Mental Health Administration in the Department of Health, Education and Welfare. When the New Frontier turned into the Nixon Wasteland, English was appointed to his New York post as a Lindsay favor to Teddy Kennedy. Now that the Corporation has fallen under criticism, many are willing to blame him for all the Corporation's troubles. In July, rumors were flying around City Hall and the Corporation's offices that English was soon to be replaced. However in August, Lindsay changed his party and launched his presidential ambitions. Now English will stay around until he becomes too much of an embarrassment to Lindsay or until Lindsay can gracefully replace him. According to one Corporation watcher, "All Lindsay has to do is say the word and his Board members will have Joe out looking for another job."

The few dissident members of the Board complain that not only is the Board politically controlled, but that it is also irrelevant to Corporation policy-making. Not only do Board members have trouble getting information from the Corporation; but they are bypassed on important issues and their directives are not carried out by the Corporation staff.

One Board member, Vernal Cave, in a
letter to the Society of Urban Physicians (an organization of chiefs of service and full-time attending physicians at municipal hospitals), highlighted the impotence of the Board in reference to the controversial affiliation program: "Please be advised that the proposed affiliation contract was never reviewed by the Personnel Committee which is supposed to have the committee responsibility in these matters, nor reviewed by the Board as a whole. I, therefore, disassociate myself from any responsibility regarding its contents. A number of things that have been put out as Corporation policy have not had the input by the Directors of the Corporation." (italics added)

Another case of Board impotence came to light recently in the New York Times.

Decentralizing Hospital Management

The Corporation was supposed to foster autonomy within the municipal hospitals under its charge. One mechanism for autonomy was to be the decentralization of authority from the central office to hospital administrators. In his Annual Report,

---

**Critics' Choice**

"As an experiment in reorganization of total community health services, it [the Corporation] will be the most expansive and total effort ever undertaken in the United States."—New York Health and Hospitals Corporation planning document

Despite the advance work done for the New York City Health and Hospitals Corporation, its ad lib performance has met with derision from the reviewers and critics at large. The New York Times notes that at the Corporation's first public meeting in June, 1971: "Not one member of the audience offered a favorable comment on the new system..."; and that at another public hearing held in November, "A parade of witnesses told a special State Assembly yesterday that there has been no improvement in patient care since the municipal hospital system was taken over by the Health and Hospitals Corporation 16 months ago."

"When legislation was sought to establish the Health and Hospitals Corporation, critics expressed fears that the independent health authority would disregard public accountability and patient interests. These fears seem to have been substantiated."—New York City Urban Coalition letter to Corporation President

"... the Health and Hospitals Corporation has failed to achieve any recognizable degree of improvement in the organization and delivery of nursing care services. Since nursing care services are a major component of health care services, it is clear that health care within the municipal system remains at a deplorable level."—Eileen McCaul, New York State Nurses Association, in public testimony

"In evaluating progress made by the Corporation, we find that it has not only ignored the very people it professes to serve, but has also perpetuated a discriminatory, two-class system of health care."—New York Chapter, Medical Committee for Human Rights, in public testimony

"On the matter of accountability, we, as civic organizations, find that even less information is available on the performance of the Corporation than from its predecessor, the Department of Hospitals... Only if the public is informed can it be looked to for support."—Letter to the Editor of the New York Times, signed by officials of the Citizens Committee for Children; the Community Services Society of New York; New York City Public Health Association; New York Urban Coalition; and the Women's City Club of New York.
“So the effect of the Corporation, and the intent, was to place another layer of bureaucracy between City Hall and the poor.”

—Herman Badillo, U.S. Representative
Former Corporation Board Member

President English spoke in glowing terms of this success. “The critical process of decentralization has begun to make our hospitals more rapidly and efficiently responsive to local needs.” (President’s Report, June 11, 1971.) Hospital administrators beg to differ with English’s judgement.

At a recent Board meeting all eighteen administrators protested the reduction of their authority to allocate money for repairs to broken hospital equipment. In order to improve efficiency, the Corporation originally authorized the administrators to spend up to $10,000 per item for needed repairs and unanticipated equipment costs. This figure was reduced to $50 this past summer, when the Corporation admitted a severe fiscal crisis. This meant that just as in the old Department of Hospitals, vital equipment like EKG machines would go unused for months while the administrators waited to get the Corporation’s OK to spend money on the needed repairs. After their protest, the administrators’ spending authority was reinstated, only to be lost once more. Because of the latest fiscal crisis administrators have been instructed not to carry out any transactions until further notice from the Corporation.

What has really gotten the administrators’ ire up, however, are the budgets that the Corporation has figured out for each of the hospitals. The administrators were dismayed when the budgets came out at significantly lower levels (approximately $37 million in toto) than the administrators had been led to expect. Claiming that there had been no measurable improvement in services since the Corporation took over, the administrators demanded to see the data which was used to arrive at these low allocations. They charged that Paul Kerz, Corporation Vice President for Program Analysis, Planning and Budgeting (previously employed by the Department of Defense) refused to release the data and that the formulae used for determining allocations had no basis in reality. All this combined with charges of racism in Corporation hiring resulted in an unprecedented threat on the part of the administrators to resign en masse, unless they were given more say-so in the operation of their hospitals and the Corporation as a whole. That the administrators themselves are under pressure from community and worker groups, lends force to their complaints. Bernard Weinstein, administrator of Bellevue Hospital, recently noted that he, “used to get a petition every month or two—now I get one almost every week.”

