1 Montefiore-NCB:
THE TUNNELS THAT BIND. The largest voluntary hospital in the Bronx swallows up the newest addition to the City hospital system.

7 Santa Cruz:
DEATH OF A HOSPITAL. A California county hospital bites the dust, shot down by its private hospital neighbors.

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Montefiore-NCB

What happens when a public official whose primary loyalty is to the voluntary hospitals designs an affiliation program as a means of providing medical staff to a municipal hospital system? One thing that happens is that 13 years later a major voluntary teaching hospital acquires a $93-million new wing of 412 beds, whose construction cost and operational deficit are borne as a public expense and whose essential superfluity is papered over by an impressive-sounding plan for regionalizing health services in its geographical area. More generally what happens is that the precedent is thereby set for the complete absorption of municipal hospitals into their private affiliates.

That, in short, is the story of the North Central Bronx Hospital (known, not always fondly, as NCB), now nearing completion of construction on New York City's northern border, adjoining Westchester County. It's fundamentally a story of health politics making bedfellows of public officials and private
medical imperialists. The participants consummated the affair in the '60's and have attempted to camouflage its offspring by secrecy and deception ever since. Now that childbirth is imminent, the public parent is too embarrassed to know quite what to say about its progeny, while the private parent smugly waits for the baby to fall in its lap, knowing full well that there's nowhere else for it to go.

**The Birth of a Sellout**

It all started back in the days when a public entrepreneur borrowed from the private sector was designing and implementing New York City's affiliation program. (That program developed into a system whereby six medical schools and seven voluntary hospitals now provide medical staff for 17 of the City's 19 municipal hospitals in return for generous lump-sum payments of public funds. See BULLETINS, December, 1971 and May, 1972.) Dr. Ray E. Trussell, then director of Columbia University's School of Public Health and Administrative Medicine, headed the staff of a mayoral commission that in 1960 recommended affiliations as the answer to the crisis of the municipal hospitals. In 1961 he took a leave of absence from Columbia, assumed the post of City Hospitals Commissioner, and proceeded to implement his own recommendations.

The mindset Trussell brought to his new job is well reflected in his published statements on the virtues of affiliation. In one article, for example, he spoke of "trying to bring the resources of our great voluntary institutions together with the stability of the tax resource—the most stable source of money that you can relate yourself to as an operating agency." (1) In another, he noted that "Any shift of training costs to a tax base through an affiliation automatically strengthens the survival potential of the voluntary system." (2, 3)

One of Trussell's most prominent and most consistent supporters in the often-delicate task of implementing the affiliation plan was Dr. Martin Cherkasky, director of Montefiore Hospital and Medical Center in the Northwest Bronx, that borough's largest voluntary hospital. His support was undoubtedly strengthened by the particularly generous affiliation contract awarded Montefiore in 1962 as affiliate to Morrisania City Hospital in the mid-Bronx. The affiliation contract itself was but part of a package deal, the other part being an assurance that when the outmoded Morrisania was eventually rebuilt, its location would be shifted north to a site conveniently adjacent to Montefiore.

Cherkasky provided the rationale for such a relocation in a 1961 medical journal article: "Today we must reckon with the hard fact that inpatient hospital care can only be adequately provided where the medical manpower is, and that the location of the medical manpower must determine the location of the inpatient facilities, . . . Wherever there needs to be rebuilding of antiquated city facilities, they must be built on the grounds of medical schools or major voluntary hospitals." (4) At about the same time, however, a study by the Hospital Council of Greater New York was noting the "lack of correspondence between the location of the medical schools and major teaching hospitals and the areas of the city in need of municipal hospital services." (5)

**The Deed That Sealed the Deal**

Act 2 of this drama of betrayal of the public interest takes place in 1969, when Montefiore formally deeded to the City 73,000 square feet of land immediately adjacent to its main building, and the City formally agreed to accept that gift subject to certain conditions imposed by Montefiore.

In exchange for Montefiore's beneficence, the City agreed to build on the donated land a general hospital that would be physically connected to Montefiore's buildings and whose design would be developed in consultation with Montefiore. The City further agreed that, if it decided not to (or no longer to) operate a municipal hospital on the site, it would pay Montefiore $400,000, the appraised value of the land, and give it an option to buy the hospital at a price to be set by the City's Board of Estimate. If the City decided not to (or no longer to) contract with Montefiore for the provision of professional services at the new hospital, it again agreed to pay Montefiore $400,000.

The legal papers surrounding this public-private transaction reflect the confused rationale (or rationalization) for the projected municipal hospital and hint at its lack of any relation to community need. Montefiore's original petition seeking judicial approval of its donation of land to the City informed the (Continued on page 4)
Letter to Our Readers

The BULLETIN has a new face. It also has a new body—larger pages, shorter articles, a fresh format and graphics. New features will be a regular part of the BULLETIN—book reviews, news briefs "monitoring" recent developments on the health scene, and an expanded correspondence section.

We hope you will find our new format more inviting not only to read but also to write for. We solicit and make every effort to print correspondence, subject only to space limitations. We will also give serious consideration to publishing original articles which we receive from people outside our staff. Should you consider writing an article for the BULLETIN we suggest that you telephone or drop us a letter first so that we can discuss subject and length of the article to see how it meshes with plans for upcoming issues.

The changes in the BULLETIN also reflect changes at Health/PAC itself. We will continue, as we have in the past, to serve community based groups concerned with changing the health system. The events of the past few years, however, convince us that this is not enough. Greater efforts must be made to reach and service the needs of those who work within health institutions and who share that concern.

In the next few months we hope to be in closer touch with groups of such workers, sounding out their needs, reflecting on their experiences, examining strategies, and, if there is sufficient interest, fostering communication between groups of like mind and situation. If you would like to be part of this process please telephone or write Health/PAC.

Unfortunately, these changes do not come without a price. The BULLETIN'S new format is more expensive and this, on top of generally rising prices for paper, printing and postage, leaves us hard-pressed for money. To partially offset this problem we will be publishing the BULLETIN six times a year. Current subscribers will automatically have their subscriptions extended so that they can be assured of receiving the total number of BULLETINS already promised. Our present subscription rate will remain unchanged so that the BULLETIN is still the best bargain in town. And as an added bonus to subscribers, we will be sending you occasional papers and pamphlets on health throughout the year. The first special report—already on its way—is Barbara Ehrenreich and Deidre English's dynamite "Complaints and Disorders: The Sexual Politics of Sickness," another excellent pamphlet by the authors of the earlier best-seller, "Witches, Midwives and Nurses," which is still available from Health/PAC.

Health/PAC has for five years faithfully served a movement which seeks a fundamental transformation of the present health care system. Year after year we have provided readers with accurate analysis of rapidly changing health developments and policies. We enter a new year convinced that we can continue to deepen this tradition. We thank you for your support and continue to solicit it for the future.

The Health/PAC Staff

P.S. We have had problems in the process of mailing the BULLETIN recently. If you have had problems in receiving it, please let us know.

Montefiore-NCB
(Continued from page 2)

court that the City had decided to replace Morrisania Hospital "and in implementation thereof proposed to construct a general hospital . . . in the north Bronx, to be known as North Central Bronx Hospital." Two weeks later, however, Montefiore had changed its tune; it informed the court in a supplemental petition that its original papers had been in error and that due to an increased need for hospital beds in the Bronx since preparation of the initial plans for NCB, "to the best of petitioner's knowledge, the City of New York presently plans that the new North Central Bronx Hospital be in addition to Morrisania Hospital."

Whatever lies behind that shift—and it may be community outrage at losing a City hospital in the Morrisania area, as much as machinations on Montefiore's part—the net result looks to be that Montefiore will have its cake and eat it too. It may well get NCB plus Morrisania (either replaced, renovated or continued in its present decrepit condition), and the City may well be supporting appreciably more hospital beds in the Bronx than are needed by its population.

