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EDITORIAL

Economic Crisis

One of the most predictable signs of spring in New York City is the appearance of a gaunt old man wearing a sandwich sign marching up and down in front of St. Patrick's Cathedral. His sign reads: "Beware the End Is Near." A careful observer of New York's hospital scene might argue that the sign-man has chosen the wrong location. His warning more aptly fits the house of medicine than the house of God.

This BULLETIN focuses on the impact of New York City's fiscal crisis on health services, especially those delivered by the city's
public hospitals. An accompanying article sketches the effect of the Great Depression of the 1930’s on the health system of that era. At first glance few similarities exist between the health systems in these two periods of economic crisis. New Deal policies in the 1930’s were designed to breathe new life into the ailing economy and accelerated the growth of hospitals, particularly public hospitals. The government’s response to the economic crisis of the 1970’s has been to put the brakes on hospital growth, and public hospitals face a particularly severe threat. Beneath these differences, however, are strikingly similar dynamics of change. During the 1930’s the American Medical Association (AMA) defended the existing organization of health care delivery against strong currents generated by changes in the economy. Initially the AMA was effective in warding off initiatives favoring prepaid group practice and the creation of a national health insurance system. Today the hospital sector, having eclipsed the power and centrality of the AMA, finds itself in a similarly defensive posture in a time of economic crisis. Hospitals are fighting to maintain their hegemony by defending the model of care they deliver, just as the AMA did in the 1930’s. Furthermore, the realignment of interests within the health system resulting from the current fiscal troubles may pose a threat as potent to hospital proponents as the Depression posed for the AMA.

Scientific medicine was in many ways a Trojan horse for the AMA.

Hospitals

The AMA emerged at the turn of the century from being one of many competing sects in an arena of dubious accomplishment into a position of prestige and power. The vehicle of its transformation was what has been called scientific medicine. But scientific medicine, as the second article points out, was in many ways a Trojan horse for the AMA and the fee-for-service, solo practitioners which it largely represented. While it legitimized the profession, scientific medicine also contained within it the seeds of demise of this form of practice. For advancing technology and medical specialization, hallmarks of the development of scientific medicine, ultimately bypassed the private physician as the focal point of the health system and led to the ascendancy of hospitals as the organizational nexus of the medical system. These developments paralleled changes taking place throughout the economy. Medicine, like other industries, was passing from an amorphous collection of small-scale competing entrepreneurs to a system more consonant with modern corporate developments.

The AMA, largely because of its enormous political power, was able to maintain the illusion that it could stem the tide of change by aggressively fighting each issue which threatened the independence of private doctors. And on any particular issue the AMA stood a good chance of winning. But, in the end, the AMA only managed to slow and distort the pace of change, not to stop it. An alternative for the AMA was to position itself to benefit from new economic and political conditions. This would have required the AMA to accept in some measure the development of large teaching hospitals, group practice, prepaid health insurance, and government involvement in health-care financing and delivery. Of course, the price of accepting these developments was to sacrifice some of the very independence the AMA fought so hard to maintain. But this high degree of independence was only possible in an earlier era of laissez-faire competitive capitalism, not in the complex and interdependent world of corporate capitalism. The AMA by its uncompromising defense of an increasingly anachronistic model of health care moved itself out from behind the wheel of health politics into the back seat.

Ironically the weakness of the emerging hospital sector during the Depression enabled it to reap the harvest of changes imposed by outside forces. Hospitals did not resist the massive wave of public hospital construction even though it evoked the spectre of government intervention and competition. Publicly financed construction set the pace for the enormous expansion of the health industry after World War II. Hospitals became important repositories of post-war investment.
Although in large part self financed through Blue Cross, this expansion created tighter dependence by hospitals on the government for the underwriting of research and construction costs. In effect, the dynamics of growth hitched the hospitals’ wagon to the government—a star they could not control. Despite their often expressed wariness of dependence on government money, the hospitals quickly lost their ability to look this gift horse in the mouth.

These economic imperatives meshed well with the development of scientific medicine. Hospitals, not doctors’ offices, had the capacity to offer the technology so indigenous to what is considered scientific practice. Hospitals, as well, could easily accommodate the dictates of specialization. Yet commitment to high-technology, inpatient medicine has led hospitals far astray from primary health care needs. Moreover the high cost of their efforts has forced hospitals into ever greater reliance on government financing as the costs of hospital care have soared far beyond the ability of many people to pay.

But the dynamics of scientific medicine, increasingly financed by government, has today created a Trojan horse for hospitals. High-technology, hospital-based medicine has become so costly and aloof that now, under the impact of the fiscal crisis, government is being forced to assess the costs and benefits of its health investment. Increasingly government is looking for new forms of health care delivery to limit its swelling expenditures while minimally meeting public expectations for health care.

Like the AMA in an earlier era, hospitals must recognize the inevitability of this development and position themselves to respond or else assume a head-in-the-sand position and stake their future on the defense of high-cost acute care medicine. The needed changes, of course, do pose a threat to the present identity of hospitals and require reorganization of existing hospital structures. Hospitals would have to deliver what they now consider to be mundane and uninteresting health care, probably without much of the fancy paraphernalia which excites doctors and trustees alike. They would have to concentrate on preventive and primary care, and, in order to do it without adding enormous expense, reorganize the super subspecialization of hospital-based practice to a practice more consonant with primary care needs.

This is a risky and difficult enterprise, at best. But there is little choice. Unless hospitals can act decisively both to trim the fat and to meet large scale health needs, including preventive and primary care, the government is likely to switch its feed bucket to leaner, more flexible institutions that can respond to these imperatives.

Who will benefit from such a switch? One might speculate that the heir to hospitals as power brokers of the health care system will be groups offering primarily organizational, administrative and financial expertise. The health industry seems headed in the same direction as other sectors of the US economy, which is increasingly replacing its Henry Fords with Robert McNamaras. Just as hospitals replaced solo practice, fee-for-service medicine as the most important actors on the health care stage, it seems clear that preeminence in the health system will pass from the deliverers to organizers of care.

Blue Cross, a group as different from hospitals as hospitals were from the AMA, is one group well suited to respond to changing fiscal and public needs. As its role administering government monies has grown in the last decade, so has its independence from the hospitals which created it. Blue Cross is not necessarily wed to the model of high-tech-
nology, high-cost medicine. Not only does it offer an already existing national structure and administrative apparatus, perhaps more importantly Blue Cross offers the rubric of maintaining private control over the health system.

Whether or not Blue Cross' efforts succeed, the current fiscal crisis highlights the incompatibility of public financing with the ever more costly hospital-based model of care. Like the AMA, the choice for hospitals is not whether to change, but whether they will try to direct that change themselves or resist and be overtaken by history.

Public Hospitals

Like the hospital sector during the Depression, the very weakness of public hospitals, stepchildren of the voluntary hospitals, may make them more adaptable to change than their step-parents. As the first article points out, the only hope for the survival of public hospitals resides in this possibility. A hybrid product of nineteenth century public infirmaries, which offered ambulatory care to all comers, and the twentieth century hospital, public hospitals need not wed themselves to the voluntary hospital model which emphasizes high cost care.

Unfortunately in this period of economic crisis in which public hospitals are most immediately under fire, they have heightened their own vulnerability. Rather than drawing upon what is best in their public tradition and/or seeing strength or adaptability in their present competitive weakness, public hospitals have increasingly patterned themselves after the standard of the high-technology, acute-care voluntary hospital. But this standard has proved impossible for these chronically underfinanced institutions. The result has been public hospitals which could neither meet the high and costly standards of voluntary hospitals, nor the more mundane primary care needs of the large, generally low-income communities which they serve. Unable to draw strength from either, public hospitals have been sitting ducks against the onslaughts of budget cutters.

Not only have public hospitals been considered second class in the eyes of medicine, but they are frequently viewed as second class by their patients, a fact which many public hospital advocates have chosen to ignore. But it cannot be ignored. Under the threat of budget cuts, public hospital advocates cannot retreat to defending an indefensible status quo. Public hospitals will only gain loyalty and political strength to the extent they are able to meet their communities' needs, and meet them well.

The pressures of the fiscal crisis have caused some well meaning public hospital administrators to try harder than ever, in an effort to balance their shrinking budgets, to imitate the voluntary model. Thus New York City's public hospitals, for instance, have limited their access, reduced primary care services and initiated private practice within the hospitals, eliminating precisely those functions which distinguish them from voluntary hospitals and further undermining their strategic position. Becoming more duplicative of the private sector surely invites the extinction of public hospitals.

The current fiscal crisis presents a unique opportunity for reorienting public hospital priorities and breathing new life into a presently dying system. Voluntary hospitals, although still the single most important force impeding change in the health care system, are on the defensive. The AMA has shrunk to a shell of its former self. The government is increasingly disaffected with the cost of health care in its present form. The public, unable to get the care it needs from either private doctors or hospitals, is growing more and more restive and is increasingly open to considering alternative forms of health care. Public hospitals must seize this opportunity to serve unmet primary, low-cost health care needs, or else, chronically weakened, they will surely die.
NYC Public Hospitals

The only way to preserve the municipal hospital system is to change it, essentially to voluntarize it,” said Dr. Lowell Bellin, New York City’s health commissioner. Promoting his plan for the future, Dr. Bellin is at the same time accurately characterizing the impact of New York City’s fiscal crisis on its public hospitals.

Voluntarization does not necessarily imply a change in ownership from public to private. Rather it describes changes in the type and scope of services delivered by the municipal hospitals. Elements in this transformation include the introduction of private practice within the public hospitals; acceleration of the shift from such traditional functions as chronic and outpatient care to acute, inpatient services; the enforcement of a fee schedule for users of municipal hospitals; and consolidation of the system around large institutions. All of these changes represent an attempt to remold the city hospitals in the image of the voluntary hospitals.

Voluntarization of the public hospitals is in part a response to the pressures of fiscal crisis. By hanging onto the coattails of the more powerful private sector, the municipal system is trying to stave off financial disaster. But the money crunch has its own imperatives, which in turn call into question the hegemony of the voluntary model.

The most immediate impact of the crisis is a government-imposed reduction in the rate of spending in both public and private sectors. A fissure has opened between proliferating, costly hospital-based care and the government’s ability and willingness to underwrite it. Health-care expenditures have strained federal, state and city budgets. To date, government retrenchment has been organized around consolidation into large hospitals. This saves money for the moment by reducing the number and availability of services and by eliminating weak public and private hospitals. In the longer run, however, increased emphasis on high-cost care may prove to be the Achilles’ heel of the health system as we know it.

The solution adopted by New York City and State reflects the strategy and priorities of large voluntary, teaching hospitals. But collapsing the system around high-technology acute care runs counter to government financial needs. The internal contradiction of a budget-cutting strategy based on monopolization around high unit costs is most apparent in the public sector, which is directly under the thumbs of the budget cutters, and which so far has absorbed the brunt of cutbacks.

The shape of things to come can be gleaned from the three-year plan adopted in January, 1976 by the New York City Health and Hospitals Corporation (HHC). After spending two years paring bits and pieces off the system, this quasi-public agency finally committed itself to major surgery. In order to realize savings of $159 million from its fiscal 1975 operating budget of about $1 billion by the end of fiscal year 1977 the HHC plans to:

- Close the inpatient and emergency services at two hospitals (Sydenham and Governor in Manhattan);
- Close five hospitals (Morrisania, Lincoln and Fordham in the Bronx, Greenpoint and Cumberland in Brooklyn) when three new institutions open (New Lincoln and North Central Bronx in the Bronx; Woodhull in Brooklyn);
- Close two neighborhood family care centers (Belvis in the Bronx, Sydenham in Manhattan);
- Enforce a fee schedule at the remaining hospitals;
- Increase the use of collection agencies and begin litigation against patients in arrears;
- Establish private and group practices in public hospitals;
- Shut down ambulatory services as budgetary needs arise.

Despite radical surgery, the plan will probably not cure HHC’s fiscal woes. First of all, the targeted spending reduction is an optimistic estimate of future revenues. The extent of the city’s financial bind has been seriously underestimated and prospects for major improvements are dim, threatening even greater cuts for the HHC. Secondly, voluntarization is likely to further weaken the political viability of the public hospitals because this model of care cannot satisfy the needs of the majority of their patients who use municipal hospitals for primary care. Increasing the disparity between patient needs and available services undercuts popular support for municipal hos-
hitals, along with their claim to the public treasury. Few politicians will pour scarce resources into HHC coffers without this base of popular support.