Fiscal Autonomy and Integrity

Corporation designers believed that many of the ills of the municipal hospital system could be traced to fiscal ineptitude, mismanagement and dependence on the City’s convoluted budgeting practices. Under the leadership of ‘professionals’, rather than civil servants, the Corporation was supposed to handle its financial affairs in a business-like fashion. This has proven to be as hard as turning a sow’s ear into a silk purse. The Corporation is now operating on a budget of $689 million, which is $104 million less than it said it needed for this fiscal year. It is also according to the Corporation $30-40 million less than what it needs to operate at last year’s admittedly deficient rate. (Some say this is a minimum deficit—that the real deficit may turn out to be much higher.) With this kind of budget crisis, the idea of fiscal autonomy has flown out the window. Under the State enabling legislation which created the Corporation, the City of New York was to contribute from tax levy at least $175 million annually to

One of the major problems facing the Corporation is that it doesn’t know what its costs really are.
the Corporation's operation. In the past fiscal year, the City contributed $287 million (46 per cent of the Corporation's total budget) to this 'fiscally autonomous' unit. In addition, the Corporation owes the City $150 million, which it had to borrow for 'start up' costs.

As a quasi-independent authority, the Corporation has two means of extracting itself from continual financial distress: 1) it could bargain in the same way voluntary hospitals do, in order to get fair and prompt third party (Medicare, Medicaid, Blue Cross) reimbursements for its services; 2) it could establish an efficient Program Planning and Budgeting System (PPBS) which would enable it to flexibly carry out its priorities.

Third Party Reimbursement—In this insurance-based health care system, most hospital care is paid for not directly by the patient or the provider of services, but rather by a third party, usually some form of insurance. The three most common third parties are Medicare, Medicaid and Blue Cross. For Fiscal Year 1972, the Corporation projects that it will collect $411 million (or 60 percent of its total budget) from third party sources—that is, if all the bills are collected. (See Chart I for Sources of Corporation Revenue.)

The Corporation has not only failed to collect bills from third party payers, it has also failed to achieve maximum reimbursement rates from these third parties. According to the New York City Department of Social Services, Medicaid reimburses voluntary teaching hospitals between $150-160 per day for inpatient care (some hospitals are reimbursed at a much higher rate, e.g., Memorial Hospital—$209 per diem; Long Island Jewish—$187 per diem). Meanwhile, the Corporation Hospitals are only reimbursed at the level of $123 per day by Medicaid. This pattern is repeated in the outpatient department, where Beth Israel Hospital gets $43 per visit, while the Corporation obtains only $34 per visit. Likewise, when it comes to Blue Cross, the Corporation fares poorly. Its present reimbursement rate is $91 per day for inpatient care compared to voluntary teaching hospitals where rates are $140-150 per diem.

Reimbursement rates are calculated by formulas established, in the case of Medicaid, by the State Department of Health and for Medicare, by the Social Security Administration. To get higher reimbursement rates, hospitals have to justify increases by proving that the cost of providing services has gone up. One of the major problems facing the Corporation is that it doesn't know what its costs really are. At the present time, the Corporation is at a loss to figure out how much an outpatient visit costs; how much a tonsillectomy costs; how much laboratory work costs; etc. This inability to establish costs is another management failure of the Cor-
corporation and weakens its bargaining capacity with third party payers for increased reimbursement rates. (See PPBS discussion below.)

When charged with failure to raise reimbursement rates, Corporation officials explain that the New York State Hospital Cost Control law has limited increases to 10 percent per year for Medicaid bills for all public and private hospitals. This 10 percent limitation has been in effect for six months. While the Division of Medical Economics of the State Health Department estimates that the average increase among voluntary hospitals over the past 18 months has been 20 percent, the Corporation's increase in Medicaid reimbursement during the same period has been only 5 percent (from $115 per diem to $123). Cost control has been less of a problem than the Corporation's inability to estimate costs.

Another ripple that the Corporation's new management has not been able to smooth out is the matter of Medicare reimbursement for physician services. Although Medicaid reimburses the Corporation on an inclusive basis which contains physicians' salaries, Medicare does not. Reimbursement under Medicare Part B involves physicians signing a special form. To date, three large Corporation Hospitals, including Kings' County Hospital, have not been able to convince their attending physicians to cooperate with this procedure. In addition, estimates of the cost of physician services are hampered by the affiliation contracts. Affiliates are often unwilling to specify the amount of time that a physician spends in teaching, research, and patient care. This makes it difficult for the Corporation to get full reimbursement for physicians' services both under Medicare and Medicaid.

Program Planning and Budgeting Systems—For the old Department of Hospitals, budgeting in the City bureaucracy was handled in a way that was first developed to safeguard against the misuse of public funds, but has evolved into a fiscal straitjacket. Lines were set aside in the Expense Budget for personnel, job by job, and for equipment, practically pencil by pencil. In order to switch money around during the year, from pencils to jobs, or from one job to another, lengthy and undependable approval procedures were followed. In addition, it was nearly impossible to determine how much it cost to accomplish a certain task, because money was not allocated program by program (in essence lumping together all the pencils and job positions needed to get a particular goal accomplished.)

The Corporation, by being its own fiscal agent, was to be freed from the constraints of line item budgeting. Using a system called Program Planning and Budgeting System (PPBS), costs could be grouped by programs, and money could be shifted around as priorities, changed or crises developed.

Whether or not PPBS is all it's cracked up to be, in the Corporation's case it hasn't freed the municipal hospitals from the old problems of line item budgeting. The Nurse Recruitment Program is a case in point. Given the fact that the "Corporation hospitals have a seventy percent heavier patient load for each nurse than the better voluntaries have." (Study-Office of Nursing Services) nurse recruitment became a central issue. Under pressure from the State Nurses Association and the Committee of Interns and Residents, the Corporation made the recruitment of nurses a top priority item of business. English announced that every nurse who applied for employment would be hired.