Pandora's Box Opens

The dénouement of the tragicomedy of NCB unfolds on the pages of an unpretentious little document dated February 5, 1973, which sets forth concretely Montefiore's intentions as to how NCB is to be operated. The document was prepared by Montefiore and sent over to the City's Health and Hospitals Corporation (HHC), the so-called public benefit corporation that in 1970 had replaced the Department of Hospitals as the agency operating the municipal hospital system. Its terms reflect Montefiore's self-assurance, that, thanks to its past cleverness and the City's past cooperativeness, what should be outrageous has become in a sense perfectly logical. (More ominously, such terms may become so acceptable that other affiliates of the municipal system may seek to build on the Montefiore precedent.)

Unlike the traditional affiliation contract, in which the HHC at least nominally administers the municipal hospitals and contracts out to the affiliate for the provision of medical staff, the Montefiore document projects a 10-year contract under which NCB will be run as an integral part of the total Montefiore complex, with a single administration and single workforce throughout, all under Montefiore's direction. This arrangement, which Montefiore justifies on the grounds of efficiency and economy, not only gives Montefiore total control but also gives it a valuable new resource to play around with: It can, for example, put private patients in the shiny new NCB and indigent patients in the aging Montefiore facility, or it can take advantage, for its own clientele, of the fact that NCB has a generously large maternity service, while Montefiore has none.

Montefiore's projected financial arrangement again departs from the affiliation contract approach and reflects its propensity to seek to have its cake and eat it too: Montefiore will collect what it can from insurance carriers, Medicare and Medicaid, and the HHC will pay the hospital's operating deficit. This stance makes it clear why Montefiore has rebuffed suggestions by the HHC that perhaps it would like to buy or lease NCB—after all, a clearance sale of NCB for a dollar would be less advantageous than a guarantee that its deficits will be paid.

Montefiore attempts to avoid the appearance of a total giveaway by providing in its document for the HHC to maintain three audit teams at NCB for the purpose of conducting administrative, fiscal and medical audits. Montefiore knows, of course, that the HHC has never seriously monitored affiliates' performance under the current affiliation contracts and that the risk of public interference in a setting where monitoring is inherently more difficult is nothing for it to worry about.

Before we ring down the curtain, we must admit that the plot is considerably thicker than the sordid little sketch presented so far. The simple motif of total sellout is in reality embellished by a number of other themes and subplots. There is, for example, the matter of the imperial ambitions of Montefiore and of a regionalization plan that smells like an expression of those ambitions. There is the question of whether NCB bears any relation to the needs of the Bronx for municipal hospital beds or whether the same regionalization plan is a clever rationalization of a superfluous institution. There is the evil and weakness of the HHC and the question of which is the predominant characteristic. And
accompanying all of the above is a growing but not-always-harmonious chorus of community outrage.

**Montefiore on the Make**

Since 1961, when our story begins, Montefiore has reached out on several fronts. On its own turf, it has built a new outpatient facility, a new inpatient building, the Loeb Home (an 80-bed extended-care facility), a 10-story research institute, five apartment buildings for staff housing and a 676-car garage. With a staff of over 5,000, it has become the largest employer in the Bronx. (It has also become a major community hospital for the upper-middle-class residents of adjoining Westchester County, for whom the City-funded NCB may well become an additional health resource.)

Montefiore's empire-building has not been so short-sighted as to limit itself to its own real estate or even to its affiliation with the municipal Morrisania Hospital (see BULLETIN, April, 1969). It has developed a relationship with the Albert Einstein College of Medicine in the Northeast Bronx that has never been cordial but has frequently been advantageous. From a teaching affiliation with the College, effected in 1963, Montefiore moved in 1969 to take advantage of the shaky financial position of Einstein's 400-bed College Hospital and absorbed it as a component part of the Montefiore Hospital and Medical Center.

Never one to settle down, Montefiore Director Cherkasky has been negotiating off and on with New York Medical College concerning the possibility of its replacing Einstein as Montefiore's medical school affiliation, a move that may have the primary purpose of keeping Einstein in line. (Einstein's financial position is currently much weaker than Montefiore's, partly because of federal cutbacks in medical research, more seriously because the latest Mid-East war has motivated many of its important donors to send money to Israel rather than to the Bronx.) Cherkasky has carried out his NCB machinations without consulting Einstein, perhaps in retaliation for the fact that Einstein had pulled off an affiliation with Bronx-Lebanon Hospital, a 600-bed voluntary, without consulting Montefiore.

The competition for affiliations has put most of the Bronx's supply of hospital beds under control of one or the other of the competitors. The combination of Montefiore and its affiliates plus Einstein's affiliated hospitals totals 67 percent of the general-care beds in the Bronx, including 82 percent of the municipal hospital beds, not including NCB. (See box below.)

Montefiore has not been so narrow-minded as to limit itself to hospitals and medical schools in the development of its power base. It sponsors the showcase Martin Luther King, Jr. Health Center (42,500 registered patients), as well as the Montefiore-Morrisania Comprehensive Health Care Center (12,500 registered patients), both in the mid-Bronx. Under City contract, it provides medical services to juveniles detained at the Spofford Adolescent Remand Shelter and to inmates

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**The Bronx Empire**

**Beds Controlled by Montefiore and Einstein**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montefiore Hospital</td>
<td>720</td>
</tr>
<tr>
<td>(Extended-care beds at Montefiore)</td>
<td>80</td>
</tr>
<tr>
<td>Einstein College Hospital</td>
<td>422</td>
</tr>
<tr>
<td>(part of Montefiore Hospital &amp; Medical Center)</td>
<td></td>
</tr>
<tr>
<td>Beth Abraham Hospital</td>
<td>502</td>
</tr>
<tr>
<td>(Voluntary, long-term care, affiliated Montefiore)</td>
<td></td>
</tr>
<tr>
<td>Morrisania Hospital</td>
<td>313</td>
</tr>
<tr>
<td>(Municipal, affiliated Montefiore)</td>
<td></td>
</tr>
<tr>
<td>Bronx Municipal Hospital Center</td>
<td>1,073</td>
</tr>
<tr>
<td>(Municipal, affiliated Einstein)</td>
<td></td>
</tr>
<tr>
<td>Lincoln Hospital</td>
<td>355</td>
</tr>
<tr>
<td>(Municipal, affiliated Einstein)</td>
<td></td>
</tr>
<tr>
<td>Veterans Administration Hospital</td>
<td>1,018</td>
</tr>
<tr>
<td>(Federal, affiliated Einstein)</td>
<td></td>
</tr>
<tr>
<td>Bronx State Hospital</td>
<td>702</td>
</tr>
<tr>
<td>Bronx Children's Psychiatric Hospital</td>
<td>35</td>
</tr>
<tr>
<td>(State, affiliated Einstein)</td>
<td></td>
</tr>
<tr>
<td>Bronx-Lebanon Hospital</td>
<td>601</td>
</tr>
<tr>
<td>(Voluntary, affiliated Einstein)</td>
<td></td>
</tr>
<tr>
<td>Total Montefiore-controlled beds</td>
<td>2,037</td>
</tr>
<tr>
<td>Total Einstein-controlled beds</td>
<td>3,784</td>
</tr>
<tr>
<td>Grand Total</td>
<td>5,821</td>
</tr>
</tbody>
</table>

The grand total includes 4,502 beds in general-care hospitals, out of a total of 6,674 such beds in the Bronx (including 1,043 at proprietary hospitals).
at the five institutions on Riker's Island (see BULLETIN, September, 1973).

For the future, Montefiore's more-or-less immediate plans, in addition to its takeover of NCB, include construction of a 300-bed patient care building (to replace obsolete beds in its original facility), a surgical center and garage, a plaza and service base and a center for post-graduate education and research. Its more long-range plans call for a doctors' office building, a motel and garage, an education tower and a conference center.

**Regionalization or Maximization?**

The capstone of Montefiore's grandiosity is a regionalization scheme known as the West Bronx Health Planning Study. Developed by Montefiore at the suggestion of its friends at the Health and Hospitals Corporation (of which more later), the document is chock full of tables, appendices, demographic projections and liberal-sounding recommendations for developing a truly rational health care delivery system for the West Bronx.