**Medicaid: Backdrop of Crisis**

As long as there have been public hospitals in New York City there has been financial crisis. Maintenance of the institutions has been a headache for City fathers since the first Bellevue opened its doors in 1736. The roots of the present crisis, however, began developing only about a decade ago. With the enactment of Medicare and Medicaid (effective July 1, 1966) many of the patients who formerly relied on city hospitals could now go elsewhere with their ills, covered generously by the government.

Over the next ten years more and more patients switched to voluntary hospitals. Indicative of the movement is the decline in the municipal hospitals' share of patient days. In 1965 public hospitals accounted for 25 percent of the total general-care patient days; by 1974 their share had fallen to 19 percent. These figures actually underestimate the shift by Medicare and Medicaid patients because in the meantime there has been a shift in the opposite direction—from voluntary to municipal hospitals—by patients without third-party coverage. The problem is particularly acute in ambulatory services. Thus the federal programs exacerbated the chronic financial difficulties of public hospitals in New York City by enabling patients made "profitable" by Medicare and Medicaid to leave the system and forcing more "unprofitable" patients into dependence on public hospital care.

Prior to the enactment of Medicare and Medicaid poor people had nowhere else to go. Thus reducing the funds for public hospitals was likened to killing people. Since 1966, however, the public system has been open to the charge of redundancy. With national health insurance somewhere in the wings, many believed that the days of city hospitals were numbered.

Medicare and Medicaid may have weakened the public system but they did not kill it. While they may have become chronic invalids, the public hospitals still had the backing of a very powerful alliance. Six of New York City's seven medical schools and eight of the city's 55 voluntary hospitals have affiliations with public hospitals, from which they derive income, make staff appointments and have guaranteed access to research and teaching "material." The remaining private hospitals have sniped at the public hospitals from time to time, but by and large they were content to see the system grow as long as its growth fit with their own plans.

In addition to the private sector, the public system was sustained by support from District Council 37 of the American Federation of State, County and Municipal Employees union (DC 37). Hospital workers were the numerical cornerstone of this, the biggest of the municipal unions. The third major group interested in the survival of the municipal hospitals was local politicians, particularly those representing Black and Puerto Rican communities. The hospitals are a rich source of patronage and local influence. All of this added up to a very large and politically entrenched, if sickly, system.

In the beginning of 1975, the municipal system included 19 hospitals with over 13,000 beds and about 42,000 employees.

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Money Doesn't Grow on Trees

The pressures of the budget crunch made the municipal hospitals' $1 billion expenditures a juicy target for the budget cutter's scalpel. Health care is one of New York City's most expensive services. During fiscal 1975 $2.6 billion for personal health services passed through the city treasury on its way to public and private providers. Forty-one per-
percent ($1.058 billion) was channeled to the HHC for the public hospitals. The Corporation’s expenditures had increased 70 percent in just five years. Created by the New York State legislature in 1969 to take the municipal system out of the morass of city bureaucracy, the HHC spent $617 million in 1971, its first year of full operation (see BULLETIN, December 1971).

Medicaid expenditures grew even faster. The total has doubled since 1970. Current estimates for fiscal 1976 are that about $350 million will go to the public system; $537 million to voluntary hospitals; $299 million to private doctors, dentists and laboratories; $428 million to nursing homes and $139 million to pharmacies, medical device suppliers, proprietary hospitals and others. During periods of economic expansion, such growth might be acceptable. But in times of crisis, these expenditures loom like a vampire, sucking dry the public treasuries.

Most of the public money for delivery of the city’s health-care services comes from federal and state sources. The city ante up about one-third of the total (including its mandated 25 percent contribution to all Medicaid reimbursements). Thus the number of health-care dollars is a problem for all levels of government. The federal and state authorities have exerted considerable pressure on the city to cut services, thereby reducing its financial obligations and their own as well. As the fiscal crisis intensified, both the President and the Governor pointed specifically to health services as a culprit undercutting the city’s ability to pay its debts.

Cut Services or Die

Between 1969 and 1975 the city’s expenditures grew far faster than its revenues. The city was forced to borrow more and more money in order to finance itself. Thus, as city services expanded, so did city debts. Debt-service payments (repayment of principal and interest) ate up an ever-increasing share of the city budget, growing from about $700 million in 1969 to over $1.8 billion in fiscal 1976. The total dollar amount owed by New York City at the end of fiscal year 1975 was $11.3 billion, just slightly less than its budget for that year. Repayment of the current debt will take until 1999. And each year a larger portion of borrowed money and interest falls due. As the city has become more and more dependent upon borrowing, its creditors have assumed an ever-increasing role in setting public priorities.

By 1975 creditors had become dissatisfied with a program of cutting expenses to meet current revenues. They wanted assurance from the city that its future obligations would not grow to the point of jeopardizing its debt service payments. They refused to continue refinancing the debt until city government slashed its services. As stated by the Wall Street Journal in an October 15, 1975 editorial, "The city’s credit cannot be restored merely by drawing a plan to balance the city’s cashflow budget over the next two or three years. Only a decrease in future liabilities can persuade the credit markets that New York City will be able to meet its obligations without raising taxes."

On June 2, 1975, the liberal Washington Post chastised Mayor Beame for seeking a "bail-out" by the banks. The Post advised the Mayor "to start chopping away at the myth so deeply embedded in New York’s politics that things are ‘free’ if the government provides them."

President Ford added his voice to the chorus. "No city," he said on October 30, 1975, "can expect to remain solvent if it allows its expenses to increase by an average of 12 percent every year, while its tax revenues are increasing by only 4 or 5 percent a year."

Ford went on to cite a litany of abuses including high wages and pensions, too much free edu-
cation, too much freeloading on welfare and too much health care.

The message from Washington and Wall Street was clear. The fiscal crisis was caused by overspending and the politicians were to blame. Their conclusion was unanimous: New York City would be assisted out of its financial quagmire only if it spent less on services.

Joseph Terenzio, former Commissioner of the City Hospitals Department (predecessor

to the HHC) and now president of the voluntary hospitals' United Hospital Fund, extended the argument specifically to the municipal hospital system. "I think New York for generations has been more compassionate," he said, comparing New York with Chicago, "Can we afford it now?" The tone of Terenzio's remarks was repeated with increasing frequency as the crisis deepened.

With decreasing utilization and increasing costs, largely from the impact of Medicare

| Banks Bust Budget |

New York City's expense budget has an illusory character about it, which can easily confound the shrewdest inquisitor. Simply trying to track down where the money comes from and where it goes and the size of the deficit is a difficult task. These obstacles notwithstanding, perhaps a little light can be shed on the budget morass.

New York City gets its operating money from several places: state and federal sources, money it collects through its own tax levies and revenues it raises by issuing short-term notes (to meet immediate cash needs) and long-term bonds (supposedly to be used for capital expenditures). According to a special report prepared in January of this year for Treasury Secretary William Simon by Arthur Anderson and Company (one of the "Big Eight" accounting firms), all of these funds (including $1.4 billion from bonds and notes) will add up to $12,880 billion for fiscal 1976. Of this amount 20 percent is to come from federal sources, 21 percent from the state, and the city is expected to collect the rest. Of the $7.6 billion the city is to raise 38 percent will come from real-estate taxes, 11 percent from sales taxes, 8 percent from personal-income taxes, 9 percent from capital funds, 6 percent from general corporate taxes and the rest from various sources. The exact amount of the deficit is uncertain since both revenue and expenditure estimates change, but the figure is somewhere near $1 billion.

As noted, the city does not have to provide all the $13 billion for its expenses from its own resources. Depending on the service, the city will have to pay anywhere from 25 percent to 100 percent of the program's cost, with the state and/or the federal government providing the matching funds. Secondary education, for example, which comprises 16 percent of the total expense budget, gets 49 percent of its funds from the city and the rest from other sources. Welfare, representing 27 percent of the budget, gets 70 percent of its funding from the state and federal governments. While the expense budget shows expenditures for these two items as $2 billion and $3.5 billion, respectively, $1 billion of the education tab and $2.5 billion of the welfare cost are actually revenues to the city.

The implication of this varied funding of programs is that when the city cuts back on services, it must do so in such a way as to maximize the amount of federal and state matching funds coming in. A one-dollar cut in the city's welfare expenditures will result in a two-dollar reduction in revenue, but a one-dollar cut in secondary education will only result in a dollar lost in revenues. The city thus minimizes its revenue losses by making budget cuts in services funded primarily from the city's coffers.

Medicaid expenditures, like welfare benefits, bring in a substantial dollar amount to the city. New York City pays only 27 percent of the $1.410 billion Medicaid total going to the private sector. The Health and Hospitals Corporation (HHC) is like education, with the city footing 45 percent of the Corporation's $1.058 billion budget. Additional expenditures on personal health care put this expense item in the neighborhood of $2.6 billion, or 20 percent of the total expense budget. The city contributes about one-third to personal health expenditures.

By contrast, the largest single item in the
budget which is funded 100 percent by New York City’s taxpayers is the debt service, representing 14 percent of the total expense budget, or $1.784 billion. The debt service is the amount of principal and interest owed to holders of New York City bonds and notes falling due in any given year. The second largest item funded primarily by the city (95 percent) is the pension fund of the city’s workers. It represents 10 percent of the total budget, or $1.3 billion.

What all these dry figures come down to is that if New York City wants to save, it must make cuts that do not jeopardize federal or state revenues. The prime targets for such reductions are those services which are in the 95 to 100 percent city-funded category, like the debt service, pensions, and uniformed services. Second priority would be assigned to the 50 percent category, such as education, and last would be the 30 to 35 percent grouping. This latter category is where personal health care fails.

A better picture of the relative cost of city-funded services emerges if federal and state contributions are factored out of the expense budget. Instead of $13 billion, the expense budget for fiscal 1975 would be reduced to $8.4 billion in obligations that the city must pay from its own tax collections. (The gap between the $8.4 billion in city expenditures and the $7.6 billion in revenue accounts for a large percentage of its deficit.) Of the $8.4 billion, 21 percent of the city’s resources go to the debt service, 15 percent to pensions, 13 percent to welfare, 12 percent to the uniformed services, 12 percent to secondary education, 11 percent to personal health services and the rest to higher education, courts, government administration, etc.

The recitation of these figures means little unless one more magical manipulation is performed—dividing the city’s expenses into controllable and noncontrollable expenditures. The largest item the city has to pay out of its own funds, the debt service, is put into a sacrosanct category called noncontrollable expenses, while the rest of the budget ($5.859 billion), except for state and federally mandated programs, is put into the category of controllable expenses. What this manipulation does is open up all controllable expenses to budget cuts and maintain a commitment to meeting the city’s noncontrollable obligations.

Aside from state and federally mandated programs, what goes into the noncontrollable category is largely a political decision. An example of this fact can be seen within the health sector. Medicaid payments to the voluntary hospitals are made according to the claims presented and are thus judged non-controllable. Medicaid payments to the HHC, however, involve a process of negotiation, which ultimately shortchanges the HHC if judged by the same standard as the voluntary hospital reimbursement procedure. Medicaid payments are thus deemed controllable with respect to public hospitals but not so with respect to private ones.

A more obvious example of this process is the classification of the debt service as a non-controllable expense—even though it is the largest expense item the city has to pay from its tax base—and opening up the pension funds and uniformed services to attack. Clearly the overseers of the city’s budget, the members of the Emergency Financial Control Board (the body established by the state legislature in September, 1975 and given final jurisdiction over all city fiscal matters, which includes heavy representation from the financial community), are protecting their investments. So important is the payment of the city’s debt that each agency gets a portion of the total debt service allocated to its expense budget. For example, $68.8 million for debt service is included as an item in the HHC’s total $1.035 billion budget.

The claim is made that the city is providing too many services at too high a price. Specifically, the HHC has been ordered to cut $85 million in tax-levy support from its expenses in fiscal 1976. Yet in pure budgetary terms, the city stands to lose far more money from that cut (since it brings in other revenue) than if the HHC were permitted to liquidate its share of the debt payments. In order to avoid defaulting on its obligations to the financial community, the city is compounding its revenue bind by defaulting on its ability to deliver health services to the city’s population.