By retaining a personnel recruitment organization to help in the effort, the Corporation came near its goal of hiring 1000 new nurses—about 900 were employed. (As many of these nurses are foreign trained, they are unlicensed in New York State, requiring that they be given time off for attending classes. Eileen McCaul, of the New York State Nursing Association, estimates that in terms of work time the Corporation has gained only 500 new nurses.) Since the goal of 1000 new nurses was several hundred less that what was anticipated in the Fiscal Year 1971 budget, and 1000 less than what was projected as actual need in the Fiscal Year 1971, it came as a shock to discover that licensed nurses were being turned away at least two hospitals (Coney Island and Metropolitan), because "all the job lines are filled." Ms. McCaul says she, "had been led to believe that they [the Corporation] would do away with this business of job lines." Furthermore in many hospitals, per diem (not full-time) nurses must be laid off when the hospitals use up their per diem allocations. At Lincoln Hospital in the South Bronx, since the budget has been frozen at 55 full-time nursing lines, per diem moneys are being used to pay for nurses who are actually full-time. When these moneys are depleted, Lincoln will return to having 55 nurses for a 385-bed hospital. While 'flexible budgeting' has not been invoked to solve the nursing problem, it has been invoked to stave-off the $40 million deficit the Corporation admits it faces this year. Following the advice of Gordon Chase, head of the Health Services Administration and Chairman of the Corporation Board, to "squeeze the water out of the sponge", the Corporation has instituted a program of 'selective at-
CHART II

Authorized Expenditures

(The Corporation has not officially released an accounting of its expenditures for Fiscal Year 1970-71 even though required by law. Therefore these are the amounts budgeted for the first year of Corporate operations rather than the amounts actually spent.)

Corporate Administration
- Costs of Central Administration (President’s expenses, labor relations, community relations, administration of affiliation contracts, central management of hospitals, the laundry, the mortuary, payments to other city agencies) ......................................................... $13.6
- Costs of Collections, Budgeting, Purchases and Program Analysis ......................................................... 9.2
- Affiliation Deductions (payroll deductions that exceed the negotiated amounts within present affiliation contracts) ......................................................... 4.5
- Fringe Benefits ........................................................................................................................................ 46.0
- Debt Service (includes long term debt=$26.4 million and interest on revenue anticipation notes=$5.1) ......................................................... 31.5
- Ambulance Service and Transportation ................................................................................................. 13.5
- Miscellaneous ........................................................................................................................................ 19.1
- TOTAL .................................................................................................................................................. 137.4

Hospital Care Services

<table>
<thead>
<tr>
<th>Municipal Hospital</th>
<th>Affiliation</th>
<th>Service</th>
<th>Amount of Affiliation Contract</th>
<th>Total Budget including affiliations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bellevue Hospital Center</td>
<td>New York University</td>
<td>General</td>
<td>$ 7.7</td>
<td>$58.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychiatry</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>Bronx Municipal Hospital Center</td>
<td>Albert Einstein</td>
<td>General</td>
<td>15.5</td>
<td>44.1</td>
</tr>
<tr>
<td></td>
<td>College of Medicine</td>
<td>Psychiatry</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>Bird S. Coler</td>
<td>New York Medical College</td>
<td>General</td>
<td>4.4</td>
<td>18.7</td>
</tr>
<tr>
<td>Coney Island Hospital</td>
<td>Maimonides Hospital</td>
<td>General</td>
<td>7.5</td>
<td>21.0</td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td>1.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cumberland Hospital</td>
<td>Brooklyn Hospital</td>
<td>General</td>
<td>6.8</td>
<td>16.4</td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td>0.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delafield Hospital</td>
<td>Columbia</td>
<td>General</td>
<td>2.0</td>
<td>8.6</td>
</tr>
<tr>
<td>Elmhurst</td>
<td>Mount Sinai</td>
<td>General</td>
<td>13.1</td>
<td>32.8</td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fordham</td>
<td>Misericordia</td>
<td>General</td>
<td>6.8</td>
<td>15.4</td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td>0.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goldwater Memorial</td>
<td>New York University</td>
<td>General</td>
<td>4.1</td>
<td>17.8</td>
</tr>
<tr>
<td>Greenpoint Hospital</td>
<td>Jewish Hospital of Brooklyn</td>
<td>General</td>
<td>5.2</td>
<td>11.9</td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td>0.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harlem Hospital</td>
<td>Columbia Presbyterian</td>
<td>General</td>
<td>18.6</td>
<td>41.0</td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td>2.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kings County</td>
<td>Downstate</td>
<td>Pediatrics OPD</td>
<td>1.9</td>
<td>64.1</td>
</tr>
<tr>
<td></td>
<td>Child Psychiatry</td>
<td>1.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Radiology</td>
<td>2.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcoholic</td>
<td>0.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metropolitan Hospital</td>
<td>New York Medical College</td>
<td>General</td>
<td>14.3</td>
<td>37.0</td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td>2.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lincoln Hospital</td>
<td>Albert Einstein</td>
<td>General</td>
<td>9.5</td>
<td>21.1</td>
</tr>
<tr>
<td></td>
<td>College of Medicine</td>
<td>Psychiatry</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Morrisania Hospital</td>
<td>Montefiore</td>
<td>General</td>
<td>10.2</td>
<td>18.5</td>
</tr>
<tr>
<td>Queens Hospital Center</td>
<td>Hillside Hospital</td>
<td>Psychiatry</td>
<td>1.6</td>
<td>36.1</td>
</tr>
<tr>
<td></td>
<td>Mary Immaculate</td>
<td>General</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Long Island Jewish</td>
<td>General</td>
<td>12.6</td>
<td></td>
</tr>
<tr>
<td>Sea View</td>
<td>none</td>
<td></td>
<td></td>
<td>10.4</td>
</tr>
<tr>
<td>Sydenham</td>
<td>none</td>
<td></td>
<td></td>
<td>7.1</td>
</tr>
<tr>
<td>Total Hospital Care Services</td>
<td></td>
<td></td>
<td>$163.4</td>
<td>$480.5</td>
</tr>
<tr>
<td>GRAND TOTAL Budget for July, 1970 — June 1971</td>
<td></td>
<td></td>
<td>$177.9</td>
<td>$617.9</td>
</tr>
</tbody>
</table>
trition.' In this latest move to balance the books, non-professional workers will not be replaced as they leave the payroll. With the hospitals' present labor shortage, this policy will soon amount to wringing blood from a stone and will undoubtedly come down hardest on the nursing staff. It is estimated that 3000 jobs will be lost through attrition, saving the Corporation $7 million. (Some anticipate another round of actual layoffs as the Corporation gets toward the end of its fiscal year, in order to make up more of the $40 million.)