The regionalization concept per se has of course much to recommend it, in terms of developing continuity of care and avoiding unnecessary duplication of expensive treatment facilities. In the hands of Montefiore, however, the concept becomes a scenario in which its empire would be guaranteed a dependable, increasingly large supply of patient bodies and in which Montefiore's considerable influence over all health care delivery in the West Bronx would be assured. The center of that empire has become a hyphenated institution known in the plan as Montefiore Hospital-North Central Bronx Hospital.

The flow of patient bodies is charted through what the plan dubs the West Bronx Health Care System. This comprises ten comprehensive neighborhood health centers feeding into five community hospitals, which in turn are backed up by one regional hospital for superspecialized care. The Montefiore-NCB complex becomes the destination for patients coming from two distinct sources.

First, the plan designates Montefiore-NCB the backup community hospital for three of the neighborhood health centers, of which one is the NCB outpatient department and two are to be constructed in adjoining areas of the Bronx. Second, Montefiore-NCB is also designated the system's single regional hospital for superspecialized care; it is estimated that this function, combined with patients from outside the system who seek superspecialized care at Montefiore, will fill 52 percent of the beds in the Montefiore-NCB complex.

"No regionalization without representation."

—Bronx community health activists

A final feature in this patient-channelling plan is what one might call the recapture provision. The plan notes with some dismay that about one-third of West Bronx residents needing hospitalization currently leave the borough, mostly to Manhattan, to get it. "It is deemed socially desirable," according to the plan, "to decrease this to 15 percent for the West Bronx by the year 1990"; this recapture is to be accomplished through the construction of new neighborhood health centers, which will presumably get patients out of the habit of going to Manhattan to see a doctor, and though "construction and renovation of more adequate hospital facilities." Nothing is said about the implication that if there are beds in the West Bronx waiting to be filled by people whose past habits have taken them to Manhattan hospitals, then there's got to be a surplus of beds, however the patients get distributed, in the two areas combined.

The plan leaves governance of the system neither to chance nor to existing boards of trustees, community boards and governmental agencies. It projects a Health Consortium Board, representing participating providers and "appropriate governmental bodies." All governmental and voluntary agencies currently involved in regulation and planning of health institutions will delegate their powers, as far as the West Bronx is concerned, to the Consortium Board. When asked about the absence of consumer representatives on the Board, Montefiore Deputy Director Mo Katz responds that the City's Comprehensive Health Planning Agency (which will be represented) is an agent of consumers. This is a description that many (Continued on page 12)
Santa Cruz

In 1968 Santa Cruz County, in the California ocean resort and agricultural belt, opened up its shiny new $2.5 million public hospital. In 1973, the County Board of Supervisors ordered the facility closed. The hospital had served thousands of low-income people traditionally turned away by the area’s private hospitals.

Now the county hospital’s rooms stand empty, awaiting conversion to some other use. Its 214 employees have gone in search of new jobs, while former patients do the best they can with local private hospitals.

What happened in Santa Cruz is a classic example of a public health system sacrificed to the financial needs of the private health sector. The three private, “non-profit,” hospitals in the county, each suffering under Nixon’s Economic Stabilization Program and two faced with declining occupancy rates, have all gained from the influx of patients who bring with them Medicare, Medicaid or county funds. How was the closure engineered? What economic forces brought it about? And what is happening to lower-income patients now that their hospital is shut down?

The Fight for Beds and Bodies

Lying 100 miles south of San Francisco, Santa Cruz County has two major population groups with a high illness risk—the elderly, at a percentage nearly twice the state’s average, and the 15 percent Mexican-Americans, mostly poor agricultural workers. The county is served by four hospitals, three of them private. With a sizeable portion of the 124,000 residents Catholic, Dominican Hospital is the most successful with an occupancy rate of 93 percent. Its 150 newly constructed beds are the choice of most of the north county’s 145 physicians.

Community Hospital, about a mile away, was built by Harold Sundean, a wealthy businessman and Seventh Day Adventist who regards the hospital as his personal cause. In spite of an occupancy rate of only 73 percent, Sundean financed an expansion of the hospital in 1971, bringing it to 180 beds. The expansion would likely have been
forbidden by the Comprehensive Health Planning (CHP) agency had not Sundeean's plan slipped in under the law's "grandfather clause" enabling him to build without CHP's approval. Today, with only 85 beds actually staffed, Community struggles along with an occupancy of less than 50 percent.

Fifteen miles south on Highway 1 and east through the orchards stands Watsonville Community Hospital, sculptured concrete and glass on landscaped grounds. It too was built in the late '60's; in the summer of 1970 the topmost of its three floors was closed off for lack of patients. Even so its occupancy rate has remained in the low 70's.

During the new county hospital's five brief years of existence, it averaged 3,500 admissions a year with occupancy ranging between 60 percent and 75 percent. A steadily increasing number of people came to its out-patient department and emergency room: 12,000 to each during the facility's last twelve months. Mental health, rehabilitation, alcohol and drug detoxification services were also available. To improve care at the hospital and attract private patients, the county administration instituted a family practice residency in 1972. The program was about to affiliate with Stanford Medical School when the hospital was shut down.

The State Wields the Axe

At the end of 1971, a Reagan-sponsored measure passed the California state legislature that has been the ruin of many of California's county hospitals (see BULLETIN, April, 1973). California's Medicaid program (called "Medi-Cal") is financed half by federal funds and half by state and county funds. The 1971 "Medi-Cal Reform Act" raised the counties' share enormously—in Santa Cruz the outlay soared from $1 million to over $1.3 million and is expected to reach $1.7 million this year. Moreover, the state reduced payments for Medi-Cal services; Santa Cruz began receiving only $15.65 per day for long term patients for whom the county had previously been paid $40.00. This, in addition to another law backed by the Governor in 1972, which forbade county governments to raise property taxes to offset increased costs, resulted in the elimination of half the county's 74-bed extended care facility.

The California state cutbacks, mirrored across the nation, were themselves a response to rapidly inflating health care costs. In Santa Cruz as everywhere else, the county hospital was costing more to run at the very time the state was pulling back its financial support.

The inevitable crisis came in March, 1973 when the press intercepted a memo from Santa Cruz General's assistant administrator to the County Administrative Officer calculating an operational loss for the hospital of $400,000. He indicated that the loss the following year would be $750,000.

The memo listed several classic causes of the demise of the nation's public hospital system. He noted that there had been a decline in patient census since the hospital was built, due in large part to shorter average stays in the hospital: down from 8.7 to 6.2 days per patient. Fewer days in the hospital mean less income for the facility.

Patient Dumping Private Style

On November 13, 1973, Daniel Gibson was turned away from Medical Center Hospital in Oroville, California, 100 miles north of Sacramento. Nineteen hours later he was dead of pneumonia.

Gibson, a 68-year-old World War II veteran and long-time Butte County resident, according to the Sacramento Bee, had been living outdoors on a rock pile since his cabin had burned down. Oroville City Councilman Don Brown, who was in the emergency room of the private hospital at the same time as Gibson, was outraged. "To me he looked either comatose or nearly so. I looked at him and thought, boy, that old man is not going to make it. He was very dirty, very wet and smelled badly. While I was there, they wheeled him out of the room on a gurney."

Doctors in the emergency room apparently decided that Gibson was not sick enough to be admitted, and he was wheeled to a cab. Taxi driver Tom Lawson, who transported Gibson from the hospital back to the rock pile, said, "He was unable to walk." Over his objections, the cab driver was told to "take him anywhere, but just take him away."
Meanwhile, Nixon’s Phase II had inhibited rate increases to offset rising costs. The bed shut-downs caused by the Medi-Cal Reform Act cutbacks "at one fell swoop [eliminated] somewhere between one-third and one-half of the number of patients in the Hospital . . . ." He also noted that the hospital took everyone who asked for care "regardless of credit risk," while doctors in the community referred their paying patients to the private hospitals. Finally, the hospital’s emergency room had ceased to be a major source of paying patients since both Dominican and Community—each within two miles—opened emergency rooms of their own.

