BEYOND SICK

New York City's Hospital Crisis

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Since its inception in 1968, the Health Policy Advisory Center—known as Health/PAC—has served as a unique progressive voice for changing consciousness on domestic and international health priorities. Through the Health/PAC Bulletin and the books Prognosis Negative and The American Health Empire, and in its outreach to a national network of grassroots activist groups, Health/PAC continues to challenge a "medical-industrial complex" which has yet to provide decent, affordable care.

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Sick Hospitals, Sick City

In New York City, where this journal is edited just a half-block from City Hall, an array of social and health epidemics are combining to drain both life and hope from record numbers of New Yorkers. Reagan’s legacies, along with the policies of Governor Mario Cuomo and Mayor Ed Koch have all contributed to the growing anguish. The poor have become sicker and more destitute as they confront life in decimated neighborhoods and in an increasingly intolerant city.

Faced with large budget deficits, the erosion of support for social programs from federal, state, and local governments, and the epidemic incidence of AIDS, substance abuse, homelessness, and violence, New York City’s health care system appears to be heading toward collapse. A costly system developed around high technology, episodic, acute-care medicine is more and more being called upon to service ever-growing numbers of the chronically ill, the forever poor, and the permanently dispossessed.

New York City’s public health services have always been in crisis. But unique to the current calamity is that the unprecedented emergency room “gridlock” and hospital “bedlock” is affecting private and public hospitals alike. Being well-off, well-insured, or well-located is no longer a guarantee of access to a hospital bed in New York City. Make no mistake about it, this trend has the corporate elite of this city worried. As New York Times columnist A. M. Rosenthal recently wrote, “The hospital problem is trickling up.”

The lead articles on New York City’s crisis in this issue grew out of a series of discussions held in a recent Health/PAC workgroup. During these talks, we raised a number of important questions about the origins of the current problems, including to what extent they are unique to New York, and which kinds of short- and long-term solutions seem possible. It quickly became obvious that what first passes as a single, well-defined crisis is, in fact, several crises of great magnitude and complexity. Perhaps this explains the lack of response from the city’s traditional health advocates to the most serious threat to health care access and quality in over 30 years.

Confronted with the enormity of the crisis, many of us have found it difficult to assign responsibility and develop local strategies for change. In the face of this difficulty, Barbara Caress, a consultant for Local 1199, the city’s largest health care union, suggests in her article some immediate, practical strategies to help bring relief.

What motivates us to broaden and expand this discussion is the belief that change is born of crisis. We fear that in the absence of progressive advocacy for humane and equitable solutions, it is likely that the responses to these problems will be shaped by the corporate rich and the politically powerful, in alliance with the medical empires. As Ronda Kotelchuck notes, it is not inconceivable that their solution might take the form of a separate system for the wealthy and well-insured, operated by the city’s medical empires, that excludes the poor and uninsured.

As more and more hospital beds are filled with the homeless, people with AIDS, substance abusers, and the mentally ill, we sense a dangerous and growing pressure to isolate such patients in their “own” hospitals—to create separate systems of care. We know all too well that separate systems are never equitable. Such a move is likely to cause irreparable harm to the most vulnerable among us, which, as New York City’s health care crisis has demonstrated, will erode the health of all of us.

—Joe Gordon, Executive Editor
—Arthur Levin, President, Board of Editors

Child waits at Brooklyn’s Kings County Hospital.

Summer 1989
Health/PAC Bulletin
NEW YORK CITY'S HOSPITAL AND HEALTH CARE CRISIS

Down and Out in the "New Calcutta"

New York City's Health Care Crisis

RONDA KOTELCHUCK

New York City's health care system has been characterized by its observers as "organized chaos," "in critical condition," and "on the verge of collapse." Whatever the description, it is painfully clear that hospitals in New York City are facing a crisis unprecedented in their history and unparalleled anywhere else in the country. Having developed entirely unforeseen by health care planners and officials, the crisis has come to the boiling point and has thrust itself into public awareness. Perhaps most significant, it has engulfed not just the public sector, in which crisis is the expected order of the day, but, to varying extents, all of New York City's hospitals.

The Symptoms

New York City's health care system has been characterized by its observers as "organized chaos," "in critical condition," and "on the verge of collapse." Whatever the description, it is painfully clear that hospitals in New York City are facing a crisis unprecedented in their history and unparalleled anywhere else in the country. Having developed entirely unforeseen by health care planners and officials, the crisis has come to the boiling point and has thrust itself into public awareness. Perhaps most significant, it has engulfed not just the public sector, in which crisis is the expected order of the day, but, to varying extents, all of New York City's hospitals.

The most visible symptom of New York City's ailing health care system—hospitals so overcrowded that the city's sick cannot count on receiving treatment there—is but the manifestation of a series of more fundamental social and administrative crises, none of which will be quickly or easily resolved. Any one of these problems alone might have been viewed as a full-scale crisis in the past. Converging all at once, however, they have left New York City's health community stunned and reeling, unable to distinguish cause from effect or to identify the sources of responsibility and the potential points of intervention. This, then, is an attempt to sort out the various underlying crises and trace their interactions in order to understand which are more fundamental and more resolvable, by whom, and how.

The Symptoms

The most obvious manifestation of New York City's health care crisis is the overcrowding of New York City's hospitals, which is centered primarily in three services: medicine/surgery (the largest, encompassing 75 percent of all hospital beds); obstetric, newborn, and neonatal units; and psychiatry. Although each service is affected by its own peculiar problems, underneath lies a common set of dynamics.

Hospital occupancy rates have traditionally been higher in New York than other cities, hovering just above 80 percent. When they dipped lower, the state, in an attempt to reduce what were viewed as unnecessary beds, imposed penalties, in the form of lower Medicaid and Blue Cross reimbursement rates, virtually forcing hospitals to raise occupancy rates by shutting down beds. Beginning in 1986, however, occupancy began to climb, peaking in the last quarter of 1987 and the first quarter of 1988. It has since stabilized slightly below 95 percent.

A one-day survey, conducted on January 10, 1989, found occupancy in the city's medical/surgical units overall to be 95.4 percent. At the city's 11 public acute-care hospitals, run by the New York City Health and Hospitals Corporation (HHC), it was only one point higher: 96.3 percent. Fully a quarter to a third of the city's medical/surgical units had occupancy rates of over 100 percent.

This same survey found 600 patients backed up in the city's emergency rooms waiting for admission. Cheek to jowl, sleeping on gurneys lining the halls, many patients wait days before they can be admitted. So routine have emergency room backups become that many hospitals have set up regular meal service in the emergency room. And neither money nor social class can be counted on to purchase a nonstop ticket to an inpatient bed, as a group of the city's business elite recently observed as they recounted their own difficulties in getting friends and family members into hospitals.

On a nightly basis, as beds fill up, hospital after hospital closes its doors to ambulance patients, who are then diverted elsewhere. When at last all hospitals are "on diversion," ambulances begin delivering their patients regardless of available beds. Voluntary hospital admissions through the emergency room have increased 16 percent over the last two years. While some have identified this as a crisis of emergency room overcrowding, the problem does not begin there. The problem stems from overcrowded inpatient units.

While it is commonly assumed that overcrowding in hospitals is a result of a flood of new patients, this is not the case. New York City hospitals are actually treating fewer inpatients than ever before. Between 1985 and 1987, the number of patients discharged actually fell by 3 percent. Hospitals are overcrowded because patients, particularly poor ones, are staying longer, causing a form of hospital gridlock. The average length of stay in the

Ronda Kotelchuck is a long-standing member of the Health/PAC board and works for New York City's Health and Hospitals Corporation.
The primary target of the epidemic is shifting from gay men, the population mainly affected in the past, to intravenous drug users. This shift brings with it changes in the social class of patients and the communities affected as well as in the kind and extent of services and social supports they need. Minorities are disproportionately affected; 32 percent of people with AIDS in New York are black and 26 percent Hispanic.

As of January, 1,740 AIDS patients were hospitalized in New York City, filling 9 percent of the city’s total medical/surgical beds. HHC hospitals, with 16 percent of that capacity, were treating 32 percent of the AIDS patients, devoting 14 percent of their medical/surgical beds to this group.