Eileen McCaul predicts that 'selective attrition' will wipe out any of the benefits of the Nurse Recruitment Program. In testimony given recently she said, "...[the] Corporation has failed to achieve any recognizable degree of improvement in the organization and delivery of nursing care services."  Pointing out that nurses spend 75% of their time in non-nursing functions, she emphasized: "An admittedly inadequately funded Corporation can ill afford to squander nursing salaries for the execution of general institutional services..." which is exactly what will happen under 'selective attrition.' She says, "the balloon is ready to burst. Nurses, in masses, will soon start saying, 'We've had it!'"

Few are happy with the Corporation's cost cutting, sponge-wringing approach to relieving its fiscal distress. In order to frustrate this cost cutting workers at Lincoln Hospital instituted a "billing action" last summer. They stopped submitting Medicare and Medicaid bills altogether and are holding them ransom until they can be assured that Lincoln will be given enough money to run a proper hospital service. Thus far they have held back approximately $600,000 worth of receivables.

Corporation Board of Directors member Edmund Rothschild offers an approach which is similar to the "billing action." It might be called a "spending action." He suggests that the Corporation allow hospital administrators to spend as much money as they need and simply let the deficit accumulate. Then when the bill collectors arrive, turn the problem over to the City. "If Lockheed can do it with the Feds why can't the Corporation do it with the City?"

Equalizing the Two-Class Hospital System

One of the longstanding complaints about the Department of Hospitals was that it ran a poor-house health system. Its service, when compared with its private voluntary counterparts, was inferior and
thus patients who could not afford private care were discriminated against. Furthermore, this two-class system operated to the benefit of the private system because, through affiliations, private medical centers were paid to provide professional staff to the municipal hospitals and use their patients as 'teaching material' for students enrolled in the private centers. The two-class hospital system guarantees that the voluntary medical centers will have a resource pool of patients to practice on; will have a dependable source of income from the public sector with which to cover their own staff costs; and will have a steady demand for their private services from middle class patients who will avoid the inferior municipal services at any cost. As one forthright municipal hospital Chief of Services wrote: "... [the present affiliation arrangement] permanently assigns to the municipal hospital second class status. ... In effect the municipal hospital is a 'farm club' of the voluntary hospitals."

'Tfarm club' expansion during the last 10 years in New York City has created a situation where the affiliates are essentially a monopoly supplier of goods and services (staff) to the public consumer (municipal hospitals). True to form, the price has gotten higher and the quality of the product has gotten shoddier. While the municipal hospitals are victimized by the affiliation arrangement, the affiliates are themselves dependent upon municipal hospital acquiescence to the arrangement. It is not an overstatement to say as one hospital administrator has been quoted: "Without the affiliations, two medical schools—Einstein and New York Medical College—would go bankrupt."

Since the Health and Hospital Corporation came into being on the wake of public scandal about the affiliations, it is not surprising that part of its job has been seen as equalizing the quality of care given by the municipal hospital to that given by their affiliated voluntary counterparts. But the Corporation is operating under the time worn Separate But Equal Doctrine. Even though limited, this goal appears to be unobtainable—fundamental to its accomplishment is a restructuring of the affiliation system. It would seem from President English's Annual Report (June 11, 1971) that the Corporation was beginning to move public health care from the poorhouse to a main house of its own. "We have begun and have made great strides in the important work of improving and strengthening the affiliation program . . ." However, in fact, the Corporation has not exercised any of the bargaining power it has as mainstay of

**Corporation Thinks HMO**

government to refine the plans and provide start-up money. A community group was drawn together to participate in the planning. A site was selected and June, 1972 was established as the program’s opening date. The site was particularly appropriate, as a Department of Social Services day-care center was going to share the building. Social Services delayed their renovation plans for the Corporation; the contractor ordered the steel.

The lease was ready to be signed and when everything was set to go, Corporation President English was visited by some private practitioners from the area. They saw the new form of health delivery as a threat to their established practices. While the official word is that the plan has been indefinitely postponed, the unofficial word is that the project is dead (the few private practitioners killed it) and that the $100,000 is being used elsewhere.