Confronted with this dramatic listing of the hospital’s woes and a projected $750,000 loss for the coming fiscal year, the Board of Supervisors decided to pull out of the hospital business. In May they announced that they would accept bids for the lease of Santa Cruz General. Initially the private hospitals in the area showed no interest in the county hospital or its patients. Doctors favored keeping it open. In March, Dr. Donald Miller, president of the Santa Cruz County Medical Society, wrote the supervisors, “I am concerned that any precipitous decision that would close this facility would cause a crisis in delivery of health care to a large segment of our population.” The medical staff of Community Hospital also telegraphed the Board indicating its opposition to closure. After all, the poor had to get care somewhere and the private sector didn’t really want them.

But attitudes changed drastically when the supervisors appeared ready to lease the hospital for $1.2 million to Health Care Services Corporation (HCS) of San Diego. HCS planned to use the hospital to operate a prepaid health plan (PHP), which would draw Medi-Cal patients away from the private hospitals. (For a booklet describing PHP’s, send one dollar to Health/PAC’s San Francisco office.) Fearing a fourth competitor in already overcrowded territory, the three private hospitals called for closure of Santa Cruz General.

Just two days before the deadline for accepting the lease, the three hospital administrators told the county that they would admit all people for whom the county was responsible, if the county would close the hospital rather than lease it to HCS. On June 7, the Board of Supervisors voted for closure and agreed to sign contracts with the private hospitals. On July 1, the hospital was shut down.

The Contracts

HCS has filed suit against the Board of Supervisors for turning down its bid at the last possible moment and entering into contracts with the private hospitals instead. HCS feels it was fraudulently lured into negotiations only to strike fear and terror into the heart of the county’s private medical sector. Whether that was indeed the county’s intention will be decided in the courts. But the specter of a prepaid health plan competing with Dominican, Community and Watsonville hospitals sent them into instant negotiations with the county, resulting in contracts favorable to both parties.

The contracts stipulate that the county
will reimburse the private hospitals for care provided to "county indigents." However the county is now reducing the number of "county indigents;" formerly this category included individuals with adjusted monthly incomes under $250, who essentially received free care at the county hospital. Since the closure, the county has reduced its income standard to $162, the same level as Medi-Cal. So the county will pay for only a small number of people—transients, emancipated minors, prisoners and aliens, who are not covered by Medi-Cal.

In another severe blow to a large number of low-income people, the contracts specify "County shall have no financial responsibility for hospital services provided to... Medi-Cal 'spend-down' patients ..." "Spend-down" patients are responsible for an initial part of their medical bill before Medi-Cal will pay the rest. The county used to write off this initial "spend-down" since patients can seldom afford to pay it. Now, the private hospitals will seek to collect the spend-down.

County administrative staff feel that they made a fine deal in shutting down the hospital and developing the contracts. From their point of view, the hospital was running $400,000 in the red and getting worse. Bill Derrick, in charge of hospital accounts, proudly announces that "We expect to pay only $15,000 for county indigent care during fiscal year '73-'74." This compares with close to $1 million in county funds spent on the hospital in fiscal year '72-'73. Much of the difference will be billed to low-income people as they seek private care.

**Sinking or Swimming in the Mainstream**

What is happening to General Hospital's former patients? In the six months since the hospital closed, the private hospitals have rarely turned away patients. But a number of patients who had been going to the county hospital are just not going anywhere now unless their condition is so serious as to require emergency treatment.

Mary Todd was a nurse at Watsonville Community Hospital before becoming a community worker for La Coalición in Watsonville. Recalling how patients were sent away from Watsonville Community to the county hospital, she feels that "once people have learned not to trust a hospital, they aren't about to just start trusting it."

For non-emergency cases, the hospitals still refer patients who can't pay to the clinic maintained by the county on the grounds of the former hospital. Offering minimal services, the clinic is open six hours a day, six days a week, and refers people back to private providers for the many problems it can't handle. This kind of shuttling around often makes staying home seem more desirable than trying to find a doctor.

Theodora Judson used to be an eligibility worker at the County Hospital, one of the people who helped patients make payment plans which met their financial circumstances. In some cases this meant deferring payment indefinitely. Mrs. Judson was outraged at the closure of the hospital. "Of course patients aren't getting the care they used to—how could they?" She is concerned especially about Mexican-Americans, who were a large portion of the hospital's patients. "Now the people sitting in the clinic are almost all white. Where are the other people being taken care of?"

Dr. Paul Berman worked at the county hospital's orthopedic clinic where he helped care for twenty patients a week. With the
specialty clinics gone, he is one of the few specialists willing to take county referrals. But now he is sent only one patient every two weeks, and muses, "I wonder what's happening to the rest of them?"

Many complications arise for patients because of Medi-Cal regulations. An older woman employed as a housekeeper has an income such that she must pay $80 a month before Medi-Cal will pay the rest. She has chronically infected ingrown toenails that make her work constant torture. At the county hospital the $80 was written off. Now under private care she must pay cash before receiving treatment, and is already deeply in debt to a credit bureau for her medical bills.

An elderly Chicano former farm laborer went to Watsonville Community Hospital in September with a painful ulcer and a hernia. Living in an abandoned car with no address, he was denied Medi-Cal. He was also denied treatment at the hospital. He turned to the Legal Aid Society which managed to arrange for care from a doctor at Dominican.

At Dominican Hospital, a list is kept of people who regularly fail to pay their bills. People on this "black-list" must pay cash before receiving care. The list now contains some two dozen names and is bound to get longer with the new influx of former county patients. What will the hospital do with chronically-ill patients who will never be able to pay their spend-down, or who "fall in the cracks" of both Medi-Cal and county aid?

The three private hospitals financially screen their patients more rigorously than did the county hospital. Private hospitals, in uncertain financial condition before the closure, do not see themselves as providers of free care. Arrangements are made for monthly payments, and accounts not paid are turned over to collection agencies. Will people return to a hospital for necessary treatment when a collection agency has been steadily threatening and badgering them to pay a bill incurred months before?

Finding doctors is also a problem for former county patients. Many doctors accept only a limited number of Medi-Cal patients, and few volunteer service to the unfunded patient. When these patients come to the private hospitals they are assigned a private doctor from the staff roster. According to private internist Dr. John Petralli, "If you're on the roster at Dominican, one day you might have to leave an office full of patients to go over and take care of someone." Dr. Petralli and a group of his colleagues tried to make the roster non-compulsory for doctors, which would have left former county patients out in the cold. Though still seeing the patients, Dr. Petralli's attitude is "County indigent patients are not compatible with private practice."

In addition to the distaste of many physicians for patients who seek help in the middle of the night, who are alcoholics, who don't speak English, or who have a Medi-Cal spend-down they can't pay, there is also the problem of people who have applied for Medi-Cal but have not yet received certification. These Medi-Cal "pendings" are anathema to all providers. Anyone treating a person in this bureaucratic limbo (which may last 30 to 90 days) does so at his own financial risk: will the patients be certified? If so, will the patient return to the provider when the Medi-Cal card arrives to turn over one of the cherished stickers that permits the provider to bill the state? "Procedures and Regulations" adopted by the Santa Cruz Board of Supervisors actually recommend that "if the 'pending eligible' patient does not require emergency care, then the provider should advise the patient to return for care when eligibility has been determined."

Bob Taylor, the eligibility worker at the county clinic, points out that it currently takes six weeks to get a Medi-Cal card. Anyone with a spend-down must re-apply every three months. Now that the county clinic offers no specialty services, part of his job is to put patients who need specialty care together with the specialists. "80 percent of our cases are Medi-Cal pending, and the problem is finding a doctor who'll take them." One group practice has agreed to take all referrals who live on the west side of the river that bisects the town of Santa Cruz. Most lower income people, of course, live on the east side.

Private Sector Wins Again

Why did the only public hospital in Santa Cruz County close down? Why are public hospitals closing down throughout California? The standard response is that the public sector just doesn't provide services as well as the private sector; it doesn't give patients what they want. Public hospitals
are old or run down, waits are long, care is impersonal and of low quality—altogether, second-class medicine. And patients are deserting them.

