Trying
To Shake
The Blues

It is indeed a comment on the times when an institution as staid and uncontroversial as Blue Cross becomes a target of public suspicion and protest. But these times are absolutely critical for Blue Cross for its entire future hangs in the balance.

As the crisis in health care threatens to shake the health system to its roots, politicians and interest groups alike are rushing forward with variations on a single theme—national health insurance. National health insurance will soon be with us; the chief question remaining is how it will be administered. Should lawmakers establish a separate governmental agency, such as the Social Security Administration to administer it, or should they hand it over to a non-governmental administrative agent or intermediary such as Blue Cross? National health insurance will supercede present forms of health insurance. Thus if lawmakers choose the latter course, Blue Cross will flourish and grow; if they choose the former, it will die.

But Blue Cross enters the ring a bit tattered this time. The image of efficiency and public interest which made it a natural intermediary in 1966 for Medicare and for many state Medicaid programs is being attacked from all quarters today. The same crisis which is spawning national health insurance is causing the public to cast a jaundiced eye at institutions such as Blue Cross. The result is the outcry and mobilization of groups ranging from Senate subcommittees to ad hoc subscriber organizations.

In late January, Senator Philip Hart, chairman of the Senate Antitrust and Monopoly Subcommittee held a three-day hearing on the role of Blue Cross in the escalation of hospital costs. Hart concluded that, due to its special quasi-public status, Blue Cross has become a virtual monopoly in the field of hospitalization insurance and that it is operated largely by and for the hospitals. During the hearings, he also uncovered some astonishing instances of fiscal mismanagement, conflict of interest, and just good old-fashioned corruption—cars rented from the companies of Blue Cross board members at exorbitant rates, winter conferences in Hawaii, travel reimbursements for conferences held at home, memberships paid at expensive country clubs, etc. These were topped by the case of a $1.2 million bill for furnishing a Virginia Blue Cross building. Not true, stated the president of Virginia Blue Cross, only $558,000 was spent on furniture. The rest was for carpets and draperies . . . Well, yes . . . the man who sold Blue Cross the furniture was a board member but, then he didn’t make any profit from the sale . . .

While Senator Hart was scratching the surface, the Federal Employees Union was suing Blue Cross in Washington, D.C. over the finding of yet another Congressional subcommittee last year. Money paid to Blue Cross by the federal government for employee health benefits had been channelled into non-interest bearing accounts in several Washington banks. These often totalled as much as $20 million—a virtual gift to the banks. Not coincidentally, officials of those banks sat on the board of Washington, D.C. Blue Cross.

While governmental committees concern themselves with where the money’s going to, local subscribers are also worrying about where it’s coming from. Local Blue Cross plans have hardly been able to let the ink dry on one rate increase before asking for another. The Greater Philadelphia Blue Cross plan was just granted a 23 percent rate increase in August and is now asking for an additional 20 percent. Up in arms, subscribers and community groups, began to organize. But when they examined established channels through which they might influence Blue Cross, they uncovered a proverbial can of worms. In Philadelphia the Blue Cross Board of Trustees is divided into representatives from medical providers (doctors and hospitals) and from the general public. The latter are elected at an annual meeting of subscribers. But the election process assures that the board will be a self-perpetuating body. In order to be nominated, a person must be included on the list submitted by the old board, or must submit a petition signed by 500 Blue Cross subscribers. The time allowed for collecting signatures is effectively limited to two weeks. Moreover, the election by-laws exclude large numbers of Blue Cross subscribers such as persons under 21 years of age and persons who have been enrolled in the local plan less than three years.

Finding themselves all but barred from the election process, a coalition of community groups, including the Philadelphia branch of the National Welfare Rights Organization, the Germantown Council, and the Consumer Review Board, organized and presented a list of questions and demands to Blue Cross at its annual meeting on February 16.
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In New York City Blue Cross is asking for its second rate increase in two years; if granted, it will mean a total increase of 71 percent. This action spurred the formation of the Subscribers’ Coalition, a group of Blue Cross subscribers organized to protest the rate increase and to educate the public about Blue Cross. The Subscribers’ Coalition made its presence felt at the two public hearings which are required by New York State law for approval of a rate increase. The Coalition charged that the first hearing, which was conducted by Blue Cross itself to solicit public opinion regarding the increase, was a meaningless sham. It was no accident that most of the testimony came from doctors and hospital administrators in favor of rate increases, charged the Subscribers’ Coalition. Blue Cross sent letters to hospital administrators encouraging them to testify, while making no similar effort to notify subscribers. The only notice which subscribers received was a newspaper ad published ten days in advance as required by law. For this Blue Cross chose the weekend before Christmas, even though it had been planning the increase for over six months. Early on the first day of the hearing a Coalition spokeswoman called for those present to protest this public fraud by walking out; half of the audience left. The hearing had to be adjourned early both days for lack of persons to testify.