The Corporation is providing New Yorkers with two more missed opportunities. In the first, the Health and Hospitals Corporation has considered assuming control of the Public Health Service Hospital on Staten Island once it is relinquished by the United State Public Health Service. But without adequate Corporation staff to plan such a move, and with an unconvincing performance in administering its present facilities, one of several outside voluntary groups may step in.

Likewise, planning health services for the residents of the Welfare Island 'new town' (a state project for the construction of an entire community) may well be turned over to Cornell Medical Center in the absence of any definitive steps by the Corporation and the Health Services Administration. As was the case in past, where there is no strong public system (or even quasi-public system), the voluntary hospitals and medical schools move in with inflated costs and private priorities.
"The present affiliation arrangement permanently assigns to the municipal hospital second class status. . . . In effect the municipal hospital is a 'farm club' of the voluntary hospitals."

—A Municipal Hospital Chief of Service

the affiliates, to bring the price of affiliation down, or raise the quality of the merchandise.

What Price Affiliation?—This year's affiliation contracts promise to be the 'giveaways' that their predecessors have been; while the Corporation is squeezing water out of the municipals' sponge; it is giving buckets to the affiliates. Affiliates will receive an average 10 percent increase over last year's contracts—$15 million to start with. This 10 percent increase will be followed by Guaranteed Minimum Incentive Payments. The amount of the payments will be determined by the degree to which the affiliates live up to the Contract, ("accuracy of reports," "completion of medical records," etc.). When most businesses would break contracts on the basis of abrogations of contracts, the Corporation will give the affiliates bonuses for merely doing what they are paid to do in the first place! Since the affiliates are not required to state how they will spend the incentives, one Corporation staffer has referred to these payments as "slush funds."

There is no indication that the Corporation will be purchasing higher quality services even though the price has been raised. When the Corporation went to the negotiating table with the affiliates, it paved its way with good intentions. The Corporation had drafted a proposal which contained several significant improvements over the previous contracts. For instance, the draft stipulated that the number of physicians assigned to the municipal hospitals would be specified and that the allocation of physician time among the various hospital functions (Inpatient, Research, etc.) would also be specified in the new contracts. This was bargained away. As in previous contracts, the draft recommended that the Corporation would have the power to reallocate and reprogram funds and services during the contract's life. This was bargained away. The draft also required that the overhead payment payed to the affiliate would be based on the actual cost of management and administration of the contract, rather than on a percentage of the entire contract cost. This was bargained away.

While the affiliation contracts have still not been signed (already four months late as of press time), there is no reason to suspect that they will result in improved patient care in municipal hospitals. Instead, the Corporation will still not know how many doctors it has hired or how much time they put in on the job. The affiliate, as never before, has the power to reallocate its funds. And the voluntary medical centers will administer the contracts on a cost plus basis. Once again, the municipal hospitals have been taken to the cleaners.

Speeding Up Construction of Facilities

New construction had been a constant source of embarrassment to the old Department of Hospitals. When the Corporation took over, the new Bellevue had been over ten years in the works and its cost had tripled since it was first contemplated. Gouverneur had been under construction for eight years; and after years of delay nothing had yet been done on the new Lincoln Hospital. The Corporation was given two means of avoiding similar shame: bonding power and its own Project Management Division. As it has turned out however, the Corporation has not used either of these mechanisms as intended and is reliant on the alternative City-State arrangements, developed prior to the Corporation's arrival on the scene.

Bonding—The enabling legislation which created the Health and Hospitals Corporation, endowed it with the power to float bonds for financing capital construction. Bonding power—a normal privilege of authorities—was thought to be especially beneficial to the hospital system because it would allow the Corporation to bypass the City's lengthy and politically unreliable capital budgeting process. Although it was anticipated that the Corporation would not float bonds for several years, it is now unlikely that the Corporation will ever gain the solvency necessary to float bonds.

The Corporation must still go through the City's Capital Budget; and since it
cannot thereby get around the City's debt limit, the bonds are in fact sold by the State Housing Finance Agency. All this means that not only is the Corporation subject to the City's own budgeting priorities, it is also subject to those of the state. As a consequence, land which was cleared two years ago for a new Fordham Hospital (displacing 300 Bronx families) will remain vacant, because the State Housing Finance Agency has voted to defer the Fordham funding indefinitely. Just as the Corporation and the City passed the buck up, the State is now trying to pass it back down. A state agency spokeswoman is quoted as saying, "We've suggested that the city try other sources of funding."

Actual construction is also out of the Corporation's hands. Although the Corporation's Division of Project Management was created to bypass the City's Department of Public Works (a cumbersome department which normally supervises City construction), it only serves a liaison function between the Corporation and the real construction supervisors. The real construction supervisors are the same old Department of Public Works (in the case of the new Bellevue, Gouverneur, and Metropolitan Hospitals) and the State Health and Mental Hygiene Facilities Improvement Corporation (in the case of North Central Bronx Hospital, Lincoln, and Greenpoint).

The Corporation still has responsibility for renovations and in this domain its accomplishments remain questionable. Community groups around Morrisania Hospital had been promised that they would receive a new two-story emergency facility. However, the Corporation has backed out of this agreement, saying that the North Central Bronx Hospital now under construction will eventually relieve their needs (even though the new hospital will be in another part of town). And so, after considerable community protest, the Corporation is now renovating the existing undersized emergency room and bringing in two trailers to serve as admitting areas.

**Insuring Public Accountability in Hospital Policy-Making**

Although the Corporation has one foot in the private sector and one foot in the public, Corporation business was supposed to be open to public scrutiny and influence through two means—public representation on the Board of Directors; and the establishment of new Community Advisory Boards at each of the eighteen municipal hospitals. These were to replace the Lay Advisory Boards which existed under the old Department of Hospitals and were composed of appointed distinguished citizens.