Unique features of the Santa Cruz situation clarify these questions and lead us to different conclusions.

Santa Cruz General Hospital was not old and run down. It was brand new and had been constructed at the direction of county residents with their tax money. Care at the hospital as judged by both providers and patients was of good quality. According to one doctor the family practice residency program “was the most significant innovation for improved care in Santa Cruz County in many years.”

Nor was the local population deserting the hospital. Occupancy rates were sinking in all the four hospitals. If any, Community Hospital had been singled out for desertion: Community, not Santa Cruz General, had the lowest occupancy rate.

The county hospital was shut down because the private hospitals acted competitively to maximize their prestige and financial status, rather than cooperatively to provide the best and least costly care for all Santa Cruz residents.

All three private hospitals built new or additional facilities between 1967 and 1971, and two recently opened emergency rooms, which are well-known sources of paying in-patients. Both were within less than five minutes of the county hospital’s emergency room.

Doctors in the community placed their private paying patients only in the private hospitals, helping to perpetuate the image of “county hospital” as “second class” (or at any rate, as serving “second-class” citizens). When patients called doctors at night or on weekends, the doctors also referred them to the emergency rooms of the private hospitals. But patients who could not pay all or part of their bill, or who were addicts, alcoholics, or “crude,” would always be generously turned over to the county facility, guaranteeing General Hospital an abundance of unfunded, expensive, and chronically ill patients, while allowing the privates to skim the funded, short-term clientele.

County hospitals which operate on a civil service system have different contractual relations with their employees than do private hospitals. The latter can fire staff at will when the patient census goes down or when the hospital wants to save money. Fortunately for civil service employees this is less likely to happen to them, but it does give private hospitals another fiscal advantage over public hospitals.

Finally, Medicaid and Medicare have supported and enriched private providers at the grave expense of public providers. In 1970-71 over $8 million came from the Medi-Cal program to Santa Cruz County’s medical providers. Only 15.5 percent of that public money went to the public hospital. The rest contributed to building the redundant private emergency rooms and unnecessary private beds that led in turn to the elimination of the public Santa Cruz General Hospital.

—Elinor Blake

Montefiore-NCB

(Continued from page 6)

community groups would take exception to, especially several that are currently suing the Agency for lack of consumer and community participation in its operations.

Katz goes on to describe the plan as “a Hegelian synthesis in which independent hospitals are related through an overall political structure.” He acknowledges charges that Montefiore would control that structure, disclaims any such intent (after all, he notes, Montefiore would only be a small part of the consortium), but goes on to observe philosophically that in any system, the people who are the most competent end up in control, even if in the minority.

Regionalization or Rationalization?

If one turns from the demographic projections of the West Bronx Health Planning Study to statistics on municipal hospital beds in the Bronx as a whole, it becomes inescapably clear that Montefiore gerrymandered the boundaries of its planning area not only for the purpose of maximizing its empire but also for the purpose of disguising the superfluity of the empire’s latest addition, namely NCB. The southern boundary
of the regionalization plans just happens to be drawn immediately to the north of the replacement currently under construction for the long-suffering Lincoln Hospital, affiliated with Einstein. (See map page .) The bed count of the new Lincoln happens to be 469 beds higher than that of the old Lincoln.

That the increased beds at Lincoln plus the 412 beds at NCB equals a surplus of municipal hospital beds in the Bronx is implicitly acknowledged by a confidential HHC staff study of the Bronx concluded last May. That study recommended that the Corporation not open 108 beds at the new Lincoln and effect a staged closing of 307 beds at other Bronx municipal hospitals with the opening of NCB and the new Lincoln, all of which totals 415 beds taken out of the Bronx municipal system. Even with these shutdowns, the study finds that NCB has 62 more beds than necessary for users of the municipal hospital system and suggests that “private patients can be accommodated” in these extra beds.

The use of the regionalization concept as a rationalization of unnecessary beds at NCB was explicitly acknowledged by the HHC in a November, 1971 internal memorandum penned by its wheeler-dealer Senior Vice President for Finance, Paul Kerz. The memo casually notes that “regionalization is the wave of the future in health care” and goes on to observe that the “development of a regional health care program for at least a portion of the Bronx” has been made possible by the “swing space” provided by the “less than relevant and therefore less than completely essential beds” represented by NCB.

Kerz proceeds to carve up the Bronx, leaving the eastern half to Einstein and its municipal affiliations at Lincoln and the Bronx Municipal Hospital Center and “regionalizing” the West Bronx with NCB, Morrisania and the projected new Fordham Hospital operating under Montefiore’s aegis. The mission of NCB would be “to centralize specialized services at Morrisania and Fordham Hospitals.” Kerz tout this regionalization scheme as providing “a rationale for the North Central Bronx Hospital which would allow the Corporation to counter charges of having ‘given away’ a hospital to the Montefiore ‘dynasty.’”

1. Montefiore, Main Div.
2. North Central Bronx
3. Morrisania
5. Bronx Municipal Hosp. Center
6. Old Lincoln
7. New Lincoln
8. Old Fordham
9. New Fordham
12. Misericordia

--- boundaries of
West Bronx Health Planning Study
The West Bronx Health Plan is "a Hegelian synthesis in which independent hospitals are related through an overall political structure."
—Mo Katz, Deputy Dir.
Montefiore Hospital

The Public and the Public Servants
Regrettably for Mr. Kerz, the Corporation has not in fact been able successfully to counter such charges, not to mention no less serious charges, such as secrecy, deception and outright lying.

The secrecy began about the time of the Kerz memo, when Kerz and his boss and buddy Dr. Joseph English, the HHC President, suggested to their friends at Montefiore that they prepare a study supporting the regionalization concept. By the summer of 1972 English and Kerz were into negotiations with Montefiore on the terms under which it would operate NCB. All of these doings took place unbeknownst not only to the general public and the various community groups concerned with health care in the Bronx, but also to the HHC Board of Directors and its Chairman, Health Services Administrator Gordon Chase. Repeated inquiries from community people as to what was going on around NCB were referred by Montefiore to the HHC (after all, it's their hospital, was the line). The HHC in turn assured inquirers that plans were still at a very preliminary stage and that community groups would be consulted at the appropriate time.

Kerz and Montefiore's Mo Katz were eventually persuaded to speak on NCB at an open community meeting held in the Bronx March 26, 1973. Both solemnly assured the audience that no definite plans for the new hospital had yet been made. Both were probably chagrined when the West Bronx Health

Workers Up For Grabs

The issue of governance of North Central Bronx Hospital is related to, and complicated by, the issue of union jurisdiction. Hospital workers employed by the Health and Hospitals Corporation (HHC) are represented by District Council 37, American Federation of State, County and Municipal Employees; those employed by voluntary hospitals are under the jurisdiction of Local 1199, Drug and Hospital Employees Union. Within the municipal hospitals, the voluntary affiliates have traditionally employed a variety of persons, such as clerks, who were represented by Local 1199, although had they been on the HHC payroll rather than the affiliate payroll, they would have been represented by DC 37.

This tradition was upset in late 1968 in the course of securing the support of DC 37 Executive Director Victor Gotbaum for the then-pending legislation establishing the HHC. In the words of an internal HHC memo, "In exchange for the support of District Council 37 of the proposed Corporation, it was agreed that almost all duality of employment would be eliminated by 30 June 1972; this agreement is known as the 'Rollback.'" Most non-physician employees of the affiliates working at the municipal hospitals, in other words, would be "rolled back" to the HHC payroll and hence to DC 37's jurisdiction.