The magnitude of resources that will be needed to treat AIDS patients in New York City is staggering. The number of hospital beds needed by these patients doubled between 1985 and 1987. By 1994, they will require approximately 2,300 additional beds—the equivalent of four to five new, medium-sized hospitals—not to mention an additional 1,100 nursing home beds, 2,600 housing units, and nearly 3,000 home care slots, all at a cost of approximately $7.2 billion, according to a recent forecast by the New York City AIDS Task Force.

Drug Abuse. While AIDS is a significant factor in hospital overcrowding, it is hardly the only one. An unabated scourge of drug abuse, caused primarily by use of the cheap, widely available, and highly addictive cocaine derivative crack, is filling New York City’s medical/surgical, neonatal, and psychiatric beds. Hospitals experienced a 35 percent increase in medical complications and a 60 percent increase in psychiatric complications resulting from drug use between 1985 and 1987. The number of babies born addicted to crack doubled during this period. And uncounted as yet are the rising number of trauma cases resulting from drug-related violence.

With an estimated total of 250,000 heroin users and 600,000 cocaine users in the city, drug treatment facilities, located largely outside the hospital sector, can handle barely 10 to 15 percent of the existing demand. Thus, despite the severe toll drug abuse is exacting through the rising incidence of AIDS, venereal disease, child abuse, violence, and crime and the resulting overload in the courts, jails, and hospitals, an addict wishing to escape the scourge must be willing and able to wait months, if not years, for help.

Mental Illness. Because psychiatric units throughout the city have traditionally operated at 100 percent of capacity, the increasing incidence of mental illness cannot be measured by increased hospital utilization. Instead, New York City’s growing mental health needs are mani-
fest in a hospital psychiatric population that is increasingly dominated by severely ill patients, including chronic schizophrenics; patients with major complications such as mental retardation and drug and alcohol abuse; and patients who are homeless and difficult to discharge. Prior to the policy of deinstitutionalization, which reduced the number of state psychiatric hospital beds from 106,030 in 1965 to 22,155 today, many of these patients would have been treated in state-run long-term care facilities.

New York City is witnessing the health consequences of an unmitigated epidemic of poverty and desperation.

Thus, in 1987 HHC found that 47 percent of its psychiatric patients had drug or alcohol complications and 24 percent were homeless. Between 1982 and 1989, the number of emotionally disturbed persons brought in to all hospitals in the city by the police increased 60 percent. Accompanying the shift to patients with more complex problems has been a rising length of stay and a small but growing group of "heavy users" of drugs or alcohol who consume ever larger proportions of inpatient and outpatient psychiatric services.¹⁰

The Crisis of Rising Poverty and Social Breakdown

Accompanying and contributing to the spread of these social epidemics is yet a deeper crisis: the growing impoverishment and immiseration of the lowest socioeconomic strata of New York City's population, causing the city to be dubbed the "new Calcutta" in recent New York Times editorials.

Poverty in New York City grew 65 percent between 1975 and 1986. Just under one-quarter of all New Yorkers now live under the poverty level, as do 40 percent of all New York's children.¹¹

Between 1980 and 1984, the number of people without medical coverage increased 22 percent. They now constitute 20 percent of the population under the age of 65.¹² Medical indigency is exacerbated by the fact that, in the very period when poverty has grown so rapidly in New York City, the number of those enrolled in Medicaid has decreased 12 percent.¹³

The growth of poverty and medical indigency reflect a shift in New York City's economy. The number of manufacturing jobs, traditionally a point of entry for the city's unskilled workers, declined 44 percent between 1970 and 1984 and are expected to fall another 23 percent by 1990.¹⁴ Unionized, relatively well paid, and accompanied by benefits, these jobs are being replaced by jobs in the service sector that are largely unorganized, pay minimum
wages, are often part time or seasonal, and generally lack benefits.

New York City's homeless population now numbers an estimated 70,000 to 100,000, including some 8,000 to 11,000 homeless AIDS patients. Fully five times the number of those who are actually on the street are estimated to be doubled up, living with friends or relatives. Encamped on every steam grate, in every park, subway train, terminal, and public space, these beleaguered masses are the result not only of impoverishment, but of the monumental loss of moderately priced rental housing, including single-room occupancy hotels, co-op conversion, gentrification, and rampant speculation in New York City's overheated real estate market.

Exposure to the elements, unsanitary conditions, the inability to store or cook food, and stress all generate illness among this group. Homelessness among patients in New York City's hospital system itself have left it less prepared than ever to deal with these new stresses.

The city's hospitals have become the intervention of last resort.

HHC hospitals has increased 40 percent between 1987 and 1988. A survey conducted in March 1989 of in-house patients at Bellevue Hospital identified an astounding 42 percent of all patients as homeless—31 percent among general care patients and 60 percent among psychiatric patients.

New York City is witnessing the health consequences of an unmitigated epidemic of poverty and desperation for which its hospitals have become the intervention of last resort. Not only have hospitals inherited the health consequences of this epidemic, they are increasingly inheriting the roles of other social systems that are collapsing under the strain. Along with medical care, they render a growing component of what would otherwise be family support, housing, nutrition, and foster care. The price is the growing length of hospitals stays and the resulting hospital gridlock.

The Crisis Within New York City's Hospitals

A variety of developments and crises within New York City's hospital system itself have left it less prepared than ever to deal with these new stresses.

Bed Reductions. State reimbursement, regulatory, and planning policies that focus narrowly on cost control and bed reduction have robbed New York City of a safety margin that might otherwise have absorbed the unforeseen increases in need. Between 1982 and 1987, New York City lost 4,100 medical/surgical beds, or 15 percent of its capacity.15 On January 1, 1987, even as hospital utilization and occupancy were rising, over 1,000 medical/surgical beds were closed to avoid stringent reimbursement penalties. Over one-third of this loss was borne by the public system.

Such bed closings have proven irreversible, as the space has been renovated, converted, and used to relieve overcrowding elsewhere in the hospital. Most recently, staff shortages have reduced existing bed capacity even further. In summer 1988 the state at last reversed its longstanding bed-reduction policy, calling for the immediate addition of 500 beds to serve AIDS patients. And while a number of hospitals responded with proposals, a full year later, fewer than 10 percent have actually materialized.

Staffing Shortages. Just as demand for services surged, New York City's hospitals found themselves facing an unexpected crisis of staff shortages that serve to further reduce available hospital capacity. The shortage of nurses, with an estimated 15 percent vacancy rate, is the most visible and is responsible for temporary bed closings. In February 1989, 1,608 badly needed beds were out of service according to a survey by the independent New York City Health Systems Agency, half of them due to lack of staff.16 Another survey by the Hospital Trustees of New York State found nursing shortages responsible for closing hospital units at 15 percent of the responding facilities, restricting admission to certain services at 46 percent, denying elective admissions at 25 percent, diverting patients to other facilities at 22 percent, and delaying transfers from the emergency rooms to nursing units at 37 percent.

Less visible but similar shortages exist among occupational, physical, and respiratory therapists; lab and X-ray technicians; social workers; pharmacists; midwives; nurse practitioners; and physicians' assistants. While New York City's hospitals once employed more workers per workload unit than hospitals in other major cities, by 1987 they employed 20 percent fewer. Staffing costs as a percentage of total hospital expenditures have fallen from 64 percent in 1980 to 59 percent in 1987.18

Hospitals are inheriting the roles of other social services that are collapsing under the strain.

These shortages not only cause unit closings; they cause internal breakdowns in services vitally needed to treat and discharge patients efficiently. A case in point is the shortage of hospital social workers whose chief responsibility is to assure adequate placement and aftercare so that patients can be promptly discharged when they no longer need acute care.

As the same workload devolves on fewer and fewer workers, a form of "managerial meltdown" takes place, which itself slows the flow of patients and thus further compounds the overcrowding problem. Staff shortages cause burnout of workers and turnover of staff. And
finally, in a seller's market, the difficulties of working in New York City's crisis-ridden hospital environment are a severe obstacle to recruiting and retaining skilled workers. The city has seen enrollments among all of its health professional schools, with the exception of medical schools, drop between 10 and 35 percent over the last eight years.