The second hearing held by the State Insurance Department, was disrupted by the Subscribers’ Coalition which presented the State with a series of demands. It asked for the abolition of Blue Cross and the establishment of a nationally-financed system of free health care which is accountable to consumers.

The Subscribers’ Coalition also brought a law suit based on three charges to halt the rate increase. First, it claims that Blue Cross violated the letter, not to mention the spirit, of the law in the timing of its hearing and the manner of notification. Second, it holds that the Blue Cross Board of Directors is illegally constituted. The law requires representatives of medical providers to be limited to one-quarter of the Board and the Blue Cross board violates this provision. The remainder of the board, is supposed to equally represent “broad segments” of subscribers and of the general public. Yet it is dominated by top executives of business, finance and government. The Coalition charges that not only are subscribers and the general public not represented, but that lower-and middle-income people are specifically excluded from representation. The final allegation deals with the deliberate concealment of information. This information about reimbursement rates and financing is essential if subscribers and the general public are to play a meaningful role in the determination of rate increases and Blue Cross policy. The suit not only demands answers to a long list of questions, it also asks that the public have the right to cross examine J. Douglas Coleman, head of New York Blue Cross, at the State Insurance Department hearing. The court denied a preliminary injunction against the State Insurance Department hearing, but a permanent injunction against the rate increase is still pending. A similar suit has been brought by the city of Pittsburgh on behalf of its employees who are covered by Blue Cross. The city is asking for the right to cross examine Pennsylvania Blue Cross officials. If successful, these suits will establish a powerful tool for subscriber efforts to expose, confront, and control Blue Cross.

However, at present there are few legal or administrative channels through which Blue Cross subscribers can seek reform. Thus, the power of local groups lies primarily in two areas: the ability to educate large groups of subscribers and the public about Blue Cross, and the ability, through local struggles, to spark similar protest throughout the country. In this respect these struggles have illuminated facts and issues that are essential to Blue Cross subscribers, hospital users, and those concerned about health care throughout the country.

Blue Cross is a non-profit, tax-exempt organization. Because of this Blue Cross has been able to offer low rates. As a result it has become a virtual monopoly in the field of hospitalization insurance. One out of every three Americans is covered by Blue Cross. In addition, Blue Cross administers Medicare and in many regions Medicaid; thus, the total number of Americans receiving benefits from Blue Cross is over 500 million—45 percent of the population. About $7 billion a year, or over half of all hospital income in the United States, comes from Blue Cross.

Blue Cross has played a major role in the sky-rocketing inflation of hospital costs. Blue Cross reimbursement policies represent a blank check to the hospitals which need only declare their costs. Blue Cross alone has the power to control these costs; yet it has consistently failed to do so. This failure is evident in the fact that costs for identical services...
may vary as much as 100 percent from hospital to hospital. For instance in two New York City teaching hospitals with identical overall costs, bed and board costs ranged from $8.70 to $18.90 per day and delivery room charges from $143 to $274. As hospitals write themselves larger and larger bills, Blue Cross passes them on to the consumer. The New Yorker who paid $15 a year to Blue Cross in 1947, today, eight increases later, is paying $103, while more and more essential hospital services such as radiology and anesthesiology are no longer being covered by Blue Cross. These charges have made Blue Cross so uncomfortable that at the Hart hearings Walter McNeary, president of the Blue Cross Association, was forced to admit that in the area of cost control, "We have not been sufficiently self-critical and innovative."

- Why Blue Cross fails to represent the consumer is no mystery. It is operated largely by and for the hospitals. Blue Cross was organized during the early 1930's to bail out financially failing hospitals by assuring that users could pay their bills. "Blue Cross has been sponsored and guided since its early days by the American Hospital Association (AHA)," reads one Blue Cross manual. The AHA still owns the trademark "Blue Cross," approves plans that may use that trademark, and approves hospitals which may receive Blue Cross reimbursement. The Blue Cross Association, the national coordinating body of the various local Blue Cross plans, shares the same Chicago headquarters as the American Hospital Association.

Thus when the interests of consumers and the interests of hospitals come into conflict, there is no question where Blue Cross will cast its weight. Not only does Blue Cross fail to control hospital costs, it makes no effort whatsoever to assure the quality of care its consumers receive for their money. "It would take far too many personnel—we just couldn't do it," claims New York Blue Cross President Coleman. If in fact Blue Cross represented the consumer's interests instead of those of hospitals, it would be a much different creature. Long ago it would have moved out of the narrow field of hospitalization insurance to provide comprehensive health care financing and especially to provide preventive health care which would frequently make hospitalization unnecessary. But Blue Cross has used its power over the years to skew the entire health care system toward hospitalization rather than toward the goal of keeping its consumers well.