There was, of course, the need to compensate Local 1199 for the loss of members the rollback would involve. The same HHC memo goes on to explain that "In order to compensate Local 1199 for the loss of 1,500-1,600 members, it was agreed by District Council 37, Local 1199, the City of New York and the Department of Hospitals that the new North Central Bronx Hospital would be set up in such a way as to permit all employees of North Central Bronx Hospital to be affiliation employees, and hence to become Local 1199 members." Thus for the sake of union support and union peace, the City obligated itself to give a voluntary hospital total con-
Planning Study was leaked to the press in mid-April—bearing a date of March 6 and marked "Confidential." (It was also reported in the press that Kerz had agreed to give Montefiore total administrative authority over NCB.) That, predictably, set off an avalanche of letters and telegrams from Bronx community planning boards, municipal hospital community boards and assorted other community groupings inveighing against "regionalization without representation." It also set off the resignation of Joe English as HHC President on April 24 under threat of a vote of no confidence by the HHC Board of Directors, who were understandably peeved at having been left in the dark.

The Study That Wasn't

At this point the outrage level clearly called for a cooling-off maneuver. That came in the form of a charge by Mayor Lindsay to the City's Comprehensive Health Planning Agency (CHPA) to assemble a task force to study the situation and make recommendations to him concerning the future of NCB.

The task force report, presented to the Mayor in October, combines a hodgepodge of particularistic interests and antagonisms with an inability to face reality. It accepts without question Montefiore's position that it and NCB should operate as an integrated complex with a single administration and single workforce but talks about NCB's integration with "a voluntary institution," a footnote naming various others as possibilities in addition to Montefiore. This doesn't mean that the other institutions have the capability of operating NCB; it means that the hostility widely felt toward Montefiore was successfully exploited by a Bronx voluntary hospital administrator who happened to wangle his way onto the task force.

Governance over the NCB-voluntary complex, the report recommends, should reside in "a separate, distinct, legal and corporate board of trustees" with at least 51 percent community representation. Presumably the voluntary institution will meekly agree to disband its own board of trustees and, on the other side, presumably the HHC Board and the legislative mandate of a community advisory board to each municipal hospital can both be shunted aside. On Montefiore's part, Mo Katz is clear that its board is not about to be dissolved—"It's a fossil, but fossils can be useful," for such things as raising money and providing the institutional stability necessary to attract good physicians. He hints that, perhaps, however, the 60-member Montefiore board could be expanded to include community representation.

As for programs, the task force wants general care for the NCB area and the Morrisania area plus a shopping list of special services (such as alcoholism and psychiatry) for the borough as a whole. The report lacks bed figures, and Katz's reaction is that the various psychiatric services listed alone amount to 2,000 beds. If the City wants to load NCB with special services, he remarks, that's its problem—such things, he notes, aren't attached to third-party payments, something about which the City might well be concerned.

The Climax That Wasn't

In any event, the task force report failed to evoke a reaction from His Honor the lame-duck Mayor, who a month after its submission issued a statement on the achievements
Regionalization provides "a rationale for the North Central Bronx Hospital which would allow the Corporation to counter charges of having 'given away' a hospital to the Montefiore 'dynasty.'"

—Paul Kerz
HHC Senior VP

of his administration that listed four other municipal hospitals constructed or under construction without mentioning NCB. The HHC Board apparently lost interest in the issue after the catharsis of the English ouster, or perhaps it decided to await guidance from incoming Mayor Beame. Within the HHC bureaucracy, inquiries about the task force report have been shuttled down to Dr. Antero Laco, Senior Vice President for Medical and Professional Affairs and relatively low on the Corporation totem pole, who pleads inability to say anything about it until the CHPA Board and the Mayor have taken a position.

At the Bureau of the Budget, the word is that no deals have been made and no one knows what's going to happen—and this time, that's apparently the truth. At Montefiore, Katz points out that the hospital will be ready for patients around May but that recruitment of staff will require several months' notice. (This last should perhaps be taken with a grain of salt in light of reports from other quarters that Montefiore has begun that recruitment process already.) Also as of May, the City has obligated itself to start paying $7.2 million annually in amortization costs to the State Facilities Development Corporation, with which it contracted to build NCB—something of an incentive to start putting patients in the place. (A footnote to the morass is the fact that that amortization figure—which divides down to about $50 per bed per day—is a lot higher than any third-party payer is likely to pay; this is particularly a problem for the HHC, since its reimbursement rate has never been based on cost anyway, it never having gotten itself together sufficiently to compute an indirect cost rate.)

In the meantime, the relevant community organizations in the Bronx are scurrying around in diverse directions. The Morrisania Community Board is vacillating between calling itself the NCB Community Board and worrying whether taking that tack will imply its willingness to preside over the demise of Morrisania. The Fordham Community Board is saying don't open NCB until you solve the financial problems of the other municipals in the Bronx. The folks around NCB itself are saying the hospital should serve primarily the high concentration of elderly in that part of the City, while community leaders to the south are saying it should provide mostly special services to the borough as a whole. The Bronx Borough President's office is leaning on the HHC to appoint an NCB planning committee (the precursor to a community board) and trying to figure out what to say in a long-expected report of an ad hoc committee put together to advise that official on NCB.

The agitation, in whatever direction, is largely imbued with irrelevancy from the point of view of undercutting Montefiore's control. The hospital is there, connected to two of Montefiore's buildings above and below ground. The HHC, having spent so much of its past energies bedding down with Montefiore (and the private sector generally), is not willing or able to staff it directly (and indeed, such an approach is by now so novel it occurs to almost no one), and Montefiore has refused a sale, a lease and a traditional affiliation contract. Keeping the building empty may have a nice symbolism, but the expense involved is considerable and it's not clear what the ultimate benefit could be. Perhaps Ray Trussell should be sent a bill for $94 million? —Louise Lander

References
3. For a full account and critique of the development of the affiliation program under Dr. Trussell's auspices, see Bur­lager, New York City's Municipal Hospitals: A Policy Re­view, Washington, D.C., Institute for Policy Studies, 1967 (available from Health/PAC for $10).
Media Scan

SCIENTIFIC AMERICAN

Special Issue: "Life and Death and Medicine," Vol. 229, No. 3, September, 1973. Put a growing $83 billion a year health care bone under the nose of a scientific establishment starving for funds and, like Pavlov’s dog, it will respond. So it’s no accident that this September health was featured for the first time in the intellectual centerfold of American popular science, the annual special issue of Scientific American magazine. Nor is it accidental that the magazine presents a spate of articles which argue, in effect, that what American health care needs most is more research.

Of course Scientific American doesn’t put the matter quite so bluntly; it’s too sophisticated for that—and so are many of its over half-a-million readers. So first it chooses a group of thirteen authors for the issue who share its views on the importance of science. Eleven of the thirteen are faculty members at prestigious, research-oriented universities and medical centers. Twelve are MD’s, but not one is presently engaged in the delivery of primary medical care. (Fully eight of the thirteen are or were Harvard faculty members and/or Harvard Medical School graduates.) Not a single contributor is a woman, a health care consumer or a health worker other than doctor. So don’t look for a diversity of viewpoints here.

Then, after a brief introduction, the magazine leads off with six traditional research-oriented articles: “Growing Up,” “Getting Old,” “The Ills of Man,” “Surgical Intervention,” “Chemical Intervention” and “Psychiatric Intervention.” The articles are all beautifully illustrated, chock-full of facts and written with great technical competence. At the same time they are quite oblivious of the broader political and economic implications of the problems they address.

For example, “Getting Old” is a comparative study of long-lived populations in three countries, the factors contributing to their longevity and a description of new research studies in aging. But for any appreciation of the enormous problems the elderly have in finding adequate health care or paying for it, the reader will have to go elsewhere. Nor does the reader get any sense of the enormously complex interweaving of physical, mental and social problems presented to the health care delivery system by people who are no longer “productive” in a society that worships the ability to produce and make money above all else. And so on for the other five lead articles. (The only exception is an article on “Dying” by Robert Morrison, and credit for this should probably go to Elizabeth Kübler-Ross and others for directing public attention to the needs of the dying patient rather than to the technical problems of “heroic” intervention.)