Hospital Financial Crisis. As if these problems weren't daunting enough, in the last two years, New York City's hospitals have suddenly found themselves facing unexpected financial crises as well. In 1987, half of all hospitals in New York City ran operating deficits. By 1988, the figure was 80 percent. According to the State Hospital Association, the loss among New York City hospitals for 1988 is expected to be $300 million. By February 1989, 14 hospitals were over two months late in payments to labor-management benefit funds, and health benefits to 2,000 workers at two hospitals had been cut off. Thus, despite the crush of rising demand and the operational and capacity problems caused by health worker shortages, New York City hospitals laid off over 1,000 workers last year in order to limit financial losses.

The Crisis of an Ill-Configured Health System

The final contributor to New York City's hospital crisis is a policy legacy of long-standing: a system oriented almost exclusively to highly technological, acute inpatient care and woefully lacking alternatives that might more appropriately utilize resources and address the needs of New Yorkers.

New York City is perhaps the world capital of academic medicine. Home of seven medical schools, it provides residency training to fully 15 percent of all U.S. medical school graduates. Nearly three-quarters of its 71 hospitals are teaching facilities, and teaching intensity, measured by the ratio of medical residents to hospital workload, is 40 percent higher than that of other large urban areas.

The heart of research and teaching interests lies in a model of "high-tech," acute inpatient care. Of those graduating from New York City's medical schools, 70 percent are specialists, and only 30 percent are primary care physicians—precisely the opposite of what is considered optimal. Only 5 percent of the state's residents train in family practice, compared to 17 percent in Ohio, 15 percent in California, and 14 percent in Texas and Illinois.

The power and politics of these mammoth medical schools have shaped an entire health system to the needs of this model. Thus, when faced with overwhelming demand, much of it social in origin, New York City's health system has only acute inpatient beds to offer. It is helpless to avert or reduce the need for inpatient care by identifying and intervening early in the disease process; and it is helpless to speed the flow of inpatients through the hospital by meeting many of the social and medical needs that must be addressed in more appropriate institutional and community-based settings. These front and back ends of what should be a full spectrum of care—the components best able to relieve inpatient gridlock—are grossly underdeveloped. And if they are in short supply for all New Yorkers, they are in shortest supply for the poor.

With payments averaging $11 per visit, Medicaid has virtually denied poor patients access to private practitioners, with the exception of Medicaid mills, and even these notorious institutions are fading. In a recent survey of ten poor communities, home to 1.5 million New Yorkers, the Community Service Society found a grand total of 22 private physicians available who were under the age of 65, who had admitting privileges, who accepted Medicaid, and who practiced more than 20 hours per
week.\textsuperscript{22} At the same time, community health centers and community mental health centers are tottering on the brink, having suffered a 40 percent cutback of federal funds over the last eight years.\textsuperscript{23}

Thus, to meet their most basic health care needs, the poor are forced into poorly organized and overcrowded institutionally based outpatient clinics and emergency rooms. Caps on the reimbursement of outpatient care, in place for nearly ten years, have become a major source of financial losses and disincentives for hospitals to reorganize or expand. Utilization of outpatient services has remained stable and, in some cases, even declined. Now, in the face of growing financial losses, hospitals are beginning to limit or cut back the very services most likely to stem the rising tide of inpatient overcrowding.

In similar fashion, the state imposed a moratorium on the growth of long-term care beds for nearly 20 years. When at last the ban was removed two years ago, the state substituted limitations on new construction costs guaranteed to make building new beds in the costly New York City market financially unfeasible. New York City's nursing homes currently run at 100 percent of capacity.

The Policy Bind

New York City's hospitals have become the stage upon which the consequences of a much larger drama gripping the city's population are being played out. The drama highlights, as never before, the distinctions between health, health care, and hospitals. Health is generated as a by-product of social, economic, and personal well-being alone. Health care providers cannot create it; they can only promote it and preserve it through education, prevention, early identification of and intervention in the disease process, and treatment offered in the most appropriate mode and setting.

When all else fails, hospitals are forced to deal with the consequences not only of illness, but of the breakdown of other social systems. Despite the gleam of high-tech medicine and the glitz of new corporate organization, hospitals have been unable to shake their roots in the almshouses of old. Like it or not, without alternate services and facilities, they are still the providers of last resort of shelter, food, and foster care as well as of medical care.

Providers cannot create health; they can only promote it and preserve it.

Health care providers and policymakers cannot be held responsible for the impoverishment and immiseration that underlie New York City's surging hospital demand. They can be held responsible, however, for creating a health system that best and most appropriately meets that demand, when and where it occurs.

In New York City, this means taking emergency action to build up the front and back ends of the health care spectrum—preventive and primary care, on the one hand, and institutional and community-based intermediate and long-term care, on the other. But, in the face of looming state and city fiscal deficits, policymakers are in a bind. More than ever they lack the resources to develop these alternative modes of care and add them onto the existing acute-care, tertiary model. And, in the face of
overwhelming demand, inpatient overcrowding, and hospital deficits, more than ever they lack the ability to reallocate resources from acute care to the only models that could appropriately meet need and relieve overcrowding. New York’s health policy chickens have come home to roost. Q

Preserving Integration
Defending the Hospital Rights of the Poor
RONDA KOTELCHUCK

What sets New York City apart from other major American cities in the depth and urgency of its health care crisis? Certainly the extent of its AIDS epidemic far exceeds that of any other city except San Francisco. Poverty and homelessness are more prevalent here than in many other large cities. (See Tables 1 and 2.) Yet cities such as Washington, D.C., Detroit, and Chicago that can match New York in drug abuse, mental illness, poverty, and homelessness do not seem to be experiencing the same kind of massive breakdown of their health systems. (See Tables 3 and 4).

What most clearly distinguishes New York City’s health care crisis, with its concomitant compromises of access and quality, is that it is not isolated within the poor community. It has become a crisis for virtually everyone in the city, regardless of race or class. And the reason is that inpatient care of the poor in New York, unlike that in many cities, is not limited to one or two public hospitals, but is integrated across many providers.

Although the city has the largest municipal system in the world, the majority of its Medicaid and uninsured patients (60 and 64 percent respectively) are treated in voluntary institutions. These are largely of two types: smaller inner-city hospitals, often referred to in health care circles as “financially distressed hospitals,” and large academic medical centers and their affiliated teaching hospitals.

There is a similar crisis of surging inpatient use and emergency room overcrowding in large, urban, public hospitals elsewhere across the country. But the crisis is limited to this handful of hospitals, while the occupancy of private hospitals in these same cities averages 60 percent and is falling. In most cities, because care of the poor is confined to a single large hospital, when morbidity explodes, the shock waves are also confined, and the compromises to the access and quality of care that result go unseen and unsung.

The reason New York City’s hospital crisis is defined as a crisis at all is that it affects everyone in New York City, not just the poor. The integration of care for the poor into the mainstream, while far from perfect, has served as a safety valve. Because all classes are affected by the health crises that affect the poor, this integration has in effect set a bottom line beneath which access and quality...
cannot fall without causing widespread alarm and action.

Policy Roots

The integration of New York's poor into hospital care is the result of a number of deliberate and traditionally progressive state and city policies designed to preserve the access of the poor to medical care. It dates to the city's early practice of purchasing voluntary services whenever demand by the poor exceeded the capacity of the public hospitals. In the 1930's, with public hospitals overflowing, fully one-third of indigent patients were treated in private hospitals.

This policy found a certain receptiveness among the city's major academic medical centers, which had their own need for teaching patients. During the 1960's and 1970's, the state increasingly viewed these high-tech medical centers, located in the inner city and presumably dedicated not to profit but to the advancement of science and medicine, as the perfect vehicle for its policies of health care delivery. In the 1960's, these centers were paired with public hospitals through affiliation agree-

ments to improve the quality of medical personnel and care in the latter. The most progressive among the academic medical centers even expressed strong sentiment for creating a "single class of care" by taking over operation of the city's public hospital system. This position ultimately came to be viewed as a self-serving rationalization for rampant empire building and was defeated by public outcry (led in large part by the newly created Health/PAC).

In the 1960's and 1970's, a number of state programs, such as the candidly named Ghetto Medicine program, and reimbursement policies, such as the Blue Cross ambulatory loss payment, provided funds exclusively to voluntary providers to further encourage them to provide ambulatory care for the poor. The choice was made to give the money to private hospitals as an incentive to increase their service to the poor, rather than to the public hospitals that presumably already did so.