Many New Yorkers have been convinced that the budget is merely a ledger sheet. Some, however, understand that it is a political document reflecting power relationships. With this fact in mind, it is interesting to note that the city fathers have announced that the budget hearings this year will be held in the Police Department auditorium.
and Medicaid, the HHC's huge budget became an irresistible target. Its long-term prospects were extremely doubtful even before the crisis. Now few believed the system could survive the onslaughts of city, state and federal budget cutters.

Setting Up for the Kill

A climate of doom concerning prospects for the city's public hospitals prevailed two years earlier at the time Dr. John L. S. Holloman, Jr., was elected president of the HHC by its board of directors in April, 1974. Holloman, a prominent Black physician, former president of the National Medical Association and long-time civil rights activist, replaced Dr. Joseph English. English, the HHC's first chief executive, had proved unequal to the job. His major qualification had been his friendship with Senator Robert Kennedy and his tenure in the Democratic administration as chief psychiatrist to the Peace Corps and head briefly of the Health Services and Mental Health Administration of HEW. The most noteworthy byproduct of the English years was an astronomical growth in HHC expenditures, outstripping those of city government as a whole.

Replacing English was a difficult chore for the members of the HHC Board of Directors. This semi-independent body is composed of three city commissioners (health, mental health and welfare), five mayoral appointees, five City Council appointees, a deputy mayor and its chairman, the head of the Health Services Administration (the superagency which oversees health, mental health, addiction services and the medical examiner's office). After election by this 15-member group, the president then sits on the Board.

Holloman was one of three or four significant candidates supported by various interested parties. The others included Gordon Durzon, executive director of Kings County Hospital in Brooklyn, the largest municipal hospital; Joseph Terenzio, candidate of the voluntary hospitals and medical schools affiliated with the HHC; and Dr. Edmund O. Rothschild, an HHC Board member then known as a persistent critic of the role of the affiliates. Two of the three city commissioners and three of the other Board members were Black. The hospital establishment, largely white, was divided between Terenzio and Durzon; Rothschild was considered a political lightweight. City Hall apparently chose not to influence the decision.

After some slick behind-the-scenes maneuvering by the city's Black and Puerto Rican politicians, which included a banner-sized, front-page story in the Amsterdam News (New York's leading Black newspaper) on the eve of the vote, Holloman was elected. His $65,000 salary made him the highest paid official in the New York City government.

Everyone concerned realized that Holloman was promoted to captain a ship that was full of holes. But some, seeing his election as a victory for advocates of the public system, hoped he could make it seaworthy again. Others wondered whether the disinterest of City Hall and the rather quiet acquiescence of the affiliates was not the most significant omen. One doubting Thomas commented: "Who better to oversee the decline of the municipal hospitals than one of the founders of the Medical Committee for Human Rights? It would be as appropriate to have Holloman, a Black civil rights activist, oversee their demise, as it was to have imperialist Winston Churchill preside over the dissolution of the English empire."

The New York Times used Holloman's election to decry the state of the city hospitals. "In four years since the corporation was formed to take the hospitals out of politics, it has done little to improve the conditions that made the system a civic disgrace." The Times was skeptical of Holloman's ability to do any better. "Some of those who voted for the new president said almost prayerfully afterward that they hoped he would surround himself with aides who would provide the administrative expertise he lacks."

Trouble From the Start

Holloman was beset by problems from the moment he assumed office. Dr. Lowell Bellin, health services administrator, health commissioner and chairman of the Board of Directors of the HHC, opposed Holloman's election.
Holloman had trouble with Bellin because Bellin is an unabashed advocate of the voluntary sector and because his two hats (health commissioner and health services administrator) entitled him to two votes on the HHC Board. Mayor Beame’s interest in the HHC did not extend much beyond its availability as a dumping ground for unwanted civil servants and as a vehicle to satisfy some of the demands of DC 37. Beame exploited the political usefulness of the HHC and paid it lip service but showed little concern about the services it delivered.

With Bellin actively seeking the demise of the hospitals, the union interested in them primarily for expansion of its membership and the Mayor uninterested in health care, Holloman faced a tough uphill battle. If he wanted to institute major changes in the system, or for that matter simply save it from the chopping block, it was imperative that he begin at once to establish an independent political base. Only then could he rally the support necessary to cut through the established political forces, whose main interest was in maintaining the status quo.

A natural place to begin building that base would have been among workers and patients dissatisfied with the city’s public hospitals but interested in preserving them. To accomplish this, however, required taking the offensive, making an honest public appraisal of the wretched state of the institutions and inviting community and worker participation in the monumental job of transforming the hospitals. Holloman had little choice. To build a base that could preserve the city system, he had to transform it into a system of good hospitals, delivering the care New York City’s people needed.

Even in the best of political climates, the job would have required great political and administrative acumen. Unfortunately, Holloman displayed neither. He never gained control of the HHC’s administrative apparatus. He was unable or unwilling to recruit people to replace some of the incompetent or hostile holdovers from the English administration. Nor did he construct a bureaucratic strategy for bypassing those he could not remove.

Symbolic was his failure to aggressively challenge the appointment of Harry Bronstein (a political hack whom Beame wanted to ease out of his job as city civil service director) to the crucial position of HHC senior vice president for personnel.

Holloman’s passive style and his attempt to go it alone among the vested interests marked his downfall. As a result, events overtook him and he slid into a defense of the public hospitals without ever having confronted the forces that created this indefensible status quo nor those actively seeking the death of the public system.

Revenues Up, Expenses Down

Soon after he was sworn in, Holloman was informed by the city Bureau of the Budget that the HHC was $55 million in the red. He was told to cut the HHC’s annual spending rate by $15 million immediately. This was an ominous sign: In the past the city had paid HHC budget overruns from city tax funds. The HHC complied by eliminating 175 central office jobs and by cutting 1.5 percent of the operating budget of each hospital. Holloman, while upset by the cuts, announced that he remained optimistic about the financial situation. He believed that enactment of national health insurance was imminent and would solve the chronic problems of the municipal system. His optimism extended to the internecine struggle between the voluntary and municipal sectors. “I would like to achieve a rise in the level of health care,” he told the editors of the New York Times, “and eliminate duels between municipal and voluntary nonprofit hospitals.”

Holloman’s faith in the financial viability of the system was apparently rewarded during the summer of 1974, when the New York State Department of Health announced a large increase in the Medicaid inpatient reimbursement rate for the city hospitals. The increase, from $169 to $205 for each inpatient day, more than compensated for the earlier cutback. The HHC estimated it would gain an additional $45 million in revenues as a result.

Meanwhile Board Chairman Bellin was gearing up for the first in a series of attacks on the public system. His Health Department staff pointed their finger at a so-called glut of

To build a base that could preserve the city system Holloman had to transform the hospitals.
public hospitals in the Bronx in a report issued on November 10, 1974. According to the report public hospital occupancy was in danger of falling below standards set by New York State's Cost Control Law, which would result in the loss of $108 million a year in Medicaid funds. (Medicaid reimbursements are penalized when long-term-care facilities dip below 90 percent occupancy, medical-surgical beds below 80 percent, pediatric beds below 70 percent and obstetrical beds below 60 percent.)

The ink had hardly dried on Bellin's Bronx report when Mayor Beame demanded that members of the HHC Board assemble at Gracie Mansion, his official residence, to reduce expenditures by another $26.9 million. Although officially he had no direct say over HHC policy, Beame informed the Board that this amount was its fair share in a plan to cut all city government spending by 8.5 percent.

Holloman reacted angrily. He immediately called a protest meeting with the medical boards, executive directors and community advisory boards of all HHC hospitals. After expressing his outrage, Holloman told the press: "The sentiment is unanimous that the system has lost $15 million in cuts already and that more would be impossible...further cuts will increase the hazard to patient care." Holloman raised the spectre of people dying in the streets. "They [the hospitals] may be forced to turn away hundreds of patients in urgent need of medical services."

Despite the bold talk, the HHC capitulated. It agreed to return to the city treasury the amount that would accrue from the Medicaid rate increase. Miraculously, the sum was exactly equal to the amount Beame demanded—$26.9 million.

The Lines Are Drawn
Substituting increased revenues for budget cutbacks did not satisfy Beame. The city's creditors wanted cuts in services, and even a symbolic cutback would have better served Beame's needs; increased revenues could not. The question of reducing expenditures versus increasing revenues was to become a key issue through the budget struggle between City Hall and the HHC in the ensuing months. The HHC argued that cutting services was self-defeating because only by seeing more patients could it enhance its revenues from non-city sources. The city officials were dubious and did not see much to be gained from increases, particularly in Medicaid reimbursements: Every 50 cents the HHC could collect from the federal government meant an additional 25 cents each from the city and state treasuries.

In late November, 1974, the Mayor again informed the Board that it had to extract cuts in the HHC's operating funds. This time the Board voted to resist the mayor, a move supported by Bellin and other Beame appointees who had been won over by a motion to "look for new sources of revenue." In this case, however, the new sources were to be the patients who had been using the hospitals.

The Board announced that, for the first time, nonemergency patients would be turned away from city hospitals if they were eligible for Medicaid but not yet enrolled—a process which involves negotiating a 12-page application form and providing backup documentation. Moreover, the Board announced its intention to enforce collection of fees from patients not covered by Medicare, Medicaid or private insurance. These actions would generated $5 million in additional revenue, the HHC estimated.

The new Medicaid and collections policies marked a significant departure for New York City's public hospitals. No longer would they be available to all regardless of ability to pay. The Board attempted to allay the fears of people potentially frozen out by cloaking its announcement in careful language, but the intent was clear. Bellin joined with Holloman in resisting Beame because he had become more concerned with using the fiscal crisis to "voluntarize" the public sector than with meeting Beame's dollar targets.

Beame himself was not mollified. His right-hand man and old crony, Deputy Mayor James Cavanaugh, reacted bluntly. "We are (Continued on page 19)
The Depression And The AMA

History seldom offers simple lessons for contemporary situations. Thus the impact of the Depression of the 1930's on the American medical system at first glance bears little resemblance to the impact of today's fiscal crisis. Economic crises, however, often act to accelerate historic trends already underway and to intensify the pressures for social and political change. How the major actors in the medical system of the 1930's responded to this pressure is the subject of this article, and it is at that level that important parallels for today's medical system exist.

In 1929, at the beginning of the crisis, the character of the American medical system was dramatically different from what it is today. (See graph.) The Flexner Report on medical education, appearing only 19 years before, marked the ascendency of what has come to be known as scientific medicine. Medical practice was then the domain of the private, fee-for-service practitioner, as medical politics was the domain of the American Medical Association (AMA). Paling beside the medical profession both in size and influence were the hospitals, which had undergone an unprecedented increase in numbers in the previous two decades and which were just emerging in the public mind from their traditional status as glorified almshouses. So new and unorganized were hospitals that in 1929 it is unclear whether they could accurately be characterized as an independent sector.

The Depression Hits

The Depression of the 1930's hit the American public with an impact vastly more devastating than that of today's crisis. By 1933 national income had fallen to half its 1929 level. Employment had dropped 40 percent, leaving a third of the workforce idle, and for those lucky enough to retain their jobs, wages had fallen some 33 percent. (1) Although some local relief agencies existed, many of them voluntary, there were no large-scale relief programs to cushion the Depression's impact—no unemployment insurance, social security, food stamps, Medicaid or federal welfare assistance.
As jobs and savings dwindled, so did the ability of patients to pay for medical services. The average income for all doctors dropped 42 percent between 1929 and 1933 (from $5,224 to $2,948). Fee-for-service private practitioners were hit even worse than the average as their income plummeted 57 percent during the same period. While doctors fared better than most of the population, physicians at the lower end of the income scale were genuinely hard hit. Similarly, hospital income derived from patients dropped 49 percent between 1929 and 1930 as the average receipts per patient fell from $236 to $59 (a 75 percent decline).

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The drop in income was serious enough for both doctors and hospitals, but it was not accompanied by a drop in the demand for medical services. In the case of hospitals, there is evidence that admissions actually increased, particularly for acute care, and patients who could not afford a private doctor flooded hospital outpatient departments. Similar figures do not exist to show the volume over time of doctor visits. Compounding the problems of falling income and steady, if not rising, demand, was an additional bind: the public expectation that both doctors and hospitals would continue to provide services regardless of their patients’ ability to pay. The one-to-one or doctor-family relationship of private practice maximized the difficulty to doctors of turning away patients simply because they lacked money. Likewise hospitals, many strongly supported by philanthropy, were still viewed by much of the public as charitable institutions whose purpose was to serve the poor.