By this time the reader has waded through two-thirds of the issue and should have gotten the message—research is the key to modern medicine and, implicitly, its needs should have priority in the health care system. The first part of this statement has real merit; research has played a major role in shaping the
modern, hospital-based health care system. But the second part, the priority given to research, not only won't solve the American health crisis, it helped create it and helps perpetuate it. After all, research and education have been the priorities of the health system since World War II. During this time, the constant introduction of new technologies and the training of highly skilled staff have helped drive up the costs of health care, while depersonalizing it and shifting its focus away from the needs of patient care. The result is a crisis in the American health system which is widely understood to be one of organization, delivery and financing of care.

The editors of Scientific American could hardly ignore this and remain in the mainstream of liberal reform thought. They are not about to examine the distortion of the health system brought on by teaching and research. But having beat the drums for most of the issue about the accomplishments of modern science, they are perfectly willing to call for a little reorganization of the system too. And that is precisely what they call for in the last third of the special health issue—*a little* reorganization.

This is made clear in the lead article of the section by John Knowles, President of the Rockefeller Foundation, almost-Secretary of HEW under Nixon (until his nomination was withdrawn under AMA pressure), former Director of Massachusetts General Hospital (Harvard), and Harvard trustee. Knowles is blunt: "The major issue facing hospitals in the 1970's is whether or not we will be able to maintain a voluntary hospital system alongside the public hospital system."

Only a spokesman for voluntary hospitals, as Knowles is, would have the audacity to make such a statement. Voluntary hospitals, especially those organized into medical empires, have dominated health care delivery in this country for decades. They have colonized and exploited the weaker public hospitals to control their staffing and reap financial gain, while using public patients as a source of research and education "material." Today the voluntaries are in trouble because in their greed they overexpanded their facilities and staff and broke the Medicare and Medicaid bank which financed them. So now, instead of just exploiting the public hospitals, they are either taking them over lock, stock and barrel (see Montefiore article in this issue) or trying to close them down completely (see Santa Cruz article in this issue). And Knowles sees the problem as the voluntaries being threatened!

Of course, since the voluntaries are the center of Knowles' health universe, he is also saying in effect: make whatever changes you want in the health care system, but
don't seriously disturb the voluntaries. If, however, the voluntaries, which largely determine the nature of health care, are untouchable, the limits of reform of the health system are pretty narrow. The only issue that's really open for public debate, then, is health care financing. And that's the way it's been for the last decade with debate centered around the self-contained issues of health care financing. The result has been Medicare, Medicaid, HMO's, and, perhaps in the future, National Health Insurance. Not coincidentally, the private health establishment has been the principal beneficiary of these programs.

Also, in contrast to other authors in the magazine, Knowles is open in asserting the primacy of research and education in health care. "Ideally all hospitals should be affiliated with medical schools [read: voluntary hospitals], but this is not possible, at least at the moment; physicians practicing in the community steadfastly resist the controls inherent in medical school affiliations." So let the medical empires grab up all the hospitals in sight, he is saying, it's only the AMA-types and other cranks in the community who are holding up progress.

He continues pompously, "The strength of the American experiment will lie in its ability to balance public and private interests, responsibility to the public good and freedom to enjoy regional self determination. A complete welfare state will result in a supine citizenry, an erosion of individual initiative and the steady expansion of an inefficient, unresponsive bureaucracy."

Such palpable nonsense might lead one to believe that Scientific American has an intellectual block against offering a comprehensive analysis of America's health problems. Chances are the difficulties are not intellectual but political. The movers in Scientific American are not political novices, after all, they are experienced liberals. For example, the magazine's publisher, Gerard Piel, has been an important and at times critical figure on the New York City health scene. At an important juncture in 1967, he headed the Commission on the Delivery of Personal Health Services, usually called the Piel Commission. The Piel Commission report was instrumental in establishing the Health and Hospitals Corporation, which controls and badly mismanages the City's 19 municipal hospitals. Since its inception the Corporation has not been a solution to the City's health crisis, but part of the problem. (See BULLETIN, Dec. '71 and May '72.)

So when all is said and done, Scientific American's special health issue does not address the social and economic issues behind this country's health care problems. Even worse, it reinforces the very distortion which lies at the heart of so many of these problems: the primacy, priority and prestige given medical research. It also reinforces an old, outdated American predilection of looking for a technological solution to our problems, rather than dealing with their social and economic causes. In the end Scientific American asks not what science can do for health care, but what health care can do for science.

—David Kotelchuck
Vital Signs

HEW APPROPRIATIONS:

President Nixon closed the old year with two surprise moves in health. First, he approved an HEW/Labor Department appropriations bill of $32.9 billion for Fiscal Year 1975 in spite of the fact that it was $1.4 billion more than he had asked. Nixon, who has taken a hard line on HEW cutbacks, twice vetoed HEW/Labor appropriations bills last year because they exceeded his request and had threatened to do so again. As a result, HEW lived hand-to-mouth under a continuing resolution last year.

But even more unexpectedly, the President simultaneously released $1.5 billion of the FY73 HEW budget which he had previously impounded. These monies will restore major cutbacks in such programs as Hill-Burton hospital construction, community mental health centers and health manpower training. This stepdown occurred in the face of a barrage of lawsuits over the legality of impoundment. To date thirty of these, involving approximately $1 billion of impounded funds, have gone against the Administration in the lower courts, while only six have been decided in its favor. It would appear that Nixon prefers restoring cutbacks to testing his right to impound in the Supreme Court.

But Nixon couldn't retreat from impoundment without a touch of vindictiveness. Aides let it be known that Nixon would approve the HEW appropriations bill if Congress would accept an amendment which would cut off money in the 1974 budget to any group suing the government for impounded 1973 funds. The Congress refused, but compromised instead by allowing Nixon to "legally" impound up to $400 million of the 1974 HEW budget. Cuts must be across-the-board, however, and cannot exceed five percent in any single program. (For discussion of federal cutbacks and impoundment, see BULLETIN, May, 1973.)

PHS HOSPITALS

The nation's eight Public Health Service Hospitals, which seemed all but dead a month ago, won a reprieve in Nixon's year-end actions. The Administration has tried repeatedly to close these hospitals in the last several years. Most recently Nixon vetoed the Emergency Medical Care bill because it included an amendment which would give Congress alone the power to close the PHS hospitals. Congress then tacked the same amendment onto the military appropriations bill, which proved dearer to Nixon's heart than Emergency Medical Services, and this time the bill was signed.

HMO'S PASS

Just before ringing in the new year, the President also signed into law the Health Maintenance Organization Act of 1973. The President started three years ago as one of the most enthusiastic supporters of HMO's, hoping they would lure private enterprise into the health care arena by making it financially profitable. So enthusiastic was he that without Congressional approval the Administration was able to divert some $30 million from other HEW programs to aid in
establishing some 80 HMO's. However, the AMA bitterly op­posed the measure, and the President's enthusiasm has cooled noticeably through the long legislative struggle.

The Act will provide $375 million over a five-year period to assist in the planning and evaluation of an estimated 300 to 500 new HMO's. It also establishes a liberal benefit package which must be pro­vided by federally-funded HMO's, including outpatient mental health services and diag­nostic dental care for children, and mandates that em­ployers of 25 persons or more offer workers the option of getting their health care through an HMO. Estimated cost per family per month ranges from $50 to $65.

MEDICAL EDUCATION

The Administration issued a stern warning that it may drastically reduce, if not cut off, federal aid to health manpower education next year. In an address to the American Association of Medical Colleges, Charles Edwards, As­sistant Secretary for Health in HEW, said that federal aid had eased the physician shortage in the last ten years and now threatens to create a physi­cian surplus. "I think that we clearly have moved beyond the point at which concerns about a shortage of physicians were genuine, if somewhat ex­aggerated.... We are now questioning very seriously whether it is appropriate for the federal government to bear so substantial a share of the cost of preparing individ­uals for careers that offer about the highest earning pow­er in our society." But the Ad­ministration is still catching up with itself. Only two months later the National Insti­tutes of Health issued a study estimating the current short­age of doctors to be 30,000. NIH estimates that 27,000 ad­ditional general practitioners, pediatricians and obstetricians and several thousand psychi­atrists are needed.