Inclusion of the poor in the state's health system received its biggest boost in 1966, when, under the leadership of Governor Nelson Rockefeller, New York adopted the most generous of any state Medicaid program. Eligibility was initially set to include the working poor, thus qualifying a quarter of all New Yorkers. The program was designed to allow recipients to purchase their medical services on the health care market. The state quickly retrenched on eligibility, and the payment for many services has fallen woefully behind. Nevertheless, since 1969, Medicaid inpatient rates have been set to be fully comparable with those of Blue Cross, thus eliminating financial incentives for excluding the poor.

In 1983 the state took another important step by establishing a bad debt and charity care pool. Based on logic similar to that of the Ghetto Medicine program and Blue Cross ambulatory loss payment, this pool initially paid voluntary hospitals 85 percent of the losses incurred by treating the uninsured, compared with only 15 percent of the losses of public providers.

Two other policies have been critical to integrating the
poor into New York's hospital care. New York State has long required all hospitals to operate an emergency service. Furthermore, unlike hospitals in the rest of the country, New York hospitals have historically been required to treat all who presented themselves, regardless of means, or face criminal penalties. These regulations significantly undercut the prerogative of hospitals, particularly those designated as major emergency receiving hospitals, to control the nature and type of patients they admit and thus to discriminate.

Finally, New York State health policy has long been hostile to health care institutions that operate for profit—those with the most obvious reasons to pick and choose their patients. For-profit hospitals have virtually been read out of existence in New York State, and it was not until 1986 that the state first allowed the operation of for-profit health maintenance organizations (HMOs), subject, however, to the important condition that they serve significant numbers of Medicaid patients.

Responses to the Crisis
Over the last ten years, the staunchest advocate of the policy integrating health care for the poor has been New York State Commissioner of Health, Dr. David Axelrod, architect of many of the measures to implement this policy described here. It is not surprising, then, that his first response to New York City's hospital overcrowding crisis was to strengthen and advance that policy. In early 1989, the New York State Health Department further narrowed hospitals' prerogatives by declaring that all hospitals must join the 911 emergency system as well as participate in a new citywide computerized census reporting system that will immediately channel patients to available beds.

Unfortunately, however, as the public comes to understand the origins of the hospital crisis in developments affecting the poor—the epidemics of AIDS, drug abuse, and mental illness and the ravages of poverty—Axelrod's policy of integration will come under increasing fire.

The first to turn up the heat was the New York State Medical Society, whose private practicing physicians are losing fees because lack of beds prevents them from admitting elective patients. In March they called for Dr. Axelrod's resignation.

Next, in what was in essence a call for polarization and segregation in the care of the poor, the New York Post, on May 14, 1989, editorialized:

Let's look at the realities. The majority of those who are likely to become AIDS patients in the early part of the next decade are IV drug users and people who are sexually involved with IV drug users. In many cases, these are people who have resorted to prostitution to feed crack habits....

But many New Yorkers who work, and thus earn medical insurance to care for themselves and their families, will not want to share hospitals with this new class of patients.

Is this a selfish, reactionary response—one with which public health officials and political leaders need not even try to come to terms?

No.

Unfortunately, the resegregation of health care as a response to the city's health crisis is a real and present danger. It offers an increasingly compelling and expedient solution for less reactionary interests as well. By confining the poor to their own institutions, private beds could be freed for middle- and upper-class patients.

### Table 2

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<th>Factors Affecting the Health Status of New York City's Population</th>
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<td>New York City has a significantly greater proportion of poor and aged in its population than other cities. It also has notably fewer housing vacancies, probably indicating a greater number of homeless people.</td>
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<th>FACtor</th>
<th>NYC (percent)</th>
<th>Other Big Cities (percent)</th>
<th>Difference (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families under poverty level</td>
<td>17.2</td>
<td>13.5</td>
<td>+27.9</td>
</tr>
<tr>
<td>(1980)b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population over age 65 (1980)c</td>
<td>13.5</td>
<td>10.9</td>
<td>+24.9</td>
</tr>
<tr>
<td>Non-white population (1980)c</td>
<td>39.3</td>
<td>38.4</td>
<td>+2.3</td>
</tr>
<tr>
<td>Rental housing vacancy rate</td>
<td>2.4</td>
<td>13.1</td>
<td>-81.7</td>
</tr>
<tr>
<td>(1987)c</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Mean figures based on the 19 next largest cities in the United States.

bCity and County Data Book 1988, U.S. Bureau of the Census.


resolving the compromises of quality and access for those who defined New York City’s health care problem as a crisis. Moreover, with large fiscal deficits looming at the city and state levels, such a policy would obviate the need for massive expenditures that would otherwise be required, offering one of the few “fiscally feasible” solutions to the city’s hospital crisis.

Dr. Axelrod is right in continuing to pursue integration of the poor into the health care system, and his policies will increasingly need to be understood and defended. The reasons that the Supreme Court found separate was not equal in education apply to health care as well. The integration of the poor into New York’s hospital care, imperfect as it is, has still acted as a safety valve, setting in motion a broad-based concern about the state of the city’s health services.

Segregation of health care must be fought at any cost.

Decency requires that all health care providers take greater responsibility in addressing New York City’s unforeseen and surging health care need. This logic is even more compelling in light of the fact that over two-thirds of these providers’ operations are paid through public funds. Decency requires, too, that all New Yorkers—health care providers, consumers, professionals, and policymakers alike—address the urgent issues of health care quality and access for all. Integration was the safety valve that brought these issues to the public’s attention, and segregation is the policy alternative that must be fought at any cost.

Table 3
New York City’s Hospital Sector
New York City’s hospitals have a longer length of stay and a higher occupancy rate than do hospitals in other large cities. Beds and admissions are lower, however.

<table>
<thead>
<tr>
<th></th>
<th>NYC</th>
<th>Other Big Cities</th>
<th>Difference (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusted length of stay (days)</td>
<td>9.4</td>
<td>7.4</td>
<td>+21</td>
</tr>
<tr>
<td>Beds (per 1,000 population)</td>
<td>4.78</td>
<td>5.78</td>
<td>-21</td>
</tr>
<tr>
<td>Admissions per year (per 1,000 population)</td>
<td>159</td>
<td>196</td>
<td>-24</td>
</tr>
<tr>
<td>Occupancy rate (percent)</td>
<td>85.4</td>
<td>69.1</td>
<td>+19</td>
</tr>
<tr>
<td>Bed reductions (1975-1987)</td>
<td>-19%</td>
<td>-1%</td>
<td>-</td>
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</tbody>
</table>


*Mean figures based on the 19 next largest cities in the United States.

Failing to Face the Crisis
ARTHUR LEVIN

The only consistent, visible, and vocal leadership in New York City’s current health care crisis has been provided by a handful of groups such as Local 1199 of the Drug, Hospital and Health Care Employees Union and AIDS advocacy and community health organizations. (See, for example, the Brooklyn Health Action Committee’s Report, “Dying Young in New York City,” reprinted in this issue.) They have been the ones to publicize the situation and call for action. Traditional health care advocates seem immobilized, perhaps by the complexity of causes and the lack of a clear culprit against which to organize. Yet the depth, breadth, and human toll of today’s crisis far exceeds anything experienced previously.

A new fiscal reality constrains the response of both the city and the state to the situation in the city’s hospitals. Both have developed large deficits as a result of changes in the federal tax laws, making them reluctant to address these issues. Felix Rohatyn, who is generally credited with having steered New York City through the shoals

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of bankruptcy in the mid-1970's, predicts that the austerity of the 1990's will be far more devastating. Compounding these revenue shortfalls is the fact that the state is enmeshed in its own program to reduce income taxes. To date, Governor Mario Cuomo has refused to modify his timetable for income tax reductions in order to make more funds available. In short, neither the state nor the city are willing to acknowledge or take responsibility for problems whose solutions they consider unaffordable.

The State's Response

The New York State Health Department, which has authority over reimbursement and regulation of health care providers, first responded to the crisis with an ineffectual call for more beds and a reduced length of stay. Next, Health Commissioner David Axelrod attempted minor adjustments to the hospital system that, while positive in their intent to maintain and improve access of poor people to health care, barely make a dent in the problem. Moving toward ever more refined regulation and rationalization at the margins of the system, he further narrowed hospital prerogatives in January by calling for universal participation in the 911 emergency system. Axelrod also announced a new online automated inpatient census system that would instantly identify and channel patients to empty beds anywhere throughout the city. He has also suggested monitoring hospital care of Medicaid and AIDS patients and called for the conversion of underutilized beds and the creation of special alternate level of care (non-acute-care) units. Finally, he imposed regulations limiting waiting times for admission in emergency rooms to eight hours, leaving many hospital administrators mystified about what they are to do with the patients after that.