The Medical Profession: Turning Back the Tide

The Depression was preceded by years of steady growth in the number of doctors, culminating in a period of consolidation in the power and influence of the medical profession as it is known today. The Flexner Report, undertaken by the Carnegie Foundation and published in 1910, capped off the AMA’s attempts to gain control over medical education, to restrict entrance into the profession and to upgrade the quality of doctors. It also represented the triumph of scientific medicine over competing medical sects and established the hegemony of university-affiliated, academically oriented medical schools over the production of doctors. By the 1920’s control of the AMA had passed from the more liberal, academically oriented doctors to those in private, solo practice and the organization that had lent its support to national health insurance just a few years earlier embarked on a rear-guard defense of the status quo for private practitioners.

The threat the Depression posed to doctors’ income was problem enough, but even more disturbing to the profession was the Depression’s effect of speeding up processes already under way that carried with them a threat to the sovereignty and centrality of private practice in American medicine. Thus specialization, centralization and corporatization of medical care would deliver it, years after other economic sectors, from the era of cottage industry to that of modern corporate capitalism. Because of its strength, the AMA could have illusions of being able to turn back these processes, and thus it took a defensive stance, seeking to maintain its narrow competitive advantage in the medical marketplace, rather than to rationalize either its medical practice or its economic base.

The AMA was swept with a sudden wave of concern about overcrowding in the profession. Amid various proposals for professional birth control, the AMA for the first time since the Flexner Report launched in 1934 a rigorous survey of medical schools. The survey found over a quarter of the schools to be below standard. Class sizes were reduced, standards for entry and performance were raised and by 1940 there were actually fewer students entering medicine than there had been in 1930.

The profession did not fight the expanding role of government in providing care for the poor, but its chief concern quickly shifted to making sure that government assistance was limited solely to the poor. Doctors became more wary of public health endeavors, fearing an encroachment on their practices.
in 1938 gave its grudging approval, but it showed its lack of enthusiasm for many decades to come by purchasing commercial hospitalization insurance rather than Blue Cross for its several hundred employees.

The AMA’s defensive posture was epitomized in its reaction to the landmark study of the Commission on the Costs of Medical Care, completed in 1932. The Commission, a blue-ribbon group of medical notables, focused on problems of supply, demand and distribution of medical services. It found appalling inequities in the care available to different income groups, and its chief recommendation, designed to address the growing problems of cost, specialization and distribution, was characterized by dark hints of collectivism and socialism. The Commission’s findings, needless to say, were never acted upon.

Hospitals: Swimming with the Tide

For hospitals the era prior to the Depression had been one of booming expansion. Voluntary hospitals in particular benefited from the prosperity of the 1920’s, the growing urbanization of the population and the impact of medical advances, which transformed them from little more than almshouses into therapeutic institutions whose services were seen as desirable by all. In the two decades from 1909 to 1929 the number of hospitals increased by 57 percent and the number of hospital beds by 112 percent. (13) (See graph.)

Most hospitals (73 percent) were voluntary in 1929, although these accounted for a minority of hospital beds (36 percent). It was primarily among voluntary hospitals that the spectacular growth of the 1920’s took place. Public hospitals were fewer (27 percent of all

New York City the medical society took issue with public immunization programs and vigorously opposed the building of public dispensaries and health centers later funded through New Deal programs. (10)

AMA opposition was probably single-handedly responsible for the omission of any mention of national health insurance from the Social Security Act of 1935. Fear that the AMA would scuttle the entire bill led President Roosevelt to drop even an innocuous provision establishing a national study commission on the subject. The AMA was also largely responsible for nipping the growth of group practice in the bud. Doctors who participated in group practices were threatened with lawsuits and drummed out of medical societies. (11)

The Depression added to already growing tensions between medical specialists and general practitioners. It hit generalists hardest. Specialists received higher incomes than generalists and were more frequently affiliated with hospitals, where they were better situated to attract and refer patients. (Of all specialists, 99 percent had hospital affiliations, compared to 66 percent of all physicians. (12) Economic considerations were thus added to the already growing attractiveness of the specialties for students. The Depression also created an incentive for young doctors to prolong their graduate training in hospitals, where they at least received room and board, rather than braving the perils of setting up their own practices.

Doctors’ attitudes toward hospitals during this era were ambivalent. Hospitals, on the one hand, were seen as workshops for doctors and as an increasingly important adjunct to the practice of scientific medicine. The AMA thus supported federal legislation that would have aided construction of small and largely rural hospitals in the late ’30’s, perhaps because much of the AMA constituency lived in rural areas. (This legislation eventually was enacted as the Hill-Burton Act of 1946.) The AMA was suspicious, on the other hand, that by virtue of their growing importance, hospitals would come to control doctors. It thus opposed programs for prepayment of hospital costs—an issue of bitter conflict when the American College of Surgeons, along with the American Hospital Association, endorsed the idea in 1933. When the wildfire growth of one such program—Blue Cross—made its existence an indisputable fact of life, the AMA
hospitals) but larger (64 percent of all beds). (14) Approximately 40 percent of public hospitals were general-care facilities, usually run by cities and counties, and the remaining 60 percent were mental, tuberculosis and other chronic-care institutions, usually run by states. (15)

Unlike the medical profession, which was strong enough to be able to direct its own destiny through the tumult of the Depression years, the hospital sector was politically weak and economically vulnerable. The Depression presented hospitals with a particularly severe threat, given the large amounts of capital investment they represented and their need to maintain minimum staffing levels, regardless of utilization, in order to attract paying patients. Added to these problems, as mentioned before, was their lingering public image as charity institutions (although by 1929 they had become 75 percent supported by patient income) and the resulting expectation that they would provide services independent of their patients’ ability to pay.

Public hospitals were crowded prior to the Depression, with occupancies averaging 89 percent in 1929. As the Depression unfolded, impoverished patients increasingly sought their services, although the total shift of patients from voluntary to public hospitals was necessarily limited. By 1935 public hospital occupancy reached 91 percent nationally. (16) New York City public hospitals were even more crowded, with the average occupancy reaching 97 percent in 1934 and occupancies in some hospitals going as high as 135 percent. (17) Particularly overcrowded were public chronic-care institutions.

As public hospitals became overcrowded, voluntary hospitals became progressively underutilized. Voluntary hospital occupancy rates fell from 65 to 55 percent between 1929 and 1933. (18) This underutilization was exacerbated by at least three factors beyond the simple inability of patients to pay: (1) more effective medical treatment shortened the time patients spent in the hospital; (2) voluntary hospital expansion had flourished during the building boom of the late 20's, and facilities begun then were completed and became available at the very depth of the Depression; and (3) voluntary facilities, catering to the needs of private paying patients, had largely expanded their complement of private and semi-private rooms—the very facilities least utilized during the Depression. (19)

With indigent patients swamping public hospitals and many voluntary-hospital beds sitting idle, local governments increasingly sought to pay voluntary hospitals to care for public-charge patients. This practice had become common even before the Depression, since most states had enacted laws making medical care of dependents a state or local responsibility, although there were few public hospitals available. (At that time only 15 percent of all US counties had public hospitals, although these counties were mostly urban and included approximately 49 percent of the US population. (20))

Public payments to voluntary hospitals increased dramatically during the Depression. New York City, for instance, which had the most extensive public-hospital system in the country, increased its payments to voluntary hospitals by 90 percent between 1930 and 1934. (21) That increase represented an even greater increase in the numbers of public charges cared for, and payments per patient fell far short of the full cost of that care. New
York City in 1934, for example, was paying only half of what it cost to care for a poor patient in a voluntary hospital. (22)

By 1932, the heart of the Depression, the survival of many voluntary hospitals was at stake. Patient income had fallen dramatically, as had philanthropic contributions, the mainstay of many institutions. From 1928 to 1938, ten percent of all hospitals, most of them voluntary or proprietary, closed their doors or merged. (21) (See graph.)

**The Feds: Building the Public Sector**

Beginning in 1933 and 1934 the federal government through the Public Works Administration and the Works Progress Administration, as well as a handful of other New Deal programs, stepped into the hospital arena with massive aid for hospital construction. But federal aid was targeted entirely at public hospitals, and its intent had little to do with hospitals or health-care needs per se. Rather these programs evolved first and foremost out of the government’s need to provide jobs, and from this point of view hospitals seemed little different from roads, dams, bridges or other public works. There appears to have been little concern that the government was building institutions that might compete with those in the private sector.

The Public Works Administration (PWA) provided funding, and by 1936 it was financing over 80 percent of all hospital construction. PWA money resulted in the construction of over 1,000 new public hospital buildings and 60,000 new public beds. (One-third of this investment was in general hospitals, one-third in mental hospitals and one-third in TB and other chronic-care institutions.) The already substantial impact of the PWA was enhanced by another, similar-sounding agency, the Works Progress Administration (WPA), created in 1934 to provide jobs for the unemployed. WPA workers constructed 200 public hospitals and made many more additions and improvements to existing buildings. (24)

Although voluntary-hospital construction had ground virtually to a halt by 1933, the infusion of massive federal aid to public hospitals allowed the rate of overall hospital expansion to continue at the pace of the previous two decades. (See graph.) By 1941 public hospital beds represented 73 percent of the total hospital beds in the US, up from 64 percent in 1928. (25)

The form and magnitude of government intervention in the health-care system is a comment on the interests and organization of the hospital sector in the 1930’s. Government aid, on the one hand, would benefit voluntary hospitals, whose chief target was middle-class patients, by relieving the pressure on them to serve indigent and chronic-care patients. Once the crisis passed, on the other hand, it would leave a strengthened public sector as a potential competitor. An alternative would have been a government subsidy for the care of poor patients in voluntary hospitals in amounts sufficient to meet the cost. This course would simultaneously have provided care for indigent patients, filled empty voluntary-hospital beds and alleviated the deficits in voluntary-hospital budgets. Voluntary hospitals in several instances lobbied to persuade local governments to do just this, but without notable success. As a large-scale solution, this approach would have to await the enactment of Medicare and Medicaid in the 1960’s.

Meanwhile, rather than addressing themselves to federal policy, an arena clearly beyond their influence, voluntary hospitals undertook a more immediately achievable task: shoring up the ability of middle-class and working-class patients to use and pay for voluntary-hospital care through prepayment plans, namely, Blue Cross. The creation of Blue Cross would eventually rescue them from the brink of insolvency and would build an economic base to undergird hospital expansion and ascendency within the medical system for decades to come.

Small prepayment plans had existed for many years, but the immediate model for Blue Cross was a plan set up in 1929 at Baylor.
University Hospital in Texas. The idea spread rapidly, promoted actively by local hospitals, which undertook public recruitment campaigns and provided initial operating capital in 22 of the first 39 Blue Cross plans established. (26) Blue Cross received the endorsement of the American Hospital Association (AHA) in 1933 and grew from one plan with 2,000 members that year to 24 plans with 340,000 members in 1936. The AHA stepped in that year to take a major organizing role, setting up a committee to facilitate organizing and establishing AHA hegemony over the development of Blue Cross. (27) By January, 1940, there were 70 Blue Cross plans with 4.5 million members. Because of the intimacy of Blue Cross and the hospitals—the hospitals having established Blue Cross and Blue Cross soon becoming their single greatest source of income—Blue Cross, unlike its commercial competitors, was placed in a central position in the developing health-care system.

The genius of the Blue Cross solution was that it served so many different interests simultaneously. For a small monthly investment, subscribers were assured access to hospital care and protected from the financial disaster it would otherwise have represented. Blue Cross offered hospitals financial stability through a mechanism under their own control. They controlled Blue Cross so well, in fact, that not only did hospitals achieve stability, they were also able to underwrite the incredible scientific and technological developments in hospital care of the following two decades—and all at the subscribers' expense. In so doing they also preempted the possibility of national health insurance for many years to come.

—Ronda Kotelchuck

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Beame Ups the Ante

The city's financial situation took a sharp nose dive during the last half of 1974. The city previously had found it relatively easy to meet its budget deficits by borrowing from the banks, but by July, interest rates on loans issued to cover current expenses had skyrocketed 4 percent in the last 5 months. The July, 1974 interest demanded by investors was 8.6 percent. By December of the same year, the interest rates reached 9.5 percent. Rising interest rates were accompanied by increasing estimates of the city's budget deficit. On October 26 the Mayor cited the budget shortfall as $200 million, then upped it to $430 million on November 8. By the end of November the Mayor placed the budget gap at $650 million, and in early December the city's comptroller said it was $1 billion.