A PRECEDENT FOR PATIENT'S RIGHTS?

A Sacramento, California trial court has established what may be an important precedent in patients' rights. In a malpractice suit, filed by a patient who claimed that neg­ligent and unnecessary sur­gery disabled him and caused such emotional trauma that he attempted suicide, the court held not only the physician, John Nork, but the hospital in which he practiced, Mercy General Hospital, responsible for "unnecessary and negligent surgery." The judge ruled that the hospital was negligent in "not knowing the physi­cian's propensity to commit malpractice" and held that the hospital governing board was "corporately responsible for the conduct of its medical staff" even if the doctor was privately retained. Nork, who has practiced at the hospital for nine years, admits per­forming at least 37 unneces­sary operations, has lost two malpractice suits and faces at least 25 more. In this instance, he was ordered to pay the vic­tim $1.7 million; Mercy Gen­eral was ordered to pay $2 million.

A PRECEDENT FOR DOCTORS' RIGHTS?

Dr. Marc Stretton, who is be­ing fired from Wadsworth VA Hospital in Los Angeles for what seem clearly to be po­litical reasons, just won a tem­porary restraining order pre­venting him from being dis­missed without due process. In addition, he has won the support of the AMA and the Physicians’ National House­staff Association for due pro­cess rights for interns and residents.

As a medical student Dr. Stretton was an antiwar ac­tivist and member of a radical student group. Consequently he has been harassed by the FBI and blacklisted from do­ing a residency in pathology, his specialty, in several states including Michigan, where he went to medical school. Dr. Stretton went to Los Angeles to begin his residency. But shortly after arriving he was notified that he would be dis­missed after his first year and would thereby be denied his California medical license. Dr. Stretton has asked the VA hospital to specify reasons for his dismissal and demanded a formal hearing. But the posi­tion of the VA hospital has been that it need give no rea­sons for his dismissal nor is it required to hold a hearing.

MONEY-MAKING MACHINE

It's hardly news that phar­maceutical companies make a lot of money or that profit margins far exceed other in­dustries. It's good, however, to be reminded from time to time of the extent of the rip-off. An investigation of the profits of the world's two leading tranquilizers—Librium and Valium—by England's Monop­olies Commission has done just this.

Librium and Valium, intro­duced in 1960 and 1963, are manufactured by the world's largest drug company, Hoff­man-LaRoche (H-L), based in Basle, Switzerland. H-L sells $1.2 billion of drugs each year. Its overall profit margin is 15 percent. This is at least
three times the profits in other industries. But H-L does even better on its two leading sellers—Librium and Valium. Profits run 40 percent on the $500 million-a-year sales of these items. Forbes magazine remarks that this is "as good as a license to print money" (June 15, 1973).

According to the Monopolies Commission, the drugs which H-L sells for $925 and $2,305 per kilogram cost $22 and $50 per kilogram to manufacture. The Commission has therefore ordered that H-L cut its price to Britain's National Health Service 60 percent. The company, which doesn't deny the Commission's finding, is naturally resisting the price cut and is appealing the decision. A final decision is expected in about two years as the case weaves its way through the labyrinths of the British legal system. In the meantime some confirmed anxious neurotics are switching to booze. It's not any cheaper but the warm afterglow helps the patient forget he's being exploited.

THE BLUES UNDER FIRE

Blue Cross, the Goliath of health insurers, is coming under increasing fire for the conflict of interest created by its ties to the hospital establishment. While serving as the major insurer of hospital services for consumers (Blue Cross pays over half of all hospital income nationally), it is dominated by hospital interests. Nationally, its trademark was owned by the American Hospital Association until last year, and hospital administrators, trustees and representatives dominate the boards of local Blue Cross plans.

In New York the Temporary State Commission on Living Costs and the Economy charged that Blue Cross ignored an internal audit that found $3 million worth of "questionable" payments to 24 New York hospitals in 1971. It further charged that Blue Cross is doing nothing to monitor payment procedures as the audit recommended. The Commission's independent scrutiny of hospital records showed that Blue Cross paid:

- $1,300 for a "regular" conference of the medical staff of Royal Hospital, a small proprietary Bronx hospital, which included food and an orchestra at a Yonkers restaurant.
- $13 million in bad debts and free medical care for physicians, their families and other hospital employees.
Salaries and benefits for some hospital administrators approaching $100,000 a year. For example, the Commission charged that Dr. David Pomrinse, administrator of Mt. Sinai Hospital, received a raise from $82,000 in 1971 to over $100,000 in 1972, in addition to being given the use of a 13-room, Fifth Avenue penthouse apartment; the salary of Dr. Martin Cherkasky, administrator of Montefiore Hospital, was raised from $79,000 in 1971 to $92,000 in 1972 in addition to his being given a house near the grounds of the hospital; Dr. Roy E. Trussell, administrator of Beth Israel, receives $93,000 a year in salary plus benefits including an apartment. These expenses are added into the cost per patient day at the particular hospital, and the bill is footed by the Blue Cross subscriber.

$25 million in additional "questionable" costs which could only have resulted from inadequate review procedures.

James Ingram, Blue Cross Vice President for Reimbursement, replied, "We do not audit to find out whether the money was spent wisely. That is not our mandate." A week after these charges were made, Blue Cross asked the State permission to increase hospital reimbursement from six to 18 percent. If hospitals are getting increases, consumer rates won't be far behind.

Likewise across the country, consumers were hitting Blue Cross on another front. Nonsubscribers in Iowa, Kansas and South Dakota are bringing class action suits charging that, because Blue Cross receives approximately 15 percent discount in what it pays hospitals for services to its subscribers, nonsubscribers are being overcharged to make up the difference. This amounts to price fixing and restraint of free competition under the antitrust laws, complainers charge.

Finally, in New York, Blue Cross' little brother, Blue Shield, is faring even worse. The State Insurance Department is charging it not with price fixing or conflict of interest, but with just ordinary old mismanagement. Last March the Blue Shield Board of Directors fired Blue Shield President of eleven years, Dr. Leonard J. Raider, for allowing the Plan's $15 million reserve fund (which is required by law) to be dissipated. (Dr. Raider subsequently committed suicide.) Now the Insurance Department is considering removing the Board of Directors as well, for the Plan's failure to make "prompt, fair and equitable" settlement of claims made by subscribers. The Commission has received 2,500 complaints against Blue Shield in the first ten months of this year—up from 687 during the same period last year. Three hundred of these have gone to court and 80 percent have been upheld. In response to this pressure, Blue Shield and Blue Cross have just come forth with a proposal that the two merge.

AMA CENSORS DR. WELBY?

The Committee for National Health Insurance is charging that in its TV series, Marcus Welby, M.D., the American Broadcasting Company consistently shows only one viewpoint on American health care—that of organized medicine—that this is unfair, and that opposing viewpoints should be given equal time. Specifically, it charges that the AMA, as a "technical consultant" to the program, edits out lines which might be critical of American medicine. Most recently the AMA censored out an offending sequence in which a doctor comments about a patient's health insurance and Dr. Welby replies by saying, "I'm sorry to say many of those who need insurance the most don't have it."

SO WHAT'S A REAL EMERGENCY?

New York's Mt. Sinai Hospital got its come-uppance the other day. Apparently being a hero of the 1956 war, a member of Parliament and brother-in-law of the former US Ambassador was not enough to get retired Israeli General Avraham Yoffe into the hospital. The general suffered a stroke while on a speaking tour of the US and was taken to Mt. Sinai Hospital where he sat for an hour in the waiting room before friends were able to make a deposit of $3,080 necessary to admit him to the hospital. "His financial responsibility was guaranteed by the Israeli government and by Bonds for Israel, a financially sound American institution," commented his cousin who accompanied him. "But it was not until an Israeli official sent down a check for the full amount that the patient was admitted." When the New York Times polled other New York hospitals, they all swore that, of course, they would never think of refusing or delaying an admission for financial reasons (a palpable lie). Mt. Sinai said, of course, it would never do so either, if it's a real emergency, that is. Oh well, you can't win 'em all.
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