The Health Department has also responded with money. The state recently granted a $183 million Medicaid rate increase to cover the additional costs of recruiting and retaining nurses. Furthermore, the all-important trend factor (the calculation that adjusts Medicaid rates for inflation) promises to reach a high of 6.1 percent. These financial infusions may ease the pain of the acute-care hospitals, but will do nothing to provide the alternative modes of care that would relieve the causes of the gridlock.

Cuomo Cuts Medicaid

Acting independently of his commissioners of health and social service, Governor Cuomo chose this spring to depart from nearly 20 years of New York State Medicaid policies that, since 1969, have sought to preserve existing benefits and eligibility at the expense of tightly controlled reimbursements for physicians. With a Reaganesque cynicism, the governor added his own full-scale assault on the Medicaid program to the burdens of communities and care-givers already reeling under sharply increasing poverty, homelessness, federal cutbacks, and social morbidity. In order to continue phasing in tax reductions that would primarily benefit middle- and upper-class New Yorkers, he targeted Medicaid to absorb fully half of
The City's Response

New York City's government, traditionally responsible for public health and public hospital services, has exhibited little recognition of the health care crisis engulfing its citizens. The two exceptions have been Mayor Koch's new AIDS effort and his funding tussles with the Health and Hospitals Corporation.

On May 14, Koch announced a major shift in city policy dealing with AIDS commencing in fiscal year 1990. As the centerpiece of the $40 million dollar program, he proposed the creation of two AIDS shelters providing 250 beds, along with the expansion of other housing aid, including rent supplements and residential placements for homeless patients. It is hoped that these new programs will relieve hospital "bedlock" by reducing the use of acute-care beds as housing of last resort. The new program will also use a broader definition of eligibility for AIDS services to get more services to more people. Many AIDS activist groups object to the large-shelter concept proposed by Mayor Koch, however, arguing that it reflects a "leper colony" mentality.

The Health and Hospitals Corporation (HHC) is the city's chief instrument of health care delivery. It operates the city's 11 acute-care hospitals, five long-term care facilities, six home care agencies, five neighborhood family care centers, and a host of smaller ambulatory sites.

More than any other group of providers, HHC's facilities have borne the brunt of the growing demand for health care emanating from the poor community. Yet through the end of 1988, the city indicated no particular recognition of this stress, subjecting HHC (its entire budget, not just the city's appropriation) to citywide budget cuts designed to address the city's own revenue crisis. In January 1989, however, Mayor Koch, in the early stages of a tough campaign for reelection, pumped an additional $20 million a year into HHC's $2.3 billion budget.

Meanwhile, HHC has formulated its own long-term strategic plan. The heart of this plan is expanded ambulatory and long-term care services and reorganization to make community-based primary and preventive care the centerpiece of the system—measures clearly essential to relieving the overcrowding crisis. The city has committed itself to expanding home care and adding 700 new long-term beds. With that exception, however, the city has sat on HHC's plan for over a year.

The Hospitals' Response

Voluntary hospitals have been slow to respond to their own developing crisis. Their trade representative, the Greater New York Hospital Association, has defined the issue in the most narrow and self-interested terms as a funding issue, focusing demands on more money for hospitals.
In a striking change of attitude, the voluntary hospitals and academic medical centers appear to have lost interest in fighting for new beds, despite their long history of expansionary fervor and aggressive resistance to reductions in capacity. Perhaps their former dreams of empire have become nightmares brought on by visions of people with AIDS, substance abusers, and the homeless, a great many of whom are minorities, filling every newly certified bed.

Meanwhile, voluntary hospitals have begun to retrench on their ambulatory services. Given the degree to which these services contribute to hospitals’ growing losses and because they are the point of entry for the groundswell of demand generated by the low-income and minority community, this trend can only be expected to increase. Columbia-Presbyterian is the first major academic medical center to announce such plans, limiting ambulatory services to people within its service area. Both Columbia-Presbyterian and Mt. Sinai also recently eliminated outpatient pharmacy services.

For the moment, however, most facilities appear to be pursuing a far less provocative strategy of quietly reducing their allocations of resources to ambulatory care. The result is longer waiting times and intolerable chaos, which take their toll on patients and discourage them from using the services. Thus, despite the burgeoning utilization of inpatient facilities, outpatient volumes have remained stable or have fallen.

Business’s Response

Finally, for the first time in the two-year-old crisis, there is mobilization of the kind of concern that may actually bring about a solution—though of what sort remains to be seen. In mid-March a group of business elite, consisting of the chief executives of some of New York’s most powerful corporations, met to consider the health care crisis. According to the New York Times, executives at the meeting recounted examples of their own recent difficulties in getting friends and associates admitted to hospitals. Commented Felix Rohatyn, “Compared to what we had to deal with in the 70’s, this is far more serious.” At the core, this group is concerned that failure to address the health care shortage would ultimately drive away business and undermine the city’s economy.

Clearly, the business leadership has the clout to get the state and city to commit additional resources—especially when the 1989 mayoral election and the 1990 race for governor will have candidates eager to curry favor. What is worrisome is that the business leadership may press for solutions that turn back the clock—ones that squeeze the poor and underinsured out of the private sector. That would be a disaster not only for the hundreds of thousands of New Yorkers who will lose access to health care, but for the city’s public hospital system and ultimately for all New Yorkers.

In Search of a Solution

The Need for Community-Based Care

BARBARA CARESS

This article is based on proposals and suggestions made in a March 1989 report by Local 1199, Drug, Hospital and Health Care Employees Union, titled “Report to Governor Cuomo on New York’s Health Care Crisis.”

What must be done to break the gridlock that grips New York City’s health care system? We must begin at the beginning. New York had an expensive and somewhat dysfunctional health care system even before the current crisis hit. With its excessive reliance on high technology and acute inpatient services to meet the health needs of the population, this system never provided adequate support for the types of services that would have averted the current crisis—primary, preventively oriented, well-managed ambulatory care. After-care resources—both institutional and community based—are similarly lacking. These are the services that can prevent hospitalizations and divert patients from the acute-care system.

Barbara Caress is a health policy consultant to Local 1199 and a former Health/PAC staff member.
The solution to New York City's health care crisis, then, lies in the creation—or re-creation—of community-based programs that can provide the services badly needed to relieve hospital overcrowding: primary care; prenatal services; preventive health care and education; substance abuse services; mental health services; early intervention with and management of chronic diseases, from arthritis to AIDS; and continuing after-care.

For this effort to succeed, these services must be integrated and coordinated. If one provider or group of providers cannot furnish certain key services (such as drug abuse or mental health services), they must be tied into a service network that can. Creating isolated programs to deal with one set of problems without such a support network will prove both expensive, because some services will be duplicated, and ineffective, because many patients will not get the services they need. In time, creating a full and integrated network of services will prove cost-effective, but at the beginning it will require the pooling of existing resources and new investment.

Ultimately, this service network will be the salvation of that part of the state's Medicaid program that supports health services for the poor. Attempts to save the system by constraining utilization or cutting back on reimbursement to providers punishes recipients and will not improve care. Much of the perceived "overutilization" of health services by Medicaid patients simply results from the search to find care that will alleviate their pain. Once a network of truly responsive providers is established, penalties for overutilization can be imposed. Until then, they would be counterproductive.

We must alleviate the current crisis while creating the foundation for a reconfigured health care system. Thus, we must address the problems in the hospitals where they are erupting, by taking steps to relieve the severe shortage of health care workers so that New York City's hospitals can provide more and better care. Simultaneously, we must relieve the pressure on our hospitals by providing alternatives to institutional care in the community. This means not only community-based primary care but also psychiatric services to relieve overcrowding of inpatient psychiatric services and long-term care facilities to remove the burden of non-acute care of the elderly and the chronically ill from the hospitals.

The proposals and suggestions presented here for discussion are intended for both the short and long term. We focus on the following areas: (1) reducing staff shortages, (2) community-based health care services, (3) increasing the supply of physicians, (4) reducing overcrowding in psychiatric services, and (5) increasing the number of nursing home beds.