By increasing the cost of borrowing, the bankers sent the mayor an important message: The era of expansion had ended. The city's ability to borrow to meet its operating deficits was now made contingent on its implementing a policy of attrition and, if necessary, layoffs. In October, 1974 the attrition policy began, and the first major round of city employee layoffs was announced in November. Thus by New Year's Day, 1975, the twin policies of borrowing and firing were established as the city's method of addressing the fiscal crisis.

The need to accommodate creditors fundamentally undercut the HHC's strategy of increasing its revenues rather than cutting its expenditures. Beame now adopted a new stance, pre-empting this strategy by explicitly demanding job cutbacks. He ordered the HHC to lay off 551 provisional employees (non-permanent civil servants) in December, 1974.

The Board of Directors seemed not to understand Beame's demands. They sought instead to mollify him with a symbolic gesture: They voted to close Morrisania Hospital in the Bronx—but with one rather large qualification. They made its closing contingent on the opening of two other new Bronx facilities—North Central Bronx and new Lincoln Hospital. They furthermore reaffirmed their intention to proceed with construction of a replacement for another Bronx hospital, Fordham. This time Bellin did not vote with the majority but retaliated with a public blast at Holloman, whom he called "craven and unworthy" for "squandering HHC dollars."

The mayor escalated his demand to 351 layoffs within a month. The Amsterdam News, a strong Holloman supporter, added stature to Beame's stance when, on the eve of the January, 1975 Board meeting, it wrote: "If the present economic trends continue, and there is every reason to believe they will, the New York City Health and Hospitals Corporation is going to have to cut back on a sizable number of its 38,000 [sic] employees, and close down several of its 19 municipal hospitals despite talk to the contrary."

The Board, with Bellin taking the lead and Holloman in the opposition, partially accommodated the mayor. It voted an attrition of up to 450 jobs, and an attrition target was assigned to each hospital based on a workload/expenditure formula.

Attrition was attractive as a job policy. It is the line of least resistance. Employees who want to stay are not threatened. Cutbacks resulting from attrition are nearly invisible, except when excessive numbers of people in the same department leave at the same time. The Union preferred attrition, even though it meant an increasingly unequal distribution of work for remaining employees. As a health-services policy, however, attrition is totally irrational, since cuts cannot be planned or channelled according to programmatic priorities. Rather it is a political response to the budget-cutting mandate, which evoked little public note or protest as attrition moved ahead.

Attrition Isn't Enough

In March, 1975 the banks refused to loan the city any more money, ushering in a new phase of the fiscal crisis. The bankers publicly laid their cards on the table in early April and spelled out the price of continued borrowing. David Rockefeller, president of 19
Chase Manhattan Bank, and William I. Spencer, president of First National City Bank, representing the Financial Community Liaison Group of some 20 banks, insurance companies, investment houses and savings banks (major financiers of the city debt), presented their plan to solve the crisis. It called for a balanced expense budget for fiscal 1976, which would mean thousands of layoffs, as well as a number of badly needed accounting reforms.

Responding to the bankers' demands, Beame blew the lid off the HHC bottleneck. In April he called for 4,900 staff reductions and the closing of four hospitals. In announcing his request for another $57 million cut the Mayor focused his bookkeeper's eye on the municipal hospitals. He named the hospitals he wanted shut and enumerated his reasons: Morrisania, very old and supplanted by the new Bronx hospitals; Gouverneur, the most expensive and underused inpatient service in the system; Delafield, the smallest and second costliest; and Goldwater, one of two chronic-care centers. (Costliness and utilization are tricky issues, however, since they are easily manipulated.)

Goldwater patients and employees mobilized effectively to oppose Beame's plan. The image of several hundred paraplegic people demonstrating in wheelchairs in the media is a powerful one. Whether it was good press coverage or the intervention of New York University Medical Center, Goldwater's affiliate, the politicians made a hasty retreat. A mayoral aide told a delegation of demonstrators that "The mayor's decision was not chipped in granite."

The Goldwater demonstration catalyzed other municipal hospitals. Throughout the spring and early summer months between 1,000 and 4,000 workers (usually organized by executive directors of the municipal hospitals) picketed monthly Board meetings. At one point Holloman told the demonstrators what they wanted to hear: "The Board is strong in its position that there would be no additional closings of hospitals."

Despite the demonstrations, City Hall pressure did not abate. At its June, 1975 meeting, the Board voted to close Delafield Hospital, a small institution adjacent to one of the city's giant private medical centers, Columbia-Presbyterian Hospital. In addition, the HHC directors voted to cut $10 million from the $175 million the corporation was paying to affiliates to staff most of the municipal hospitals with doctors and in some cases, ancillary personnel. This shift of fiscal trouble onto the shoulders of the affiliates drew the obvious response. Dr. S. David Pomrinse, head of Mt. Sinai Hospital, one of the larger affiliates, remarked, "Great! Where are you going to get the doctors?" It was a good question, since physicians are hired through the affiliation program.

An accounting on August 1, 1975 showed that while HHC employees had declined by 1,946, the HHC had exceeded its budget by $15 million. Holloman attempted to explain that HHC income from third-party payments had risen, so that city tax support of the system actually declined by $70 million during the preceding fiscal year.

Holloman's explanation fell on deaf ears. The city Bureau of the Budget may have appreciated new revenues, but that was not the point. The point was the necessity of an explicit reduction in the number and scope of services and a concomitant reduction in staff. HHC budget overruns hardly helped the city in bargaining with the financial community.

**Collapse of the Defense**

The defense of the municipal hospitals had been based on the support of a coalition consisting of DC 37 and local Black and Puerto Rican politicians, whose constituencies were the workers and patients in the system. Al-

"Some fucking federal judge would have himself a potful of patronage."

Jack Bigel
Union pension consultant

though the union did in fact negotiate a respite for the HHC, ultimately it proved a weak foundation upon which to rest the defense of 19 hospitals. During the fall of 1975, the union scuttled its support of public hospitals in favor of what it deemed the city's (and its own) fiscal viability.

The refusal of the bankers to forward money to the city made the possibility of default real, and this possibility, more than any other factor, explains the collapse of the de-
fenders of the public hospital system. Default most likely would have brought New York City affairs under the jurisdiction of a federal judge. Bankruptcy proceedings would have voided existing contracts. As Jack Bigel, pension advisor to the unions commented: "Some fucking federal judge would have himself a potful of patronage."

Abrogation of its contract was a particularly devastating threat to DC 37 because of its peculiar composition and history. The bulk of DC 37's growth had taken place in the years just prior to the fiscal crisis—from 35,000 members in 1965 to 110,000 in 1975. This resulted largely from intimate connections with Democratic party politics and the occupants of City Hall, not from organizing struggles. DC 37 is composed of many locals whose separate memberships share neither history nor job-related contact. The glue holding together these diverse pieces is the contract.

The heart of union membership comprises permanent civil servants, as distinct from provisionals, also union members but who, for a variety of reasons, have failed to negotiate the intricacies of New York City's civil-service system. Even before the prospect of default, the union was committed first and foremost to protecting the interests of its permanent members. As early as January 18, 1975, DC 37 entered into a collective strategy with other major municipal unions (fire, police, sanitation) to protect permanent civil servants, even if it required wage freezes and the firing of dues-paying provisionals. Victor Gotbaum, DC 37's chief, actually demanded the layoff of provisionals in July, 1975 so that some permanent civil servants could be rehired.

With default threatening, the union made common cause with the city to avoid bankruptcy proceedings at all costs. And cost it did. To stave off default, the union was forced to invest its substantial pension funds in city notes and bonds. Being at once investors and employees put the union in a double bind. As an investor it had to concern itself with the city's solvency, which implied a reduction of the workforce; yet as a union, it was dismayed at the prospect of losing membership. The union found itself in the peculiar position of screaming about the need to pay off creditors while decrying layoffs.

The bind worsened in August, 1975, when the City Council gave Beame the authority to impose a wage freeze on city employees and to defer contract gains already won. The city offered the union a face-saving alternative: If the union would voluntarily accept the contract deferral within a month of the offer, the city would grant it a favorable payment schedule for the city's contribution to the union pension fund. DC 37 was the first of the municipal unions to accept Beame's proposal.

DC 37's fate thus came to be inextricably tied to that of the city, and the interests of the unions and the politicians became one. DC 37 thus jettisoned its opposition to dismantling the billion-dollar, 19-hospital, 42,000-employee municipal hospital system.

With the collapse of organized support from DC 37, Holloman's strategy collapsed and HHC defenders were thrown back upon their only remaining sources of support—patients and workers (qua health workers) in the system. Until now, however, Holloman's defense of the HHC had been on narrow political and fiscal grounds and his strategy had been based on the support of forces whose main concerns were neither the services the hospitals provided nor the working environment—issues of vital concern if Holloman wanted to mobilize the support of patients and workers. Addressing worker and patient
issues would have meant a major change in the character of the hospitals. Having initially thrown his hat in with the union, Holloman precluded for the most part the long-shot possibility of making fundamental changes in the hospital system.

Without major changes Holloman was hard-pressed to defend the system. For most patients the municipal hospitals are a last resort if they cannot go to a private physician or a voluntary hospital; chronically demoralized employees see little hope in resisting cuts, much less in altering their working situations or the care they provide. But at this late date Hollomon was powerless to address these issues—a precondition to building widespread, organized support among patients and workers—and without this support he was left, slowly sinking into the quicksand of the fiscal crisis. His strategy at this point became more akin to rearranging deck chairs on the Titanic than to steering clear of the iceberg.

**New Forces—Old Tactics**

The threat of default meanwhile undermined the remnants of the HHC's fiscal autonomy. Its enabling legislation had given the HHC some budgetary independence from the mayor, but this privilege was lost under the onslaught of the budget crunch. Before state and federal authorities would come to the rescue of the city, they insisted that management of all city budgets be vested in more "responsible hands." State legislation enacted in September, 1975 created one agency, the Emergency Financial Control Board (EFCB), which was given the authority to approve all city government budgets and contracts, including the HHC's. Beame and the city controller, Harrison Goldin, were given one vote each on the EFCB, compared to three votes for the financial community and two for the state. The financial community is represented on the EFCB by Albert Casey, chairman of American Airlines; David Margolis, chairman of Colt Industries; and William Ellinghaus, president of New York Telephone, a group hardly reflective of the city's population. Together with the governor and the state attorney general, Louis Lefkowitz, these men were given the right to "review, control and supervise the formal management of the city."

Elected city officials were forced to comply with this usurpation of their most important power out of fear of default. Bankruptcy, resulting in administration by a federal judge, would have reduced the city's elected officials to helpless onlookers or at best compliant flunkies. The EFCB gave the city's politicians nominal representation and the financial community a means of enacting its policies. Default then became a bludgeon used to gain acquiescence for the creation of the EFCB and implementation of its policies from politicians and unions.

The EFCB's mission was clear from the start: restore investor confidence in New York City; this translates into making sure politicians are not remiss in laying off workers or cutting services. **Barron's**, an influential financial weekly, commented, "Bankrupt or not, the city sooner or later must change its profligate ways....'Financial interests,' cries the Mayor, 'are using cash as a weapon in an attempt to direct the social and economic policies of our city.' It's about time."

Pressures on the HHC to close hospitals and reduce expenditures intensified throughout the fall of 1975. The city's Budget Bureau announced that it was withholding $2 million a month from the HHC until it brought its spend-

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**"There should be little doubt that the inaction of the Board in the face of the City government's repeated requests to reduce expenditures constitutes legal cause for removal."

memo to Dr. Lowell Bellin**

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ing into line with City Hall mandates. Dr. Bellin had a memorandum prepared outlining a means of dissolving the HHC Board of Directors and turning control over to the mayor on behalf of the EFCB. The memorandum stated, "Since the present leadership of the Corporation is unwilling or unable to plan and implement the needed changes, it seems clear that the city government can achieve them only by taking direct operational control of the Corporation....There should be little doubt that the inaction of the Board in the face of City's government's repeated requests to reduce expenditures constitutes legal cause for
removal.” The action outlined in the memo was never initiated, but the memo was anonymously mailed to HHC Board members. If the consequences of continued resistance to budget cutting were unclear before, whoever mailed the memo made them crystal clear now.