If doubt about Blue Cross' loyalty still lingers, one need only examine the sole way in which Blue Cross does claim to control hospital costs—through its participation on hospital planning councils. Since it costs a hospital nearly as much to maintain an empty bed as it does a full one, it is in the interest of hospitals to maintain very high occupancy rates. In the case of New York City, Blue Cross has played a major role in the Health and Hospitals Planning Council (HHPC), a planning group which has the power to approve all new hospital facilities in the metropolitan area. (Eight Blue Cross trustees and officers sit on the HHPC Board of Trustees; five of these are HHPC officers; Blue Cross gives HHPC $100,000 a year, making it HHPC's largest non-governmental contributor.) HHPC has effectively limited the building of new hospital facilities in New York for the last twenty years, pushing occupancy rates of existing facilities to a dangerous 90 percent. Of course, this does reduce overall hospital costs, but it does so at a tremendous human cost to those who must postpone needed surgery or who in an emergency can find no hospital beds available.

- The composition of Blue Cross boards of directors are the final clue to its real interests. Except where state law requires otherwise, boards of Blue Cross' 75 local plans overwhelmingly represent the hospital industry. 50 percent of board members throughout the country are hospital administrators. To meet the requirement in New York that only one-quarter of the Board represent medical providers, Blue Cross switched one member, Charles Delafield, a former hospital board member and for eleven years a provider representative, to the category of "general public." In Philadelphia the same was done with a former hospital administrator who was one of the original founders of Blue Cross and had represented providers for over 30 years. Furthermore, the law considers medical educators to be consumers or general public, not providers. But medical schools comprise the core of large medical centers, complexes of voluntary and municipal hospitals, which are fast becoming the primary unit of health care delivery.

Speaking to the question of representativeness, New York Blue Cross President Douglas Coleman rationalized what has long been the Blue Cross policy. "The word 'representative' is actually a misnomer," he stated. "I mean—who could possibly represent eight million subscribers in New York City? 'Trusteeship' is more nearly the function board members ought to serve—acting on behalf and looking after the interests of subscribers." And in Blue Cross' reasoning, who is more qualified to serve that function than those who know most about hospitals—hospital administrators? While Blue Cross transforms the concept of representation into benevolent trusteeship, more and more consumers are asking why should any hospitals be on the policy making board of a group purporting to represent consumers? Do corporation presidents sit on the executive committees of trade unions?

- In its policies Blue Cross has become virtually indistinguishable from commercial insurance companies. Originally Blue Cross, unlike commercial insurance companies, was considered a community service because the entire community shared the cost of hospitalization. All subscribers paid the same rate i.e. they were "community-rated." However, over the years that practice has changed. To compete with commercial insurance companies,
Blue Cross has given more and more groups the option of becoming "experience-rated," or having their rates determined by the frequency with which their members used hospitals in the past. Needless to say, those who choose experience-rating are those who use little hospital care and can obtain a reduced rate. Those who remain community-rated use more hospital care. They tend to be lower-income, have poorer and riskier jobs, work for smaller employers, have larger families, and are less able to afford health care which would prevent hospitalization. Thus because they are in the weakest position to resist and because they are a greater risk, Blue Cross seeks to raise their rates. In New York and Philadelphia this group alone bore the last rate increases; and, if approved, it will also bear the proposed ones. Whether experience-rated groups have had their rates raised proportionately is not known. These contracts are negotiated individually with each group and the information is not available to the public.

Blue Cross argues that these policies have not deterred subscribers. Coleman recently boasted that Blue Cross had gained 250,000 new subscribers in the New York area last year. He did not boast that Blue Cross had, in fact, lost 84,000 community-rated subscribers and gained 333,500 experienced-rated ones. In the last four years experience-rated subscribers in New York City grew from 45 percent to 53 percent of all subscribers. If Blue Cross' policies become indistinguishable from commercial companies, why should it enjoy such a privileged tax status?