Reducing Staff Shortages

The inability to recruit, train, and retain workers is at the heart of the hospital crisis. Upwards of 1,000 beds are unused because of staff shortages. Increasing both the supply and stability of the health care work force is an imperative. We must break into the vicious cycle at the point at which lack of adequate compensation creates the understaffing, which produces stress on the remaining workers, leading to greater turnover and continued staff shortages.

Health care workers are among the lowest paid of the state's unionized work force. In fact, the average wage of
nonprofessional workers is about 20 percent below the hourly average reported for all workers in the state. Prior to negotiating a new industrywide contract, effective July 1, 1989, the majority of maintenance and service workers were grossing just $320 a week, or $64 a day. That just isn't enough to support an individual or a family in New York City in 1989. No wonder, then, that the turnover among these workers is substantial. On any given day, fully 10 percent of the hospital workers represented by Local 1199, the Drug, Hospital and Health Care Employees Union, are still within their 60-day probationary period.

An additional effect of the hospital crisis and the precarious financial position of some hospitals is to put the workers' benefits in jeopardy. Among the 31 hospitals represented by Local 1199, 14 were more than two months behind in making payments to the health insurance fund. Two institutions were so far behind that the fund's trustees were forced to cut off health insurance benefits to over 2,000 workers.

Just throwing money at the related problems of staff shortages and high turnover among workers is no solution. The shortages among technical and professional workers have been long in the making. Enrollment in nursing schools is down 30 percent since 1980, according to the New York State Department of Health, and 14 percent fewer LPN's are being trained. The number of programs granting degrees in physical therapy declined 13 percent, and 20 percent fewer pharmacists graduated in 1985 than had in 1980. The list goes on and on—it's the same story for virtually every health profession.

The solution to the problems of both labor supply and stability lies in large part in creating real opportunities for people coming into the system as unskilled workers to become better-paid technicians and professionals. If most work were not dead-end, but rather a stepping stone to a career, more young people would be willing to suffer the rigors and unpleasantness of service and maintenance work. And, of course, no one should be asked to work for less than a living wage.

Specific recommendations to reduce the shortages and increase the stability of the work force include:

1. Increase wages and secure benefits.

2. Create a well-funded career ladder training program for current health care workers. Sufficient funds are needed to enable people to go to school full or part time while receiving full pay. A small add-on to the Medicaid and other third-party reimbursement formulas (0.5 percent) would provide enough resources to train upwards of 1,200 hospital, nursing home, and home care workers a year in New York State as nurses, lab technicians, X-ray technicians, and the like.

3. One of the most straightforward and effective ways to relieve the burdens of many health care workers' lives would be to provide day-care assistance.

4. An added inducement for people to consider hospital and nursing home work would be housing assistance. Institutions could use their tax-exempt status to purchase or construct housing at below-market costs for their employees.

5. To remove some of the inequities between well-heeled institutions and those serving primarily poor patients, facilities with severe staffing shortages should be entitled to additional reimbursement tied to recruitment and retention of people in shortage jobs.

Community-Based Health Care Services

Community-based health services are different than hospital-based care in that they are designed to meet specific needs of the patients or community. In the case of hospital-based services, ambulatory, mental health, and addiction services are all provided more or less grudgingly—they are never the main mission of the institution. At best, they are by-products of the training and research of residents. At worst, a hospital offers these services because the state health department has in some way coerced their creation.

Community-based services, on the other hand, must satisfy some community need, particularly if their income depends on patients using them. They are therefore more likely to be responsive to the particular problems of a community than hospital services.

Community-based services can be organized in a variety of ways under a number of auspices. They can be provided by community health and mental health centers and through small group practices. They may be run by local government, nonprofit organizations, or independent practitioners.
Community health centers have a proven record of effectiveness and acceptance. But over the past 15 years, much of what made health centers unique—their community education and outreach activities—has been virtually wiped out by the stringent financial constraints imposed by federal and state funders. (See review of The U.S. Experiment in Social Medicine: The Community Health Center Program, by Alice Sardell, in this issue). Still, and despite a multitude of self-inflicted problems, health centers are a major resource in many communities. In the Bronx, for example, upwards of 100,000 people depend on that borough’s health centers for their care.

Even the best of health centers suffer from two basic problems—inadequate funding for treating uninsured patients and implementing capital projects, and insufficient management expertise. Both problems can be addressed through increased state and federal funding, channeled through regional or community development corporations.

Health centers and hospitals combined supply less than half the primary care received by people living in low-income communities. Even in the Bronx, where there are probably more health centers per capita and greater use of hospital clinics than anywhere else in the country, most people still depend on office-based practitioners. The problem is the quantity and quality of the doctors available to residents of low-income areas.

Few physicians choose to locate their practices in poor neighborhoods. Most who work in these communities are there because, as members of a minority group or as graduates of a foreign medical school, they haven’t the funds to set up their own practice in a more affluent area, they can’t get jobs in another practice elsewhere, and they haven’t the academic credentials to join the clinical faculties of a medical school.

The most mercenary of these physicians know that few poor people are in a position to demand high-quality care and, as a scarce and needed resource, they can get away with ripping off their patients—working neither very hard nor very long hours. A 1988 survey by the New York City Community Service Society (CSS) of primary care physicians located in ten of the city’s poorest neighborhoods found that over one-third of these physicians spent less than 15 hours a week in their offices and almost none had even an answering service to take calls outside of office hours. Less than four in ten had admitting privileges at a hospital, and 80 percent had graduated from a foreign medical school. In fact, the survey, which located 701 physicians working among the 1.7 million people living in these areas, found that only 54 of them were graduates of one of New York State’s 14 medical schools.

Yet some physicians are actively interested in establishing practices in poor and minority communities. The Health and Hospitals Corporation recently helped 10 young doctors to establish private offices in Queens and Brooklyn, and Presbyterian Hospital has opened three hospital-affiliated off-site centers employing 30 physi-
cians in northern Manhattan. Neither had difficulty in recruiting doctors. The major obstacles to creating substantial numbers of similar private practices are obtaining funding for capital and start-up expenses and ensuring sufficient revenue from patient care. With Medicaid reimbursement set at $11 a visit, these doctors are otherwise tempted to resort to assembly line and "ping-pong" style care to produce enough visits and procedures to generate adequate compensation.

Community mental health centers, another source of community-based care, are burdened with caring for the chronically mentally ill patients left out by decades of deinstitutionalization. There is rarely time or resources to do crisis intervention, preventive education, adolescent counseling, or community outreach. In fact, most community mental health centers can do nothing for someone with an immediate crisis or a serious addiction problem.

Perhaps the most direct solution to hospital gridlock is to provide community-based care through greater utilization of home care. But, although New York City's home health care system is probably the most extensive in the country, it is often hard pressed to find and train enough workers to meet the demand. In addition to the poor salaries and benefits home workers receive (particularly the lack of pensions), they are discouraged by the multiple licensing and certification processes imposed by the different state agencies that fund their patients' care. Frequently a worker must have three different licenses to care for the same patient because the patient's funding status changes as she or he depletes various entitlements.

The process of invigorating community-based care could begin with these specific recommendations:

1. Provide state and federal funding for regional community health center development corporations that would pool funds for capital investment and administer new allocations to pay for the uninsured.

2. Provide capital and start-up funds to qualified practitioners—physicians, midwives, physician assistants, and nurse practitioners—who are willing to establish practices in low-income communities, and raise their Medicaid reimbursement rate.

3. Refinance and expand funding for community mental health centers.

4. Improve wages and benefits of home care workers. Consolidate licensing under one authority.

Increasing the Supply of Physicians

Physicians tend to practice in communities similar to the ones they grew up in, and, by extension, minority physicians are more likely than others to practice in minority neighborhoods. But, far from encouraging those who would be likely to set up practice in New York's underserved low-income areas, its medical schools have a shameful record in educating minority physicians and an equally abysmal track record in producing primary care practitioners.

Of the 903 students entering one of New York City's seven medical schools in 1987, 63 were black and 30 were Latino, according to information gathered by the Association of American Medical Colleges. Only one in five came from a large city. Virtually all the rest came from the suburbs. True to form, very few planned to become primary care practitioners. Despite the fact that fully 15 percent of the nation's residents train in New York, fewer than 5 percent are enrolled in family practice programs. Even if we include general internal medicine, only 30 percent of the slots are allocated to primary care specialties—family practice, internal medicine, pediatrics, and obstetrics/gynecology.