Intimidation was not the only lever applied to bring the HHC Board into line. In late summer, 1975, the State Department of Health certified a new Medicaid reimbursement rate of $215 an inpatient day for the HHC hospitals. There was one catch, however. Before the rate became effective it had to be approved by the State Budget Director. This ordinarily pro forma step new became a bludgeon. The state held the new rate hostage throughout the coming months of negotiations between the HHC and the EFCB.

Open Hospitals or Else

The HHC continued to resist the intensifying pressure to close institutions. Holloman offered “[budget cutting] alternatives involving every one of our hospitals. I’m not going to finger any one institution.” The City’s Comprehensive Health Planning Agency (CHPA) and Bellin, chairman of its Board, presented a plan for closing eight hospitals and drastically reducing ambulatory and long-term care. DC 37 also proposed a plan for budget-cutting. It was considerably more fanciful in terms of dollars saved than the CHPA’s.

The union assumed that Morrisania would be the only hospital dropped from the system. Its plan proposed enhancing third-party collections by penalizing doctors who did not fill out the required forms correctly. It is hard to believe that this was intended as a serious contribution to the debate. The more likely explanation is that the document was for the consumption of union members to convince them that the union was really watching out for their interests.

The most significant plan, the EFCB’s, was also the least public one. While Bellin, Holloman and the union were jockeying for position, the governor in his role as head of the EFCB appointed a special task force to produce a “fiscally sound plan” for the HHC. Chaired by Mathew Nimetz, a corporation lawyer and political friend of Governor Carey, this plan called for a 30 percent reduction in personnel and the closing of seven hospitals. No plan would be accepted by the EFCB unless it included the reduction of staff and the closing of hospitals. The governor continued to hold the new reimbursement rate hostage until the HHC complied with the state proposal.

Why the insistence on closing hospitals? Closing hospitals does save money, but not in great amounts. Even if the most expensive inpatient unit in the system, Gouverneur Hospital, were dismantled, for example, the net savings to the HHC would only total $7.49 million, about one-third of Gouverneur’s current operating budget. The reason is that Gouverneur would continue to service its ambulatory patients, while an estimated 40 percent of its inpatients would go to other HHC hospitals. Closing other hospitals would result in proportionately smaller savings. So why close hospitals?

From the point of view of the state and the EFCB, if a hospital remains open pressures to increase its expenditures remain great. Public hospital proponents might, for example, initiate a press campaign showing that EFCB-ordered understaffing caused the death of patients. This would be politically intolerable, and thus the state and the EFCB opted for a strategy of hospitals out of sight and patients out of mind, a policy successfully pretested by the state with its mental hospitals (see BULLETIN, July/August, 1975).

Most importantly, closing hospitals and clinics was seen as the best way to reduce long-term spending. The proponents of closings subscribed to the view, first articulated by Milton Roemer, that in health care, supply creates demand. Shutting down institutions and services was intended to reverse the equation: Remove services and thus reduce demand and concomitant expense.

Holloman knew full well that once a facility closes it is virtually impossible to retrieve. The experience of Delafield added weight to that conviction. Within a month after the doors were locked, other municipal hospitals had stripped its equipment, and its electrical and plumbing systems were out of
order. Delafield’s patients with Medicare or Medicaid coverage were transferred next door to Columbia-Presbyterian Hospital, as were about 3,500 of its outpatients. The rest had the choice of either traveling across town to Harlem Hospital or not using the municipal system for their health care.

EFCB Lays Down the Law

At the end of October, 1975, the EFCB stopped playing footsy with the HHC and ordered it to implement an $85 million reduction in operating expenses. The message was transmitted through Mayor Beame. The Board responded by voting to close Fordham Hospital—an item that had been on the budget-cutter’s agenda since Bellin’s Bronx report was released a year earlier. The Board also made a transparently political move calculated to create a public uproar. It voted to close five preventive services throughout the system: family planning, venereal disease, well-baby, dentistry and podiatry clinics. Finally the Board ordered a study to reassess the number of chronic-care beds. The Board’s actions hit precisely the two types of services private hospitals are not willing to provide—long-term and preventive ambulatory care.

The HHC’s decision to close the clinics drew a hue and cry, just as expected. The Health Department announced that its budget would not allow for any expansion of preventive services. The chief of the venereal disease section of the Public Health Association, Dr. Leonard Heimoff, announced that closing hospital clinics would produce “a medical crisis.” "If the present trends continue—and there is no reason to believe they won’t because of the financial crisis—anyone hit with venereal disease can start a chain reaction affecting many more.” Dentists interning in municipal hospitals brought suit against the HHC for violation of their training contract. The city budget director, Melvin Lechner, rejected the proposal to cut clinics. Lechner wrote, “A substantial portion of the cash savings projected by the Board is managerially difficult, if not impossible, to realize.” The decision to close the clinics on a citywide basis was rescinded.

The EFCB Gets Its Way

During the closing days of 1975 and the early days of 1976, the battle between the HHC and the EFCB went behind closed doors. At issue was the HHC’s refusal to close more hospitals and the state’s unwillingness to re-

Flighty Reason

One of the most widely propounded explanations for New York City’s fiscal crisis has been offered by Joel Harnett, president of the City Club (a major representative of the city’s business community). “The reason for the financial crisis in New York City,” Harnett said, “is that its underlying ideology is socialist and the rest of the nation is capitalist.”

Rather than redistributing income, Mr. Harnett contends that the “socialist ideology” of New York’s politicians has resulted in the flight of the white middle-income class from the city and the loss of its tax base. The remaining population of the city grew in its dependence on welfare and make-work jobs provided by the city. The latter category of workers is particularly objectionable to Mr. Harnett because he believes they are employed at relatively high union wages but are not very productive. According to this reasoning the city finds itself in trouble due to the decreasing tax base among the dwindling middle class and the increasing expenditures the government has to make for over priced labor.

If the causes of the fiscal crisis are traced to middle-income class flight, then it follows that the solution to New York’s woes would involve luring the middle class back into the city while reducing the city’s labor costs. The budget cuts, however, have made the city a less attractive place to live. They have resulted in reduced police protection, fewer sanitation pick-ups, less fire protection, overcrowded and deteriorating schools, and a greatly reduced public hospital system. While all these cuts have been made, the city has not changed its tax structure which relies heavily on the middle-income class and the poor to generate revenue through sales, income, and real estate taxes paid in large part by homeowners and renters. This regressive taxation policy together with the reduction in the city’s standard of living accelerates the flight of the middle-income class from the city rather than enticing them back.

It is the corporations and the banks not the middle class who have benefitted from the city’s fiscal policies. Big business and banks manipulated the tax system, paying less and less of the city’s expenses, while making a
Harnett's explanation does not hold water, then what does the financial community have in mind for the city?

Felix Rohatyn, often called the Kissinger of New York finance, chairman of the Municipal Assistance Corporation and chief advisor to Governor Carey, has put forward the predominant program of reconstruction: give tax breaks to business so they will invest in New York City, blacktop large areas of the ghetto communities to create industrial parks, reduce city labor costs and restrict services. This program of stimulating private investment and consequently private employment at lower wages (compared with higher paid public jobs) bespeaks an attempt to populate the city with lower middle-income workers. With the city forced to make substantial debt payments over the next 25 years, with a regressive taxation structure in place to pay for that debt, and with reduced services, the middle-income class in New York (both white and black) will be kept to a minimum.

Rohatyn said in a New York Times article on February 2, 1976, "New York City is entering a state of siege in a war of survival for its life and soul." The thrust of this war has been directed at middle-income workers as well as against the poor and working poor. The effects of the budget cuts thus far have been to make the city a more efficient mechanism for paying its debts, but a less efficient one for serving its people. If anyone should doubt that this attack on the city's working population will continue, little comfort will be found in Rohatyn's summary of the city's efforts to fend off default, "We have won a battle, the war goes on."
pitals (Delafield is already closed), opening three new hospitals at less than capacity, initiating private and group practices inside the hospitals, extracting increased fees from patients without third-party coverage and cutting ambulatory and inpatient services which lose money. In sum, the HHC plans to meet its budget targets by generating new revenues through higher reimbursement rates and increased patient self-payment, and reducing expenditures by closing hospitals and reducing services.

The impact of this year’s cumulative cuts on the hospitals is difficult to access. But already there has been dislocation of some services and increased inconvenience to most patients.

**The Reductions**

HHC employees fell by at least ten percent during 1975 and 1976. These reductions cut right into the heart of union membership and political patronage—the less skilled titles which suffered a disproportionate share of the cuts. Thus although housekeeping, dietary and clerical/administrative workers comprised 45.5 percent of the total workforce at the start of 1975, they absorbed 60.5 percent of the cuts during the year. Cut least were the nursing staff, reduced by seven percent; the greatest number of cuts were among aides and the fewest among RN’s. Technicians were cut by eight percent and management by nine percent. Meanwhile the number of doctors on HHC payroll rose by six percent.

Entire wards in some hospitals have been shut down; in others, beds cannot be used because of the lack of nurses; services and personnel have been reduced at all hospitals. At Lincoln Hospital before the cuts, for example, a typical medical ward with 28 patients was staffed by one RN, one or two LPN’s and one aide on an average shift. During 1975, at least one aide from each ward was laid off. Coverage on some shifts has fallen by 25 percent. Other effects of layoffs and attrition at Lincoln include long delays in messenger services; lab services so curtailed that on weekends blood chemistries and urinalyses can be done only with the special approval of a chief resident; absence of respiratory therapists on weekends; X-rays unavailable after 11 pm because of lack of clerical staff in the department; and reduction of the already inadequate medical records department to near paralysis by the firing of six clerical workers.

The story is the same at other city hospitals. Harlem Hospital patients now wait two hours instead of 45 minutes to have prescriptions filled. At Kings County, X-ray services in the emergency room have been eliminated on weekends. Coney Island Hospital in Brooklyn has mothballed three of seven operating rooms and cancelled all elective surgery. The list goes on and on. Every hospital reports long delays for appointments, insufficient services in the emergency rooms and inadequate coverage for inpatients.

**Coney Island Hospital in Brooklyn has mothballed 3 of 7 operating rooms and cancelled all elective surgery.**

**No Plan—No Defense**

The Holloman administration has continued for the past two years to act as if New York City’s fiscal crisis were not real, but merely a pretext for a full-scale assault on the municipal hospital system. Thus it never produced a plan for a rational appropriation of cutbacks. Therefore important aspects of care deteriorated even further, leaving the HHC even more vulnerable to budget cutting.

The only way the HHC might have withstood some of the devastation of the budget cutters was by arming itself with the active support of the more than one million New Yorkers who are entirely dependent on the public hospitals for their care and the hospital workers. But to create such a movement the Holloman administration would have had to begin reorganizing to provide the patients with the promise of good and appropriate care and the workers with an environment worth fighting for. It did not even try. Instead the Holloman administration fought the closing of hospitals and defended the present model of care.

What is the present model of care? It is, for all intents and purposes, a poor attempt to reproduce the voluntary hospital model—a model based on delivery of high-technology inpatient care, teaching of medical students
There are, of course, many compelling reasons why the voluntary hospital model dominates municipal hospitals. Third-party reimbursement formulas create incentives for it, and the professional staffs organized by the voluntary hospital and medical school affiliates abet it. Most important, however, clinical medicine as it is practiced in the voluntary hospital has become the central organizing concept of American medicine. But the municipal hospitals are poor imitators and because of their structural limitations, they are open to repeated assertions that the voluntaries can do the job better.

The voluntary hospital model works best for private patients who use hospitals only for acute, inpatient care—patients whose primary medical needs are met elsewhere. In New York City, when voluntary hospitals attempt to provide ambulatory services to low-income and Medicaid patients, their appearance of superiority over municipal hospitals evaporates. The outpatient departments (OPDs) of voluntary hospitals are just as wretched as municipal OPDs; municipal hospital emergency rooms are considered far superior. Hospitals as presently organized are simply not designed to deliver primary care. Most of the patients of municipal hospitals, however, come for primary care. Thus the prevailing hospital model does not satisfy the needs of the bulk of municipal hospital patients. As second-class imitators of the voluntary hospital model, the municipal system produces dissatisfied patients and disgruntled workers.