- Blue Cross' tax position and quasi-public status raise a host of other issues. For instance, why should Blue Cross advertise for subscribers? In New York it claims that only .3 percent of subscriber income is used for advertising but, this is over $1.5 million a year. If it is a public corporation, representing consumer interests rather than those of the hospitals or of private enterprise, then its books and records should be open to the public. The public has a right to know where it invests its money, what banks it uses and their relationships to the hospitals, who sits on committees which make crucial decisions, what it charges experience-rated groups as opposed to community-rated ones, exactly what practices it uses to control hospital costs, the role it plays in health planning agencies, what it pays for advertising and lobbying costs through the Blue Cross Association, and numerous other questions. This information is fundamental if Blue Cross consumers are to participate in any meaningful way in Blue Cross. It is even more crucial if Blue Cross is asking to handle any program of national health insurance. The Subscribers' Coalition suit in New York, as well as the suit in Pittsburgh will establish important precedents regarding the public's right to information about Blue Cross.

But ultimately no reform in Blue Cross is going to cure all the ills of the health system or necessarily provide better care for larger numbers of Americans. Everyone knows this, including politicians, hospital executives, Blue Cross, and the subscribers themselves. That is why the President, Congress, the labor movement, the American Medical Association, the American Hospital Association and assorted other interested groups are all jockeying to get their particular proposal for national health insurance on the Congressional table.

Where does Blue Cross stand in all of this? It stands quietly by, shining its shoes and combing its hair, ready to step into the prime candidate for intermediary or administrative agent for national health insurance. This is perfectly consistent with Nixon's propensity for subsidizing the private sector to provide public services. After all, is there a more likely candidate than Blue Cross? Who has more experience (in providing insurance or acting as an intermediary for federal health programs) or a better administrative network to take on this task? Blue Cross stands by, ready to quietly subvert and hand over to the hospitals any benefit national health insurance might bring to the consumer and taxpayer.

This is why struggles of groups like those in New York and Philadelphia are important, not for the small dents they will make in the present operation of Blue Cross, but for the light they cast on the present interests and power within the health system and the public awareness and pressure they bring to bear on coming national "solutions" to the health care crisis.—Honda Kotelchuck

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**I'll Huff**
**And I'll Puff**
**And I'll Blow**
**Your House Down**

Irvington House, a nationally known center for the treatment and study of rheumatic fever, is soon slated to close its patient services. The announcement by the Irvington House Board of Directors in November led to an outcry by the national medical community. The announcement has also prompted the formation of a group of outraged patients, doctors, workers and medical students involved at Irvington House (IH) who are fighting to keep it alive.

Although the information provided by IH administrators has been fragmented, incomplete and even contradictory, one clear fact has emerged: patient services are being eliminated so that future funds can be used strictly for research purposes. Costs for the latter at IH have risen nearly eight times as rapidly as patient care costs in the past four
Fifty years ago, IH opened its doors to provide convalescent care for children with rheumatic fever. With the advent of penicillin, however, rheumatic fever and its recurrence became preventable and the need for convalescent care diminished.

In 1947, IH affiliated with New York University to increase its research facilities. The subsequent increasing emphasis on research became even more apparent in 1952 when Irvington House opened a free clinic in New York City at New York University Hospital for "research in prevention." Finally, in 1963, IH closed its convalescent facilities in Irvington, New York, and shortly thereafter opened a day facility in the NYU Hospital for acute but non-bedridden patients.

Research facilities expanded with the formation of Irvington House Institute in 1963. Since then the program at NYU has been divided into two units: Irvington House, which does clinical research and operates two out-patient clinics and the day hospital; and Irvington House Institute, which does non-clinical research. In the last five years the research emphasis at the Institute has become esoteric—what some critics have called "curiosity-oriented" or "public relations" research. This type of research utilizes monkeys, electron microscopes and principles of molecular biology; it is laboratory rather than patient-oriented research.

Irvington House Institute has meanwhile been rewarded with federal research grants. NYU has shared the accolades since many of the studies were directed by members of the NYU Medical School faculty who use the facilities of the Institute (housed in the NYU Institute of Rehabilitation Medicine).

Irvington House's clinical program, located entirely at NYU Medical Center, has served about 600 young patients (ages 4-25): 500 in the rheumatic fever out-patient clinic; 80 in the out-patient juvenile rheumatoid arthritis clinic; 7-8 daily in the day hospital. The population using these services is about 65 percent black or Puerto Rican and 35 percent white. All come from poor or working class families.

Although deficient in comprehensive care, the clinics have served several useful purposes. Since rheumatic fever has the tendency to recur and regular monthly treatment over many years is usually necessary, the clinics' main concern has been follow-up; in addition to examinations and medication, car services were provided for children who needed them and schooling was given to the children in the day hospital. All of these services were free.