Edmund Rothschild, one of the most vocal dissenters on the Board of Directors, debunks the notion that even the City Council appointees can be considered effective public representatives: "This governing board totally lacks consumers... It's a bizarre situation. No one on this Board ever uses a municipal hospital. Members of this Board should be in there scrapping as health advocates. If I had my choice, I'd remove the votes of ex-officio [agency heads] members and replace them with bona fide consumers." Since Board meetings are neither open to the press or public, it is impossible to know exactly what interests are being presented there. A motion to open the meetings to the press has been on the agenda for five months but the chairman has refused to bring it up for a vote. At present the public can only receive summary—not verbatim—minutes of Board meetings.

Unfortunately at this time the notion of publically accountable Community Advisory Boards must also be challenged. During its first year, the Corporation issued Interim Policy and Guidelines for such boards. The guidelines are weak from a consumer point of view, and they favor the hospital administrators. The Boards are only guaranteed the right of participation with the providers. The Boards have no powers over the affiliation contracts; nor do they have the power to replace the present hospital administrators. The hospital administrators, however, are given the power to determine how community boards shall be selected.

In its second year of operation, the Corporation made the establishment of advisory boards a top priority item of business. Thus far, Goldwater Hospital on Welfare Island is the only one to have
pulled together a board. Since there is no community on Welfare Island in the usual sense of the word, the hospital’s chronic care patients make up the Board’s consumer representatives.

In some respects the Corporation has been able to withdraw under its quasi-private cover when it comes to releasing information which previously could have been considered ‘public information.’ For instance, the public has not been able to see the proposed affiliation contracts, and due to the fact that municipal hospital budgets no longer appear in the City’s Expense Budget, no one can determine the amount proposed to be spent on the affiliation contracts. Despite the fact that an estimated $160 million of public funds will be spent on the affiliation contracts, the Corporation has refused to release these figures.

The Health and Hospital Corporation has achieved a degree of secrecy which has not been known before in the New York municipal hospitals. It has also achieved a subtle distance from public influence. By being removed from the ‘political arena,’ the role of the Mayor and partisan politics has been disguised. As Congressman Herman Badillo said on his resignation from the Corporation Board of Directors: “So the effect of the Corporation, and the intent, was to place another layer of bureaucracy between City Hall and the poor.”

Despite this negative environment for public accountability and influence, the Corporation is not entirely untouchable. Workers can still have some effect on hospital management, even if their methods must be unorthodox, as in the billing action at Lincoln Hospital. Renovation of the Morrisania emergency room, the development of one Community Advisory Board and the speed-up of the new Lincoln Hospital construction can be attributed to public pressure on these issues. Another example, the Nurse Recruitment Program resulted from a concerted effort on the part of interested outside parties.

Continual pressure on the Corporation is limited at best to short-run success in concrete terms. Its long-run success lies in showing that a public hospital system will have difficulty supporting itself in a profit-oriented health system—that a system which is not accountable to its consumers will not be responsive to their needs—and that a system which relies on private interests to maintain public quality will remain second class.

—Constance Bloomfield, Oliver Fein and Howard Levy

In his health message to Congress last February, President Nixon announced that the nation’s “massive crisis” in health care had “deepened.” He also announced what he hoped would be a large part of its solution: The Health Maintenance Organization (HMO).

The HMO, Nixon explained, is any organization that provides a given set of health services for a single annual fee. This structure, he claimed, would greatly benefit the consumer. “Shopping” for health care would be simplified, because only one payment need be made, and all services would be provided by a single organization. Furthermore, since the provider may pocket the difference between the cost of each enrollee’s care and the enrollee’s annual premium, it would be to the provider’s advantage to “keep the patient healthy” (and hence less expensive to care for) by extensive utilization of preventive care and other beneficial “health maintenance” programs.

The history of the Administration’s moves to date, however, shows that the HMO program will benefit consumers very little. Rather, it appears that the HMO is simply a device to hold down health care costs without significantly altering the
### HMO Grant Recipients

<table>
<thead>
<tr>
<th>Category</th>
<th>Recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private doctor-dominated groups (including Medical Society Foundations)</td>
<td>12</td>
</tr>
<tr>
<td>Hospital-based groups</td>
<td></td>
</tr>
<tr>
<td>Private or voluntary hospitals</td>
<td>12</td>
</tr>
<tr>
<td>Public hospitals</td>
<td>4</td>
</tr>
<tr>
<td>Medical school related groups</td>
<td>3</td>
</tr>
<tr>
<td>Prepaid group practices</td>
<td>2</td>
</tr>
<tr>
<td>Insurance companies (Blue Cross/Blue Shield and commercial insurance)</td>
<td>3</td>
</tr>
<tr>
<td>Health planning councils</td>
<td>7</td>
</tr>
<tr>
<td>Federal government sponsored programs</td>
<td>3</td>
</tr>
<tr>
<td>Model Cities</td>
<td>2</td>
</tr>
<tr>
<td>OEO Neighborhood Health Centers</td>
<td>1</td>
</tr>
<tr>
<td>Consumer sponsored groups</td>
<td>2</td>
</tr>
<tr>
<td>Miscellaneous (difficult to categorize)</td>
<td>4</td>
</tr>
<tr>
<td>Texas Instruments (Dallas, Texas)</td>
<td></td>
</tr>
<tr>
<td>Bionetics Research Laboratories (Bethesda, Md.)</td>
<td></td>
</tr>
<tr>
<td>Family Health Care, Inc. (Washington, D.C.)</td>
<td></td>
</tr>
<tr>
<td>Health Facilities Research, Inc. (Port Charlotte, Fl.)</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>52</strong></td>
</tr>
</tbody>
</table>

Further planning grants will be announced December 15, March 15 and June 15. HMO operational grants are due to be released March 15 and June 15.