The HHC’s manner of handling cutbacks further exacerbated the dissonance between patient needs and what municipal hospitals were providing. Cutbacks were made on an institution-by-institution basis. Executive directors made deals with department chairmen, worker groups and house-staff organizations which would bring the least flack. When they met resistance in one department, they simply applied the cutbacks to another. At Kings County Hospital, for example, mortuary workers stopped doing autopsies when they were informed that their ranks would be pared by 50 percent. Three days and 40 bodies later, the layoff order was rescinded. Since Kings County still had to meet its layoff quota, people from other departments had to be fired instead.

The line-of-least-resistance tack pertained systemwide. RN’s at Bellevue, Jacobi and Elmhurst conducted a sick-out in early October and as a result, RN’s were excluded from the attrition policy. When the dental interns protested the closing of the dental clinics and brought suit against the HHC, the HHC worked out an agreement to satisfy them. New York University Medical Center, the affiliate of Bellevue Hospital, protested that the reduction in its affiliation contract was disproportionately heavy; most of their money was restored. While some of these restorations benefitted patient care, the actions focused understandably on the retention of jobs, not on good patient care. The budget-cutting process simply reinforced the status quo and with it the most firmly entrenched advocates of high-technology, high-cost, labor-intensive medical care.

The impact of the present fiscal crisis will further obliterate distinctions between the care delivered in municipal hospitals and in voluntary hospitals. This will further erode
the city's ability to deliver primary care to the poor and the working poor—the municipal hospitals' traditional constituency—and preventive care to the whole population.

**Planned Obsolescence**

The three-year plan for the HHC will be a major vehicle for voluntarization of the municipal hospitals. The shrinkage of the system around revenue-producing activities, the introduction of private practice, the reduction of primary and preventive health functions and the enforcement of fee collection from patients not covered by third parties all point in this direction.

Indicative of the HHC's direction is the new collections policy—the increasingly relentless pursuit of dollars from patients not eligible for third-party coverage. The availability of care to all people regardless of ability to pay, more than anything else, has distinguished public from private hospitals. Care at public institutions, of course, isn't free. In fact, the people who pay for the system through their taxes are the very same people the HHC has decided to pursue for their fees. Justifications for hiring a collection agency and initiating court action against recalcitrant patients are argued by Joseph Giglio, the HHC First Vice-President for Finance:

- "Our image of efficiency, as perceived by third parties and governmental bodies, will be enhanced."
- "The community will come to realize that it has an obligation to assist us in the maintenance of our work and, hopefully, thereby engender a closer feeling of cooperation and interdependency."

The HHC does not expect to make up much of its deficit through the new collections policy. The HHC staff estimate an increased yearly return of only about $3 million. As Giglio stated, the primary reasons for this policy change are political.

Private practice, on the other hand, is expected to yield significant new revenues. Dr. Edmund O. Rothschild, Senior Vice-President for Quality Assurance of the HHC, in a draft paper advocates private practice because it would result in "increased utilization... and the resultant increased revenue." Dr. Rothschild is sanguine about the fate of the municipal patients who do not have private doctors. "To the extent that this situation has been resolved in voluntary hospitals, it can be easily resolved in HHC facilities." Anyone familiar with the two-class care given by voluntary hospitals, as Dr. Rothschild should be, would not be quite so cavalier about the difficulties.

Few oppose the private-practice plan. Dr. Holloman thinks that private patients might provide financial salvation for the public system. The HHC could increase its collections from third parties and "with an extra $350 million a year we could make this the equal of any hospital or hospital system in the nation," he asserted. The idea is also popular with many segments of the medical community. One-third of the physicians in private practice in New York City have no hospital admitting privileges, and for them the advantages are obvious. For those voluntary teaching hospitals like Bellevue's affiliate, New York University Hospital, that have very high occupancy rates and increasingly selective admissions, the prospect of using several brand-new city hospitals for their patients allows them to expand without incurring any capital expenses.

The executive director of Bellevue, Bernard Weinstein, is in full accord with the private practice plan. Weinstein worries about the viability of a system which, because it serves the city's poor, has a weak claim on the city's resources. Weinstein's remedy is to open municipal hospital doors to private patients, thus expanding the political base and transforming the system into something "middle class people will want and will fight for." Unless this happens, Weinstein asserts, public hospitals are doomed. "I think," he said recently, "times are going to get tougher, not easier, and those public institutions that depend on local and state money will be in serious trouble. Those [hospitals] that don't learn from the voluntaries how to survive will die."

Voluntary Hospitals Tread Water

The impact of the fiscal crisis has clearly affected voluntary hospitals less than munici-
pal hospitals, yet they too are on the defensive. On February 4, 1976, New York State Governor Hugh Carey announced that state financing for the unlimited expansion of health care was a thing of the past. Carey proposed a $320-million reduction in state Medicaid expenditures for fiscal 1976 in a plan that would concentrate remaining resources in large hospitals. Major parts of the plan include:

- A freeze on hospital reimbursement rates;
- A freeze on nursing-home reimbursement rates;
- A 10 percent cut in the 1975 clinic reimbursement rates;
- Elimination of chiropractor, podiatrist and dental services for adults;
- Elimination of all non-institutionally based therapists and radiologists;
- Elimination of over-the-counter drug coverage;
- Requirement of a second opinion on all elective surgery;
- A 20-day limit on inpatient care unless the case is certified as exceptional;
- A maximum of one day preoperative hospital stay;
- Elimination of certain categories of elective surgery (i.e., cosmetic surgery).

Carey's fiscal experts think some of these proposals may be thrown out by the courts, but they expect that in the meantime the freeze may force marginal institutions to go under.

The voluntary sector, represented by the Health and Hospitals Planning Council of Southern New York (HHPC), responded to Carey's call for cutbacks with a retrenchment plan of its own. In a preliminary report of its Task Force on Health Services and the Fiscal Crisis, the HHPC acknowledged that "government revenues are simply not adequate to continue funding programs at past levels." Thus "the financial situation has made it necessary to identify and eliminate unnecessary institutions and programs to help preserve the viability of all essential services." To this end the HHPC recommended closing 27 general-care hospitals in New York City and 400 beds in other institutions. By happy coincidence, the HHPC recommendations for public hospitals corresponded exactly to those of the EFCB. The HHPC did, however, throw some of its weak sisters to the wolves—mostly proprietary institutions and a few small voluntary hospitals. The only large hospital the HHPC took on was French-Polyclinic Hospital, which has already formally gone into bankruptcy.

HHPC's reasoning makes little financial sense: The average Blue Cross and Medicaid reimbursement rate is less than $110 a day at the hospitals they want closed. Costs in most of the hospitals they want kept "financially viable" exceed $150 a day. Clearly financial considerations are not the sole motivation. Since the total amount is going to be cut the HHPC is trying to concentrate what is left on its most important members—the large voluntary hospitals.

Voluntary hospital executives (quoted in Hospitals, the official journal of the American Hospital Association) make the HHPC's reasoning explicit. "A silver lining to New York's fiscal woes, some hospital officials suggest, is the opportunity it provides for a reorganization of the entire hospital system..."

Hospitals
January 16, 1976
organized around high-technology, labor-intensive, acute inpatient care. (Technology in the unique case of health care generally increases labor costs rather than reducing them.) Voluntary hospitals are inherently expensive.

The voluntarization of the municipal hospitals is thus happening at the very moment that the viability of the voluntary model is beginning to be questioned. The needs and interests of voluntary hospitals for more and more resources are on a collision course with those of the government, which is increasingly paying for health care. The process of monopolization, accelerated by the fiscal crisis, means that if the lid is kept on public expenditures, health services will be available to fewer and fewer people as the unit costs of care increase. There is no reason to think that the voluntary system, or, unfortunately, the public system is about to embark on a course of fundamentally altering the type of care delivered. And with fewer people able to get the services they need, the political pressures on the government to take its pound of flesh from the hospital system will increase.

Faced with the prospect of more costly medicine for fewer people, it is quite possible that the government in its role as financier and legitimizer of the system will have to develop a different vehicle to provide some semblance of health services to the bulk of the population. While the future organization of health care is uncertain, it is clear that the hospital sector will increasingly be on the defensive. The main antagonist is likely to be some form of low cost, ambulatory care. Governor Carey in his 1976 State of the Health Message, for instance, suggests that “Out of the pain of the current fiscal crisis has emerged the opportunity to change the direction of our inadequate system of providing health and mental health care. We must use this opportunity to make these systems less costly, more rational, more effective—more humane.” Toward this end Carey proposes:

- Emphasis on preventive health care;
- Deinstitutionalization of our system of care;
- Better utilization of existing resources;
- A more ethical and equitable health care system.

This new direction in the health system, reflected in Carey’s proposals, could have negative, as well as positive, consequences.

Preventive health care could be either a new modality for addressing fundamental health problems or, in a climate of fiscal austerity, it could be merely an excuse for retreating from the provision of health care. John Knowles, president of the Rockefeller Foundation, hints at the latter prospect: “The individual must realize that a perpetuation of the present system of high-cost, after-the-fact medicine will only result in higher costs and more frustration. The next major advance in the health of the American people will result only from what the individual is willing to do for himself.” (Wall Street Journal, March 22, 1976.)

Deinstitutionalization allows for the possibility of low-cost, accessible care, but it could also be simply an entry point to screen patients for high technology inpatient care. Better utilization in the Carey platform could mean more equitable distribution of health services or could be a veiled attack on proliferating high-cost care, resulting in decreasing availability to people in need.

Deinstitutionalization holds within it the possibility of a low-cost, worker-community controlled decentralized system delivering preventive and comprehensive care. It could offer the possibility of addressing some health needs the present health care delivery system avoids—e.g., hypertension, cancer and other environmentally related diseases. On the other hand, the entire Carey program could add up to little more than the alibi for a massive assault on government-financed health services (see BULLETIN, July/August, 1975).

The current fiscal crisis highlights the contradiction between high unit costs and public

“The individual must realize that a perpetuation of the present system of high-cost, after-the-fact medicine will only result in higher costs and more frustration.”

John Knowles
financing. It has created a unique moment for the advocates of a public system. They could, with a vengeance, seize upon the movement away from the voluntary model and become important actors in the process of reshaping the health system. Unfortunately the defenders of New York City’s public hospitals have missed the boat. By steering the city-run institutions in the wake of the voluntary hospitals, they are reproducing, in a politically weaker form, the very contradiction which is wreaking havoc with the rest of the health system. Rather than cresting with the tides of history and fundamentally altering the character of care, New York City’s public hospitals have set upon a course which guarantees them irrelevance, if not annihilation.

—Barbara Caress and Steven London

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CUTBACKS IN SHEEP'S CLOTHING

Question: When is federal catastrophic health insurance for the elderly not a gain? Answer: When it masks a drastic cutback in existing Medicare benefits. Thus President Ford has proposed, in his fiscal 1977 budget message to Congress, that Medicare pay all healthcare costs over $500 a year, while requiring elderly patients to pay 10 percent of all hospital costs up to that amount (over and above the $107 patients themselves are now required to pay for the first day of care). This measure would aid less than one-half of one percent of all Medicare recipients. But it would save an estimated $1.4 billion in 1977—straight out of the pockets of the elderly. So unpopular is the measure that the President is having trouble finding Congressional sponsors.

Other major health proposals in the budget message included a limit of 7 percent on increases in Medicare reimbursements to hospitals and the amalgamation of 16 different federal health programs, including Medicaid and health planning, into block grants to be given to states.

HEW: SEE NO FLEECE

Why have blatant Medicare and Medicaid abuses such as those cited above run rampant? One reason may be that HEW, which has never hesitated to blame recipients for abuses, has been notably less zealous about pursuing the issue with providers. Until January of this year the entire $14.5 billion Medicaid program had only one half-time investigator and a single study committee looking into the problem of fraud, while the whole Department of Health, Education and Welfare had only 18 fraud investigators. Responding to the lab scandal, Dr. M. Keith Weikel, HEW's Medicaid Commissioner, said he had found "a reluctance in the department to look at fraud—which I believe to be more prevalent among providers of care than recipients—because it might reflect badly on the program.” The fiscal 1976 budget, recently approved, will beef up the Medicaid investigations staff to 120; HEW has just set up an investigations office, which will be staffed with 74 persons.