In October, 1970, IH's Executive Director told the staff that IH was operating at a small deficit of $60,000 to $80,000. A few days later the Board of Directors announced that the deficit was $214,133. The import of this announcement became clear when the Board unanimously voted in November to close down the patient care services. Their resolution read: "that the main emphasis of Irvington House be the support of the Irvington House Institute program of research into the causes and mechanisms of rheumatic fever, rheumatoid arthritis and allied diseases, and, in view of our serious financial condition, that we eliminate patient care services." The day hospital closed on December 23rd and the termination date for the rheumatic fever and juvenile rheumatoid arthritis clinics was set for February 28, 1971.

Responding to the announced closing a group of angry parents, medical students, faculty and hospital workers began meeting in attempts to pressure NYU to keep Irvington House open. Over 100 persons picketed and demonstrated at NYU Medical Center demanding that (1) Irvington House remain open and free of charge to all patients and (2) that NYU officially assume financial responsibility. With pressure mounting, Dr. Ivan Bennett, Director of NYU Medical Center and Dean of NYU Medical School, agreed to meet with the demonstrators. However, for several weeks he refused to come to any meetings. Meanwhile a petition stating these demands had been circulated and signed by 1000 persons.

When Dean Bennett finally appeared at a meeting on February 1st, he stated that a $4.2 million deficit of NYU Medical Center prevented it from assuming the financial burden of Irvington House. A budget drafted by a committee led by Dr. Mario Spagnuolo, IH's Clinical Director, projected that Irvington House could run its clinical program on $120,000 per year—less than 3 percent of the Medical Center's deficit. During a meeting many of the people in the group offered to raise money for the budget if Dean Bennett would only help them. Bennett's response was cool. He implied that he would only be a sponsor if the money was raised first, and noted Irvington House ran the only free clinic in the Medical Center. He indicated that since patients paid at other clinics, there was no reason why this clinic should not also operate on a "fee-for-service" basis.

Group members responded angrily to Bennett's suggestion, suspecting that it was NYU which had influenced IH's Board of Directors to continue research while eliminating patient services. Since IH's Board is partially composed of philanthropists and business men also on the Board of NYU's Medical Center, such influence is probable.

An examination of IH's budget audits and annual report highlights the shift from patient care to research. In the past four years, the patient care budget rose by only 14 percent while the research budget rose 111 percent—a ratio of nearly 1:8. Furthermore, the rise in research expenses has been financed from philanthropically derived income, not from federal research monies which actually declined over this period. Clearly, if the IH Board of Directors had wished, patient care...
services could have continued.

Why didn’t the Board make this decision? Many group members are convinced that NYU wanted the clinical program discontinued.

- The research program subsidizes more faculty for the University than the clinical program. The clinical program requires more non-doctor staff, such as nurses, receptionists and aides who take away money that could be used for research doctors and equipment.
- Irvington House pays only $50,000 for the 20 rooms it occupies in the basement passageway connecting University Hospital and the Institute of Rehabilitation Medicine. Some group members have fatalistically speculated that this space could be used more profitably by the University as rented examination room space for faculty physicians or for another department.
- NYU, faced with cutbacks in federal research funds, is angling for money, no matter how small in amount, to maintain its research activities. Cutting off two or three researchers in this time of scarcity may be much more traumatic to NYU than cutting off 600 patients, most of whom are black and Puerto Rican and poor. Whatever the reasons, the Medical School has been content to sit by while yet another patient care program is sacrificed for research.

As this BULLETIN goes to press, Irvington House’s fate is still unknown. Dean Bennett has prepared a mailing to be sent to all parents of patients seeking their response to instituting a fee-for-service clinic, with a per visit fee of $25.

But the worker and parents group previously rejected the fee-for-service proposal. As one parent noted: “[Just] as you must eat to live, my child needs this... medical service to live. I will use every means possible to prevent the disbanding of this clinic, whether my action be called those of a radical, militant, trouble-maker, or whatever; I fight to hold proud what I consider to be expected from every American Father.”—Marsha Hanelman

St. Vincent’s Hospital: Up Against The Community

After three years of unproductive shilly-shallying around, the Ghetto Medicine Program in New York City is being taken to task, and to court. That is essentially what’s behind the recent legal action brought against St. Vincent’s Hospital and Medical Center by its Ambulatory Care Advisory Committee. The Committee wants access to St. Vincent’s financial records; if the Committee wins, a major precedent in consumer-hospital relations may be established.

The Ghetto Medicine Bill was passed by the New York State Legislature in 1968. It was developed shortly after Medicaid funds were severely cut back; and it was viewed as a pacifier to the poor municipal hospitals which faced drastically curtailed budgets without Medicaid money. At the time, the program held a lot of promise. With state help, cities could begin to finance expansion of outpatient and emergency services in public hospitals—on the condition (1) that these ambulatory care facilities provide comprehensive care and (2) that community advisory boards be established, “in order to insure that the organization and operation of ambulatory care programs is of maximum value to the community served.”