The Administration's first really significant move, however, came in late summer, when HEW announced its intention to give out $23 million in grants in four cycles during the fiscal year for the planning of one hundred HMO's. Acting well in advance of Congressional authorization, HEW shifted these funds from appropriations for Neighborhood Health Centers, family planning and health services research and development. These grants have been surprisingly small: the first 52, announced in September, averaged only $100,000 each.

The first list of such planning grants and contracts shows that any of the current modes of medical practice can potentially be called an HMO. Grants have gone to prepaid group practices with full time doctors on salary, such as the Group Health Cooperative of Puget Sound in Seattle. Others have gone to medical foundations, as in Nassau County, New York. Foundations permit a county medical society to represent private (usually solo) practitioners and enable them to retain their present form of practice and at the same time care for an enrolled population as an HMO (see BULLETIN, June, 1971). One has gone to an OEO funded Neighborhood Health Center, Martin Luther King in New York City. Hospitals and medical schools have been well represented among the grantees. A large grant has gone to Blue Cross of Rochester to underwrite a large HMO, primarily for Xerox and Kodak employees.
Rochester, N. Y.

HEW has given one of its largest HMO planning grants ($272,000), to the Rochester Hospital Service (Blue Cross) and Group Health Association of America (GHAA), "to establish a program which will serve as a model for communities across the nation."

Planning for the new HMO began on September 1st, and the operation is scheduled to begin within eighteen months. The HMO will primarily serve employees of Kodak and Xerox, Rochester's two largest employers. (Kodak had been toying with the idea of prepaid group practice for some time in the hope of cutting the costs of employee health benefits.) The proposed HMO will serve 30,000 people, who, besides the Kodak and Xerox employees, will include some other persons, including some welfare recipients. Land has been acquired from Rochester General Hospital for the construction of a new facility and 15 to 25 doctors reportedly have been recruited.

Blue Cross is already relatively strong in Rochester, writing 85% of the hospitalization insurance in the city. Its expansion in the Rochester area has been going on for some time. In May, 1970, the Medical Society of Monroe County formed the Monroe Plan for Medical Care, Inc., a typical foundation plan, in which subscribers pay a premium in exchange for a variety of services provided by local doctors. Blue Cross writes the premiums.

A further example of its expansion into a new field lies in Blue Cross's relation to three neighborhood health centers being developed in low income areas of the city. When and if they become stabilized, it has offered to join in the financing, reportedly in return for a voice in their operation.

While Nixon speaks of using HMO's to foster pluralism and competition among health care providers, it seems that in Rochester an HMO contributes strongly to the Blue Cross hegemony.

Significantly, only two of the 52 initial grants have gone to clear-cut consumer groups, substantiating the claim of Dr. Merlin DuVal, chief federal health spokesman, who told Senator Kennedy's health subcommittee in Senate hearings last July: "I think it is very important for us, first off, to sell HMO's as a concept to those persons who are in the last analysis providers . . . and they are slow to accept co-equal consumer participation."

Later, the Administration hopes to seek funds for actual start-up costs (enrolling members, building facilities, hiring doctors, and so forth) largely from the private sector. The Administration sponsored HMO bill, S.1182, would appropriate funds to guarantee loans to private HMOs. The Administration plans to seek $300 million in authorizations. Banks, insurance companies and other investors will have their loans and interest guaranteed. In successful HMO's, which will not require government subsidy, the interest charges over many years will be borne by the premium payers.

It appears, that this $300 million in loan guarantees may not be sufficient to carry out the full intent of the Administration's program. The Administration has stated that it hopes to see 100 HMO's at least in the planning stages within the year. Observers have estimated, however, that to build a self-sufficient HMO from scratch may take as much as $10 million over a 10 year period. Clearly, $300 million is insufficient to meet this goal. Because the Administration is giving such small amounts to back start-up costs, HMO's will be developed, in most cases, from pre-existing programs rather than from scratch. Thus, the Administration will favor already organized hospital and medical society groups over fledgling consumer based organizations.

There are other dangers for the consumer lurking in the HMO. Federal guidelines state that an HMO provides "an agreed upon set of comprehensive health maintenance services." But no standards have been developed to specify which services will be included. S.1182 says only that the minimum includes emergency, hospital, physicians' and preventive services. The health provisions in the Social Security amendments now before Congress, HR 1, say that HMO's getting Medicare funds for the elderly must give all benefits now provided for Medicare beneficiaries. However to receive Medicaid funds for the poor, HMO's appear to have no minimum benefit standards at all.

In some cases, HMO's can be a wedge to reduce benefits and services. For instance, federally funded Neighborhood
Health Centers were set up a few years ago in low income areas, usually with fairly comprehensive health and social programs. They have proved costly to run. As continued deficit financing for these centers dries up, federal pressure has increased to get them to convert to HMO status. But the benefits specified for HMO’s—and backed by Medicaid and other government payments—often do not include health center services such as comprehensive dental care, programs for alcoholics and drug addicts, and community health outreach. Unless non-HMO funds can be found, these services will be cut back.