Even fewer medical students, 14 percent, said they would be willing to locate their practices in a "deprived area." Still, these 125 or so students could potentially fill a big part of the gaping hole in New York City's supply of primary care providers in low-income communities. The deficit, according to the CSS survey of the ten poorest areas, is a minimum of 550 to 650 full-time physicians. Unfortunately, after four years of New York City medical school and three to five years of residency training, these 125 will likely be reduced to no more than a handful.

Obviously, any hope of finding the people trained and willing to form the backbone of community-based care ultimately depends upon changing the admissions practice and educational philosophy of the medical schools and the structure of the residency programs.

The following recommendations are suggested to begin this process of transformation:

1. Limit reimbursement for the direct and indirect cost of medical education to training primary care physicians. Training of specialists can be financed entirely from
patient care revenue. Provide a five-year phase-in during which the training institutions would be required to reverse the 30-to-70 ratio of primary care physicians to specialists.

2. Make state capitation assistance to medical schools contingent on implementation of affirmative action goals.

3. Establish and enforce affirmative action goals for residency training programs. Not even the hospitals of the city-run Health and Hospitals Corporation (HHC), whose patient population is 77 percent black and Latino, train many minority residents. Including graduates of foreign medical schools, only 12 percent of the 3,538 residents at HHC hospitals for whom ethnicity was reported in 1988 were either black or Latino.

Reducing Overcrowding in Psychiatric Services

Hospital psychiatric units are operating at 100 percent of capacity. On most days, hundreds of mentally ill patients are being held in emergency rooms or being discharged to nontherapeutic environments. But the outpatient mental health service system can't cope with the need for crisis care. People wait four to six weeks for even an intake appointment at community-based facilities.

The problem is obvious—the dearth of ambulatory intervention, drug addiction services, clinical after-care treatment, and residential placements for the mentally ill. With sufficient resources, many hospitalizations could be prevented or shortened. The revolving door of admission, discharge, and readmission could be slowed or stopped.

New York’s medical schools have a shameful record in educating minority physicians.

Acute-care hospital psychiatric bed capacity acts like a sponge that is never completely saturated. The moment a service is opened, it is filled. A large part of the problem is the lack of discharge alternatives. The experience of HHC is illustrative. Bed capacity was expanded 40 percent between 1982 and 1987, but the number of patients treated in the facilities was down 6 percent, because they were staying longer. The average length of stay increased from 12 to 26 days during the same period. Some of the increase was no doubt due to an increased number of people with complex psychiatric problems complicated by drug abuse. Most of it, however, was caused by the inability to find adequate supportive places to discharge patients to, particularly those with complex or drug-related problems. For example, almost none of the community-based agencies funded by the New York City Department of Mental Health will provide psychiatric or counseling services to people with drug abuse problems, not even those enrolled in detoxification or methadone programs.

The solutions are as obvious as the problems:

1. Establish more supportive residences in the community to provide discharge alternatives.

2. Convert some of the vacant space in state psychiatric facilities to residences and lease the facilities either to other providers, such as hospitals, or to community-based service organizations.

3. Establish relationships between inpatient and outpatient mental health providers. Most ambulatory mental health services, including hospital clinics, draw their patients from a relatively small catchment area; hospitals serve much larger geographic areas. There is almost never a relationship between the inpatient service and the various outpatient facilities, even in the same hospital.

4. Require publicly funded voluntary mental health agencies to provide services to hard-to-treat patients.

Increasing Nursing Home Beds

With nursing home occupancy also at nearly 100 percent of capacity, patients who might otherwise be released to the nonexistent long-term care beds continue to occupy acute-care hospital space. New York State's explicit and implicit policy of severely restricting construction of nursing home facilities is thus contributing to the gridlock in its hospitals. The facilities just aren't there to accommodate the needs of the rapidly increasing age group of those 85 and over. The city's fastest-growing population group, their number is expected to grow by 120 percent between 1980 and 2000.

Moreover, people with AIDS will increasingly be competing with the elderly and disabled for nursing home beds. In February 1989 there were 128 persons with AIDS in nursing homes in New York City. The New York City AIDS Task Force estimates that that number will increase tenfold this year and more than double again between the end of 1989 and the end of 1993. AIDS patients are thought to need more intensive medical services than the typical nursing home is prepared or willing to provide. Despite the establishment of very generous reimbursement rates for AIDS treatment in skilled nursing facilities, few nursing homes have stepped forward.

Clearly, an accelerated building program for nursing homes is needed. Some recommendations that would help speed the process include the following:

1. Lift the capital cap to encourage new construction. This ceiling on spending for nursing home construction is now set at $70,000 a bed, while realistic estimates of actual costs range from $90,000 to $120,000. Despite the recent authorization to approve applications for up to 2,000 additional beds in New York City, there have been virtually no takers.

2. Assist potential nursing home developers to assemble land parcels large enough to accommodate a facility in communities with the greatest need. The state or localities might create projects by assembling the property and then leasing it to the developer on a long-term basis.
3. Establish a central computer bank of available long-term care beds. Hospital social workers spend hours on the telephone trying to locate beds for patients who are ready to be discharged. It is not uncommon for them to make 50 telephone calls for one patient. To make such a system work, nursing homes would have to be required to list their beds on the system as a requirement for receipt of Medicaid reimbursement.

4. Lease unused beds from the Veterans Administration hospitals for long-term care of AIDS patients. Hospitals could become providers of long-term care for AIDS patients without converting any more acute-care beds and without major new construction by converting unused Veterans Administration space.

Enormous public pressure will be needed to compel the city and state to create community-based services capable of providing care to people where and when they need it. Continued attempts to “save the system” by discouraging the poor from using the few existing services available to them will only condemn our existing health care institutions to a crisis-ridden future.

Dying Young in New York City

JIM REMPEL

The struggle of communities to prevent their decimation is the current front line of public health action in New York City. Chronic health and social problems stemming from poverty are now overshadowed by emergency conditions such as homelessness and drug dependency. One group working to stem the assault on its community’s physical and social well-being is the Brooklyn Health Action Committee. Founded in 1980, BHAC is a network of community groups and individuals from the Fort Greene, Bushwick, Williamsburg, Bedford-Stuyvesant, and Flatbush sections of Brooklyn. BHAC does organizing and advocacy work around issues of community-based health planning, women’s health, AIDS, substance use, access to prenatal care, and the availability of primary care services. It recently concluded an investigation of public health conditions in congregate health facilities for infants and young children, titled “Inexcusable Harm: The Effect of Institutionalization on Young Foster Children in New York City.” BHAC is sponsored by the Health Action Resource Center, a citywide health advocacy group that provides assistance to community groups organizing around health issues.

This report, originally titled “Growing Genocide: Frightening Increases in the Early Deaths of Young Women during the ’80’s in New York City,” was prepared for BHAC by Jim Rempeal and is excerpted here in slightly edited form. It describes the inextricable link between social conditions and health and the need to confront health issues within this larger context.

-Cheryl Merzel

During the 1980’s, New York City has experienced radical increases in the early deaths of women in their childbearing years, age 15 to 44. In 1987, 2,753 such women died. This signifies a 37 percent increase since 1982, 12 times the increase among women of all ages. The increase was even more rapid in the subgroup age 25 to 44, where the increase was 43 percent. These deaths form the core of a rapid deterioration in the general health and welfare of young families since the New York City fiscal crisis of the late 1970’s, when the city was “saved” with a renewed war on the poor.

One searches in vain to find any significant recognition in the plans and programs of the public or private sector of the psychic scars and long-term mental health consequences which legions of women have experienced secondary to the epidemic of homelessness, battering, drug dependence, incarceration, etc. Nor can one find the needs of their tens of thousands of vulnerable children at the heart of our urban agenda. Thousands of their children are wandering around in the collapsing foster care system, and thousands of them, mostly very young, have experienced temporary institutionalization in hospitals and infant shelters. From 20,000 to 30,000 babies have been detoxified from drugs. More than 1,000 children have died of neglect and abuse during the past decade. And, with the prospect of 30,000 women dying during their childbearing years in the next decade, we could
AIDS epidemic. Therefore, the 33 percent increase in AIDS deaths in women between 1986 and 1987 (almost double the increase in men) is a serious underestimation. Overall, more than one-third of all deaths in women age 15 to 44 years were due to homicide, drug dependence, cirrhosis, and AIDS, all causes heavily linked to cocaine, heroin, and alcohol abuse either by the women themselves or by their sexual partners. (These deaths are a factor in only 1 out of 36 deaths in women of all ages.)