However, when the City Health Department, Rockefeller, and the voluntary hospitals got through with the bill, there was little left in the program which resembled the original idea. The money ($14 million worth) is now being used by 22 voluntary hospitals in New York City. They are not public; some are not near ghettos; and they don’t provide new services. The voluntaries haven’t had to do too much to get the money. They have had to agree to plan for improved ambulatory services. They have also had to agree to sit on joint hospital-consumer boards, which are supposed to advise on the planning of the rumored new services, but which have vague powers and little authority.

Basically, the whole thing amounts to a shuck: using public monies to help pull private institutions out of the hole, with no benefit to the poor. Consumer members of the Advisory Committees began to get suspicious of the Program when some committees couldn’t even find out how much money their hospitals had been given under the Ghetto Medicine Program.

The intent of the suit which the consumer members of the Ambulatory Care Advisory Committee have filed against St. Vincent’s is to “begin to spell out consumer powers where public funds are used for consumer services.” This seems to be an innocuous enough idea, until one realizes that virtually all private service institutions are heavily subsidized by public funds and yet public accountability is unheard of. Voluntary hospitals in New York City receive an estimated 45-75 percent of their incomes from public coffers. St. Vincent’s gets 53.5 percent of its income that way. Even the New York Times recognizes the significance of the case “[it] could have citywide — even nationwide — consequences in the growing public movement for consumer participation in health-care programs of all kinds.”

The Advisory Committee came into existence shortly after St. Vincent’s embarked on
plans to demolish a Greenwich Village landmark theatre in order to build a nurses’ residence. Community protest had forced the hospital to promise that two floors of the structure would house ambulatory services for the surrounding area. The consumer members of the Advisory Committee saw this as an excellent opportunity to help plan for the new services and structure.

In September 1970, plans for the new building were shown to the Committee. When members then requested individual copies of plans so that they could study them in detail, the hospital agreed. The hospital reneged on this promise however; they said it was pointless to release the plans since they were not final. The Committee argued that it was only possible for them to play their proper role while the plans were still fluid. Finally the hospital said that the Committee couldn’t have the plans, because the Board of Trustees had decided that the hospital couldn’t afford to build the building. Quite naturally the Committee then requested the information which the Board used in arriving at its decision not to build. After three months of equivocation by the hospital, the consumer majority of the Advisory Committee decided to sue for the information.

In announcing the suit, the Committee drew the clear connection between the equivocation of the hospital and the ambiguous intent of the Ghetto Medicine Program: “We do not believe that the primary blame for our difficulties lies with the hospital. Rather, we believe, our difficulties have reflected a basic shortcoming in the Ghetto Medicine Bill itself. We believe that unless the law is substantially changed, committees like ours cannot succeed, and public accountability cannot be achieved.”

The committee does not use the militant language or tactics of other health movement groups. It has not taken any public actions, like setting up grievance tables and it specks of community control only by inference: “We do not seek powers to make decisions that are properly the province of the professional hospital staff. We do seek powers that would make it possible for us to serve as an effective public watchdog where public funds are involved. At the very least, we seek the power to compel information. If the law does not give us that minimal power, then the law is a fraud.” Being an effective public watchdog, as they define it, could be a substantial blow to the power and public irresponsibility of voluntary hospitals and medical centers. It could become difficult to continue business as usual with an effective public watchdog panting around, even if its bark is worse than its bite.

St. Vincent’s has acted like a perfect set-up for this suit. The Advisory Committee’s legal brief contains a careful construction of letters and minutes which documents their own earnest attempts to see information basic to their advisory role; it also exposes St. Vincent’s evasiveness and unwillingness to release that information. The Committee’s suit makes the hospital look extremely foolish and blundering, especially since the Committee members don’t feel that St. Vincent’s is deliberately trying to hide some bit of scandalous information. Rather it seems that St. Vincent’s is acting like many of the so-called “public” institutions in the city—e.g., Con Ed, Transit Authority, Blue Cross—it hasn’t ever had to talk to consumers, gets nervous at the thought of having to, and certainly doesn’t want to be held accountable to anyone other than its own Board of Trustees.