NEW YORK TIMES, FEBRUARY 19, 1976; MEDICAL ECONOMICS, NOVEMBER 24, 1975.

FLEECING MEDICARE AND MEDICAID

One of every five dollars paid by Medicare and Medicaid to clinical laboratories is either fraudulent or unnecessary, an investigation by the Senate Committee on the Aging estimates. This amounts to $45 million of the $213 the two programs pay for laboratory services each year. "This figure is deliberately conservative and a reasonable case can be made that 50 percent of current payments are inappropriate," the report adds. The investigation, which focussed on several large states, found:

- Small numbers of labs controlled the vast majority of Medicare and Medicaid business.
- Kickbacks to doctors averaged 30 percent of fees received by the labs.
- Schedules of fees paid to labs have not been updated to take account of the growth of automated testing, and labs.
are still being reimbursed on the basis of manual testing. Thus many labs are paid $15 for tests that now cost $0.25. This has given rise to an industry of small "labs" that do little more than pass tests on to automated labs, paying their fee, collecting the manual fee from the government and reaping windfall profits in the process.

- Atrocious practices were common, particularly in some small labs. One lab, for example, tested many different urine samples with a single dipstick.
- Many small labs had no adequate procedure for disposing of tested samples, but simply poured them down the drain or put them in the trash.

"Any medical testing laboratory which is so inclined can bill Medicaid for a patient a doctor has never seen, for blood never drawn, for tests never performed, at a rate exceeding four times cost and twice the prevailing charge for private paying patients with a nearly absolute assurance that they will not be caught and prosecuted," the Committee staff said in summary.

(New York Times and New York Post, February 16, 1976.)

MEDICARE FLEECES ITSELF

Due to a loophole in the law, Medicare needlessly spends millions of dollars each year for the rental rather than the purchase of medical equipment for the sick and disabled elderly, audits in New York and New Jersey recently revealed. For example:

- A wheelchair that cost $168 to purchase was rented for 72 months at a total cost of $1,080.
- A hospital bed that cost $283 was rented for 22 months at a cost of $1,654.

Medicare pays 80 percent of the cost of medical equipment, which beneficiaries may either rent or purchase. If they purchase equipment, however, they must pay the full cost themselves and then wait to be reimbursed in installments by Medicare. This is impossible for many elderly poor and strongly encourages the rental of equipment. How much is wasted each year by this loophole is impossible to estimate, but it ranges in the "millions and millions of dollars every year," officials state.

(New York Times, February 2, 1976.)

TAKING THE NATION'S TEMPERATURE

Health, United States, 1975, the first in an annual series of reports on health and health care in the nation, has just been issued by HEW. Among its findings:

- The poor still spend a disproportionate share of their income for health care. Families with incomes under $2,000 spent 12.6 percent of their income on health care in 1970, compared to families with incomes of at least $7,500, who spent only 3.5 percent of their income on health care.
- Utilization of health services by the poor has increased since Medicare and Medicaid took effect in 1966. In 1964 28 percent of the poor had not seen a physician in two years, a figure that had dropped to 17 percent by 1974.
- Regarding health status, the report finds mortality down, communicable disease deaths down, chronic disease deaths up and deaths from car accidents, murder and suicide up.

The 600-page report, which examines health costs, financing, resources, status and utilization, was mandated by Congress and conducted by HEW. Apparently it will not be available for broad distribution.


MEDICAL SCHOOL SCOREBOARD

Enrollment up: Medical-school enrollment was up 3,188 during the 1974-75 school year over the previous year, totaling more than 54,000 medical students in 114 US medical schools, according to the AMA annual report on medical education (printed in the Journal of the American Medical Association, December 29, 1975). Although no new schools were opened last year, 27 have become operational in the last 10 years and 11 more are in the planning stage.

Cost up: Medical-school tuition is increasing dramatically, due not only to the increasing cost of medical education, but also to the phasing out of federal capitation grants, which had previously provided $1,500 per year per student. Medical schools are projecting tuition increases ranging from 35 to 159 percent over the next three years, according to American Association of Medical Colleges estimates. Tuition now averages $3,660 a year in private schools and $1,195 in public schools. Without capitation grants, these are expected to rise to $6,300 and $3,100, respectively, by the fall of this year.

Class background up: With medical-school tuition skyrocketing, medical students are increasingly coming from wealthier families. Median family income of the 1975 entering class rose 9 percent over
that of current senior medical students (from $19,553 to $21,333). Seventy percent of seniors will graduate with debts exceeding $9,000.

Women up: Last year 3,260 women entered medical school, a 360 percent increase over the number entering four years ago. Of the 1975 graduates 13.4 percent were women, the highest number and proportion in history. Pediatrics was the most popular specialty among women, attracting almost 25 percent of women residents.

Minorities down: Minority students entering medical school decreased, reversing a previous trend. In 1975, 1,391 minority students entered the first year of medical school, down from 1,473 in 1974. The AMA blames the decline on decreased federal and private financial aid.

Primary care up: Of doctors graduating in 1974, 58 percent entered advanced training in primary care specialties (family practice, obstetrics and gynecology, pediatrics and internal medicine), compared with 38 percent in 1968. While the AMA declared this a “quiet revolution,” more detached observers say subspecialization trends within these fields continue as strongly as ever. (Washington Report on Medicine and Health, January 5, 1976; Medical World News, January 26 and February 23, 1976; Hospitals, February 1, 1976.)

REGULATING THE HAND THAT FEEDS YOU

Over 150 officials of the Food and Drug Administration (FDA) own stock in companies the agency regulates and are thus violating conflict-of-interest rules, reports a recent General Accounting Office (GAO) study. An additional 203 employees failed to file financial disclosure statements as required by the agency. The FDA had previously found 61 employees to have a conflict of interest but failed to follow up an order it issued to get rid of their holdings. The GAO is planning 40 such studies of conflicts of interest in federal agencies.

(Busting the Doctor Trust)

BUSTING THE DOCTOR TRUST

First the Federal Trade Commission (FTC) challenged the AMA ethical code forbidding advertising by doctors, claiming that it restricts competition and violates antitrust laws. Just as preliminary hearings were getting underway on this issue in February, the FTC then announced that it was investigating physician control of Blue Shield Plans. Rumor, reinforced by FTC announcements, has it that the agency is testing the usefulness of antitrust laws in cutting the rising cost of health care. Its actions follow a recent Supreme Court ruling that the American Bar Association’s ban on advertising and use of fee schedules by lawyers violates antitrust laws. (Washington Report on Medicine and Health, March 1, 1976.)

MORE ON ANTITRUST

A San Francisco physician, Dr. Stanford Acherman, has just won a lengthy lawsuit in which he charged that the San Francisco Medical Society ostracized him and attempted to ruin his practice because of his outspoken support of Medicare 13 years ago, while organized medicine still bitterly opposed the legislation. Dr. Acherman was dropped from the staff of four hospitals and his malpractice insurance was cancelled, even though there had never been a claim against him. Dr. Acherman won $60,000 in damages and his hospital privileges were restored. (Committee on Public Health and Safety, Newsletter #7.)

EVERYTHING THAT’S FIT TO SELL ADS

Pharmaceutical companies have cancelled 200 pages of advertising worth $500,000 in Modern Medicine, a magazine owned by the New York Times Company, in response to a five-part series on medical incompetence and malpractice published in the New York Times in January, the newspaper reports. In an attempt to disassociate itself from the Times, Modern Medicine has subsequently advertised in the Times, criticizing the series. (American Medical News, February 16, 1976.)

INHUMAN EXPERIMENTATION

Prisoners in Washington and Oregon had X-rays beamed into their testicles in Atomic Energy Commission experiments in the 1960’s on the effects of radiation on fertility, it was recently revealed. Prisoners whom experimenters deemed likely to father deformed children as a result of the experiments were later given vasectomies. The federal government cites evidence that the radiation caused cancer or any permanent disability, although followup examinations are not being conducted. The reason? The federal government cites reluctance by state authorities and prisoners, many of whom have since been discharged. Many prisoners temporarily became
sterile. Although all later regained their fertility, many still complain of physical and psychological side effects. The prisoners formally consented to the experiment, although the possibility of voluntary consent in a coercive environment such as prison has come into question.

(New York Times, February 29, 1976.)

DOCTORS FLEE CHICAGO

A recent study found Chicago to be the only large city with fewer private physicians today than 15 years ago. With a physician-population ratio of 0.98 physicians per 1,000 persons, Chicago falls one-fourth below the national average for large metropolitan areas of 1.31 per 1,000. Between 1970 and 1974 the city lost nearly 1,000 doctors, many to the suburbs. “Virtually all the physicians who were practicing in two ghetto zones in 1960 have moved out since,” says Pierre de Vise, University of Illinois urbananologist and author of the study. Foreign medical graduates now comprise three-quarters of all physicians in the city.

(Hospitals, January 16, 1976.)

TURNING OFF THE PVC ALARM

Workers are striking the Goodyear plant in Niagara Falls, New York, protesting dangerous working conditions due to leaking polyvinyl chloride gas (PVC). Until recently an alarm warning workers of dangerous PVC levels in the plant went off regularly 10 to 15 times a day. Each time, production would come to a halt as troubleshooters searched for leaky valves and other mechanical failures. Then, mysteriously, the alarm system was turned off.

The workers, members of Local 8-277 of the Oil, Chemical and Atomic Workers Union (OCAW), are asking support from the local community. A major point of concern is a recent Ohio study which found that babies born in communities near PVC plants suffer birth defects at a rate nearly twice the national average. Recently Dr. Irving Selikoff of Mt. Sinai Medical Center in New York City uncovered a number of deaths attributable to PVC among workers at the Niagara Falls plant.

BREATHING MAY BE HAZARDOUS TO YOUR HEALTH

Still wonder about the effects of air pollution? A New York doctor testing police officers just finishing patrol-car duty found:

- 10 percent of the officers had abnormally high levels of lead in their blood.
- 25 percent had high or abnormal concentrations of carbon monoxide in their blood.
- 25 percent had abnormal cardiograms.

Announcements

The United Farm Workers (AFL-CIO) are seeking doctors, nurses, technicians and other medical personnel to work in clinics it maintains in California and Florida. The clinics, financed through the union’s contract and run by the union, are part of a UFW program to address the quality of migrant farm worker life above and beyond wages and working conditions. They will stress preventive care, health education and the training of community health care teams, in addition to providing medical care. Interested persons should contact UFW National Office, Box 62, Keene, California 93531 or UFW New York Office, 331 West 84th Street, New York, N.Y. 10024, or call (212) 799-5800.

Friendship seeks support for reconstruction aid to Vietnam. Key projects requested by the Vietnamese for which Friendship is presently raising funds include a massive venereal disease detection and treatment program and provision of large quantities of steel tubing from which the Vietnamese will manufacture wheelchairs and school desks. Friendship also seeks to educate the American public on the impact of the war and the nature of US-Vietnamese relations; it has literature, films and speakers available. Interested persons should contact Friendship, 235 E. 49th Street, New York, N.Y. 10017, or call (212) 486-0580.

Urban Planning Aid (UPA) of Boston is in danger of losing its funding from the Community Services Administration (formerly OEO). Massachusetts landlords, incensed by UPA’s role in tenant organizing, have conducted a concerted campaign to have it defunded. UPA has existed since 1969 and provides technical assistance on issues such as housing, unemployment, job safety rights, community media, mass transit, welfare and prison reform and public and private housing. UPA asks its supporters to contact their congressional representatives, especially any who may serve on the Senate and House Subcommittees on Labor, Health, Education or Welfare. For more information contact UPA, 639 Massachusetts Avenue, Cambridge, Mass. 02139, or call (617) 661-3220.

The Black Lung Health Center in Jacksboro, Tenn. is seeking a new administrator. The Center consists of a primary care clinic and an outpatient respiratory care program, and is looking for an administrator who is interested in developing a rural health care program. Interested persons should contact the Black Lung Health Center, Box 466, Jacksboro, Tenn. 37757, or call (615) 582-9483.

The Critical List is a new monthly magazine presenting a critical perspective on Canadian health care. It presents muckraking, analysis, information and education on social and political issues in health care, the health industry and the medical profession, as well as on issues of personal and preventive care. Subscriptions are $8.00 for 12 issues, and may be mailed to Critical List, 32 Sullivan Street, Toronto, Canada M5T 1B9.

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