Nixon is right when he says HMO’s will solve someone’s health care crisis: his own. The Federal government has been increasingly pressured by rising health care costs; and Nixon faces a potential coalition of liberal reformers, community and worker groups demanding sweeping changes in the delivery system. The HMO may, indeed, help solve this crisis by giving the provider an incentive to keep costs down, even at the expense of service; and, although in fact the HMO does not bring any significant changes in the delivery system, it will, by appearing to be a major change in Federal health policy, divert attention from more substantive reforms.

But the HMO doesn’t even come close to solving the crisis of the millions of people who are getting poor care. As the Physician’s Forum stated last June 5: “HMO’s will guarantee the economic health of the provider, rather than the physical health of the patient.”

—Des Callon and Anne Lawrence. (Anne Lawrence, presently working at Health-PAC, is a student at Swarthmore College.)

Nassau County Foundation

$64,000 in HMO planning money has gone to the newly chartered Nassau County Medical Service Foundation in suburban Long Island, New York. This organization was formed by the county medical society last year. In the grant application to HEW, the society plainly stated its HMO intents: “The development of a foundation-HMO plan was initiated because it seemed to many of the responsible members of the health community that this system of organization would tend to preserve many of the more highly valued attributes of the traditional system of health care delivery that are directly threatened by the more radical changes now being proposed and introduced.”

The Nassau County Foundation allows the county’s medical practitioners to contract collectively to provide a set of services to an enrolled group of patients for a pre-set yearly sum. No group practice is necessarily involved. Fee-for-service solo practice would actually be unaffected: HMO patients would be seen with existing patients in the doctor’s office. Early plans in Nassau call for enrolling county welfare clients and also employees of a large firm and their families—the Long Island Lighting Company is being considered.

The Nassau County Foundation, unlike some foundations in other states, does not plan to become an insurance carrier itself. Accordingly, its charter indicates that it does not fall under the control of the State Superintendent of Insurance. Since it will not be furnishing medical care itself, the foundation has succeeded in getting an exemption from regulation by the State Public Health Council as well. So the question properly arises: will its operations be subject to review by any public body?

“I’d define the HMO as the bandwagon everyone will get on as soon as they can find it.”

—Observer, Senate Hearings
I am writing to share my thoughts on the Free Clinic issue. Your discussion of the subject was magnificent ... I do want to raise one issue, however.

It is time to start recognizing that free clinics cannot be viable counter culture institutions until they stop being dependent on donations and volunteers. Try as hard as they may, even successful free clinics cannot get away from the money problem, and here as elsewhere the struggle for funds corrupts. There are several approaches to financing: donations, bonanzas, rip-off, benefits, and participatory. The donation approach depends upon other people, other companies, other communities' goodwill and charity. Most of these donations do not come to promote the struggle for health, but rather to support a "charitable service to the needy." Not only do they come from outside the community, but the community's struggle must often be hidden—and may even be suppressed—in order to attract "kindly" donations ... 

[At the other extreme], a participatory approach might entail all of the clinic's support coming from the community of which is a part. It is important to explore this approach because it is most consistent with the free clinic's development as a community and its survival as an alternative institution. Since free clinics are committed to health care as a right, services must continue to be free at the point of delivery. There can be no fees: but there are other mechanisms for patients' participation, e.g., through providing time and manpower, in-kind goods and services, and participating in clinic or community activities ... 

Analysis of the use of volunteers in free clinics runs along the same dimension as the search for money. The use of volunteers, especially physicians, is currently crucial to the existence of most free clinics. Again clinics are in the position of depending upon resources which threaten their evolution. It becomes especially important therefore for clinics to devote time and energy to orient and educate their volunteer providers from outside the community. But a trend is clear. More health workers are being sensitised to the needs of the clinics and their communities and the issues they represent, both in their education and by working in the clinics, and more and more they are finding out that volunteerism is totally inadequate. A growing number are abandoning their ascribed roles to become involved with and to serve in the clinics full time.

This augurs well for the future, for the growth of free clinics as alternative institutions, and for the maturation and strength of counter communities. In fact, I believe that unless this trend grows, the free clinic movement stands a great risk of being coopted.

Jeffrey B. Gordon
San Diego

I thought the Free Clinic BULLETIN was one of the best I've read, giving an overall fairly accurate and perceptive view of an extraordinarily difficult subject. Some questions came to mind, however ... 

1. How have the free clinics affected sector organizing? The influence on nurses has been especially great here, with women previously cynical about their profession now raising new ideas about its potential. The notion of transfer of skills, while conflicting in part with quality of care, has raised expectations and blurred roles in many instances that are very healthy. Several of the nurses now active at Cook County organizing the Illinois Nurses Association came out of a free clinic experience. I wonder what the effect of women's clinics have been on nurses, lab techs, etc. in raising their consciousness about being women workers. Has this been translated into institutional struggle?

2. The involvement of students, both medical and nursing, is also complex. Some clinics have refused to involve students to guard against becoming "teaching material." Yet we have found that those clinics that have an active clinic experience. I wonder what the effect of women's clinics have been on nurses, lab techs, etc. in raising their consciousness about being women workers. Has this been translated into institutional struggle?

3. Several students in the Urban Preceptorship are now developing an overview of outreach programs across the country, assessing which ones have worked, how they've involved communities, etc. LADO is just starting an outreach program to organize block by block our previous patients. We have very few examples of how to organize a community, how to be prepared for urban renewal, how to establish the independence and range of services required to be self-sufficient, yet struggle with existing institutions for control of resources. We think well-coordinated outreach, which prepares for long-term organization, will show the ultimate values of the clinic, the welfare union, the school, etc. However, the energy and time needed to develop the ongoing services may compromise the strength (or point up the weakness) of the initiating group.

Barbara Bishop
Chicago