What is more ironic, St. Vincent’s doesn’t seem to learn from its past mistakes. When the Committee was told of the decision not to build the proposed building, they were also told that St. Vincent’s was considering establishing a commercial parking lot on the site of the former landmark. Even though the Committee suggested that temporary buildings housing ambulatory care services might be more warmly received by the Villagers, St. Vincent’s has announced its intention to use the space for parking. In Greenwich Village that kind of action is even more foolish than denying public access to information. Villagers are already talking about chaining themselves to bulldozers.—Constance Bloomfield

**San Francisco:**
**Striking Out For Patient Care**

In January, 1971, 90 percent of the interns working at San Francisco General Hospital struck for four days. Faced with a growing patient load, without any increase in personnel, the interns felt pushed to the wall. In November they laboriously detailed 101 demands for improved patient care and increased intern benefits. But the hospital’s response was long on words and short on action. Tired, with no sense of other options, the interns walked out January 21st.

Although it is a public hospital, San Francisco General Hospital (SFGH) is affiliated with the University of California Medical School which appoints its doctors. SFGH has been a focal point for community and hospital worker pressure for better health care for more than a year. Last year, workers at SFGH triggered a city-wide strike of municipal workers (See Health-PAC BULLETIN, July-Aug., 1970). At that time, interns refused to join the workers’ strike action.

But when the new interns arrived at the hospital in July, 1970, they formed their own organization, the Interns Association, which began to collect grievances. By November, the association had drawn up 101 demands,
Staten Island: Struggle For Community Hospital

A new front in the growing public battle for responsive health care opened in late January on New York’s Staten Island with a public rally that included hospital workers, students and community groups.

The rally resulted from events that began in late 1970 with an announcement from Washington that Staten Island’s Marine Hospital, a federal Public Health Service facility primarily serving merchant marines and military personnel, would terminate patient services in July, 1971.

Although it came as a sudden blow for the 1000 Staten Islanders employed by the hospital, the announcement has since generated a growing alliance of both workers and consumers aroused by the possibility that Marine’s closing could be transformed into an answer to Staten Island’s chronic shortage of hospital facilities.

Staten Island, New York City’s smallest and fastest growing borough (population 325,000), has no municipal hospital. The one proprietary and three voluntary facilities now serving Staten Island face constant bed shortages and crowded services. Four to five week delays in medical and surgical admissions are reportedly common.

Clearly, Staten Island has long needed additional hospital facilities. But as a federal institution, Marine Hospital has only admitted a handful of local community residents on an emergency or “special studies” basis. The 636-bed facility operates at an average of only 66 percent capacity in a borough where medical and surgical services in other hospitals usually exceed 100 percent capacity.

In response to this and to the announcement of Marine’s closing, a public rally was called in January by the Health Workers Council (HWC), an organization of licensed practical nurses, laboratory technicians, dietetic staff and other workers at Marine Hospital. Their purpose was to demand the transformation of the hospital from a federal facility into a “Staten Island Family Hospital,” financed by the City, but directed under community and worker control.
What is the source of the Health Workers Council's concern for the health needs of Staten Islanders in addition to its own morepressing employment needs? Like many worker groups joining with community forces around the country, HWC's concern developed during long months of organizing. The Council began by organizing workers at Marine Hospital in early 1970. The focus of these early activities was workers' rights and fringe benefits, since the federal government severely restricts wage and salary bargaining. HWC developed a trade union-like "unity platform" including demands for: free health care services for workers and their families, a free day-care center, a travel allowance to and from work, one free meal a day, and worker-controlled grievance table.

Backing up its program, HWC staged a series of actions dramatizing individual demands: an "eat-in", a cafeteria boycott, a free pre-school physical examination for the children of workers, and a "sick-out" protesting reduced patient care, the firing of workers and the lack of worker health care. The Marine Hospital administrators reacted by either firing or suspending thirty of HWC's most active members.

As HWC was pulling itself together from this blow, the Public Health Service (PHS) administrators in Washington announced that Marine Hospital, along with eight other PHS hospitals and thirty PHS clinics nationwide would close in July, 1971.

HWC organizers saw the announcement as an opportunity to broaden their struggle. Hence they took the early lead in organizing a coalition of organizations of senior citizens, students, women, tenants, welfare recipients, black community people, youth, and other worker groups on Staten Island.

This coalition supports the pullout by the PHS from Marine Hospital. But by demanding that the City convert it from a federal facility that "didn't serve the needs of the community anyway" to a municipally-financed but publicly-controlled hospital open to all, the Staten Island coalition has become one more example of a growing national movement for worker-community control of health.—Doug Dornan, graduate student, Columbia School of Social Work

THE COLUMBIA 33
Worker unrest continues to bubble to the surface at New York's prestigious Columbia-Presbyterian Hospital. The latest event involves the firing of 33 black and Puerto Rican workers at the non-union institution due to the color of their underwear. The firing has prompted community and student protest rallies that have attracted over 200 supporters to date.

The firing is only the most recent symptom of a blend of blunder and audacity by Columbia-Presbyterian administrators in dealing with community and worker groups (see Health-Pac BULLETIN, October, 1970). It came after workers had responded to a series of provocations by the administration.

Events began to crystallize several months ago when Columbia attempted to separate the 75 workers in the food service department into two shifts—one essentially all black and the other Puerto Rican. Workers protested this arrangement and Columbia backed off.

Workers have a long history of unionization attempts and other fights with Columbia. Administrators have responded by establishing an internal spy network, complete with dossiers on activists, and by harassing the activists at every step of the way.

In late November, the administration arbitrarily demanded that all food service workers begin wearing white undershirts beneath their uniforms. Previously, workers had worn undershirts of varying colors which were visible only at their open collars. Workers protested the undershirt order and it was subsequently rescinded.

Columbia's administrators, however, could not let this example of increasing independence among its workers pass. In early January of this year they fired one worker and suspended another; both were suspected leaders of the previous protests.

Other workers stopped work in protest and the next day, 33 workers were barred from the hospital and were told they were fired.

Protests have continued around the firing, but, at least for the moment, the workers remain out of work.

HEALTH/PAC announces its first occasional paper:
CONÉY ISLAND HOSPITAL
A CASE STUDY IN THE POLITICS OF HEALTH
This 16 page HEALTH/PAC report documents the politics and decision making of a New York City municipal hospital. It is a case study of Coney Island Hospital—who controls it, how they control it, and the power of the present leadership. The report concludes with concise recommendations for improved health care delivery. Though focussed on a New York City hospital, the power analysis is applicable throughout the country.

The Coney Island Hospital Report is available from HEALTH/PAC for 50 cents
Fortunately, political activity in the Federal Bureaucracy is not limited to Nixon, the Cabinet, or the Congress. Ever since the Moratorium activities of 1969, groups of federal employees have been churning up the waters around the Potomac.

At the Department of Health, Education and Welfare (HEW), there are now two regular opposition newspapers, three organizing committees, and a blossoming of union activity. DRUM, an organization of clerical and college-trained black employees, is most well known in the department. It puts out a newspaper and in early December produced an action: DRUM members seized a hallway outside Secretary Elliot Richardson's office to protest discrimination and dead-end jobs for blacks within the Department. Fifty-two people were busted.

Last summer, the HEW Action Project was organized. The project has about 30 dues-paying members and has just hired a full-time organizer. For some time, their energies have been devoted toward getting a day care center started for HEW employees. HEW agreed to establish a center and let a $100,000 contract to the Thiokol Corporation to develop the center. Thiokol's previous experience had been largely limited to making solid propellants for rockets. HEW has been paying Thiokol for six months, but employees have seen no progress toward their center. In fact, HEW and Thiokol are still squabbling about who is to provide the space for the center.

The Action Project has just been recognized by the higher-ups, which means they can now set up a table for membership recruitment. The Action Project uses the "Advocate," a gripe sheet, and Friday night seminars to reach more HEW employees.

Union enrollments have increased in all the Federal Departments as well as within HEW. Locals of the American Federation of Government Employees (AFL-CIO) are organized along departmental lines and apparently control of more of these locals is being taken by younger and more progressive employees. These government sanctioned unions have largely limited their activities to grievance work. The unions are prohibited from striking and bargaining collectively. Other public employee organizations have decided not to observe these prohibitions; the postal strike of last year is a case in point.

Thus far only one HEW organization has concerned itself with issues outside of their work place. The National Institute of Health/National Institute of Mental Health Moratorium Committee has been able to mobilize widespread support for anti-war actions.

All the various committees around HEW are tentatively considering tackling HEW's execution of Nixon domestic policies. According to one source, "the level of consciousness about the country's drift to the right is very high among committee activists." As the list of HEW's reactionary policies grows longer and longer, protest from within the agency can become increasingly valuable to clients, recipients, advocates and human service workers on the outside.

THE AMERICAN HEALTH EMPIRE: POWER, POLITICS, AND PROFITS

A REPORT FROM THE HEALTH POLICY ADVISORY CENTER

Our first book, this is an angry and hard-hitting analysis of the American health system—who profits from it and who loses. It follows the growth of the health system from "cottage industry" to today's Medical Industrial Complex, exposing the ruthless priorities of the medical empires and corporations which dominate today's health scene. It documents—with vivid case studies—the bankruptcy of recent health "reform" programs, from Medicaid to National Health Insurance. It reports from the front lines of ongoing community and workers struggles for humane and democratic alternatives in health. A must for BULLETIN readers, and anyone else who cares about the quality, and quantity, of American life.

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