Who are these women that are dying and where do they live? They are disproportionately Latina and African-American, most living in the poorest neighborhoods of New York City. Over 80 percent of female AIDS deaths are Latina and black. Death rates for non-white women age 15 to 44 have increased almost 50 percent from 1980 to 1987. In 1987 these rates were 65 percent higher than those for all women in the age group. Nine out of ten of the leading community districts in total deaths of young women age 15 to 44 years are more than 85 percent Latino and African-American.

Geographical concentration of deaths in the poorest neighborhoods is also evident. The top ten community districts with the highest death rates secondary to homicide, drug dependence, and AIDS are overwhelmingly the poorest in the city—districts like central Harlem, Brownsville in Brooklyn, and Morrisania in the South Bronx.

For further information on the Brooklyn Health Action Committee, contact Judi Clark, (718) 596-0100; Karen Benker, (718) 287-2216; or write BHAC c/o Lafayette Avenue Presbyterian Church, 85 South Oxford Street, Brooklyn, NY 11217.
The Warehousing of Baby Jones

CAREN TEITELBAUM

In his ten years as a nurse, Jim Rempel has treated some of the most vulnerable babies in the city. These include infants who suffer from drug addiction and, more recently, AIDS. This is the story of one of those children, Bobby Jones, a child cut off from his family and nearly forgotten within the walls of a giant health care institution.

Rempel, whose official title is neonatal/infant specialist, is a tall, slender man, with a visible intensity. Not long ago, he sat in a small basement room of the sprawling hospital complex where he works and recalled the difficult early months in Bobby's life.

Born addicted to drugs two years ago, Bobby was abandoned by his mother, who had recently tested HIV-positive. In the first two months of his nine-month hospitalization, he went through a long and torturous withdrawal. Then, he was virtually stored in a no-care land of stark, pictureless walls and steel cribs as he awaited placement in a foster home.

Shortly after his birth, Bobby was admitted to the newborn convalescent ward. Rempel manages the ward and first met the child here. A lanky black boy with big eyes and a dimple in his chin, Bobby literally sweated out his addictions to methadone and cocaine. He was given heavy doses of sedatives to calm his intense restlessness. Instead of attending to his new world outside the womb, as healthy infants do, Bobby could do little else but eat, cry, and sleep.

As it turned out, Rempel already knew the Jones family. Three years earlier, he had cared for Bobby's older brother, Duane, who had also endured a traumatic drug withdrawal during infancy. Duane was unforgettable. By age 1/2, he could curse in two languages, English and his Haitian father's native patois. Rempel recalls a bright but hyperactive and seemingly angry child, who startled people with his tough posture.

The boy's mother, a tall, trim woman in her late 20's, had given birth to these children during different stages of what Rempel described as her "progressive collapse." Before Duane was born, Monique Jones had lost the father of her oldest child—a precocious 6-year-old girl—in a housing project drug war. Given the scarcity of support services in the city for even the most severely mentally ill, Monique found her solace in drugs. At first, she dulled herself with "street" methadone, and later with crack.

Even in her depression, and despite her obvious poverty, Rempel recalled, she managed to care for her children. "She was fairly stable, as far as addicts go," he explained. Duane's father, a cab driver, was also providing some financial support.

At the time of Duane's birth, Monique was living in Brownsville, an impoverished Brooklyn neighborhood with one of the highest infant mortality rates in the city. A year and a half later, she told Rempel that she was moving to Connecticut, and he lost track of the family until Bobby was born.

By the time he encountered them again, Monique had tested HIV-positive. She left Bobby immediately after giving birth to him in the hospital.

It was Monique's HIV status that left the child prey to overburdened health and child care bureaucracies almost hostile to his needs. Because of his AIDS stigma, the foster care system found Bobby difficult to place. After his two-month withdrawal from drugs, he was moved to the so-called "boarder baby" room, with five other abandoned babies. There, volunteer grandparents and nursing assistants cuddled him, talked to him, and gave him the attention he so desperately needed.

A month later, however, he had to be moved again. More babies were streaming into the convalescent ward from the acute-care unit, and, to make room for them, other infants had to be transferred to the boarder baby room. The only bed available for Bobby was in the acute-care infant ward, where he was no longer under Rempel's care.

So, Bobby, a child in need of foster care, was
deposited in a ward that cares for children with acute medical needs. He was shuttled from an atmosphere of comparative security to one where little attention could be paid to him. Rempel describes this ward as a “dismal, dull, demoralized” place, where infants are often restrained in their cribs so that they won’t climb out and disrupt the work of busy staff members. Others lie in oxygen tents or have IV needles taped to their arms. Many of these babies cry, unattended, for long periods of time.

About six months later, Rempel decided to find out what had happened to Bobby. He stopped by the acute-care ward to inquire and was disheartened to find that Bobby was still there. And when he looked into his crib, he was shocked by what he saw. “I found what I would call a ‘feral child,’” Rempel told me. “I would have never thought in my wildest imagination that as a health care professional in the middle of the financial capital of the world, I would find a child who had been so abandoned by a health care institution that he had turned into an ‘animal’!”

“I said I had this child who needed to get out of this ‘hell hole’ called a hospital—quickly.”

Rempel spoke slowly and angrily as he recalled the 9-month-old’s deteriorated condition. “He was guttural. He rocked himself constantly when he was awake. He was completely gaze-aversive—he would not look at me. And he would have fits. And when I went to his chart, I discovered that the physicians who were taking care of him—while they had this animal child in front of them—had noted only one thing month after month. And that is that his growth curves were normal.”

Rempel knew at once that he had to get Bobby out of there. He approached the director of inpatient pediatrics, offering to take Bobby back up to the boarder baby room, which he now describes as “the only safe place emotionally for any child in that institution.”

The move was approved. Within ten days, Bobby began responding to the constant attention of the staff and volunteers. He was held whenever he was awake and was never left alone in his crib. Soon he began looking people in the eye, and would even smile. Later, even when left alone, he rocked far less. At that point, Rempel contacted a foster care agency with a special interest in placing children with AIDS and spoke with its director. “I told her that I had an emergency, that I had this child who needed to get out of this ‘hell hole’ called a hospital—quickly.” Within two weeks, Bobby was placed with a foster family in the Bronx.

Now 2½, Bobby has tested negative for HIV and is being adopted by his foster parents. The agency, says Rempel, considers him to be one of their most “sociable” children.

Jim Rempel is also a public health advocate. As a member of the Public Interest Health Consortium for New York City (PIHCNYC) and a second health advocacy organization, the Brooklyn Health Action Committee (BHAC), he has gathered and helped publicize statistics about children such as Bobby. In a recent report to BHAC, he wrote that in 1988, there were approximately 5,000 to 10,000 babies in New York City born addicted to drugs, and 1,600 to 1,700 HIV-positive women who gave birth. “Assuming that most of these [HIV-positive] women have average sized families,” he concludes, “all of the 1,600-1,700 babies, infected or just exposed, will be orphaned together with 3,000-4,000 of their siblings.”

Bobby Jones’s experience during his first year of life is a harsh reminder of just how ill-prepared the city is to meet even the minimal needs of such fragile infants—let alone the needs of their mothers. The tragedy is that many more Bobbys will lie, as the crack and AIDS epidemics worsen, in the steel cribs of overburdened hospitals.
**Vital Signs**

**Exxon's Earlier Oozing**

On March 6, 1989, less than three weeks before the Exxon Valdez oil spill wrecked the fragile ecology of Alaska's Prince William Sound, the Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor announced its final rule covering response to emergencies involving hazardous waste—including petroleum and petroleum products. This important regulation (Hazardous Waste Operations and Emergency Response, Code of Federal Regulations, Part 1910.120) requires all operations that deal with hazardous waste to develop written health and safety and emergency response plans and to provide site-specific training for all personnel involved with hazardous waste and emergency response.

In the preamble to the regulation, OSHA refuted criticism of its decision to classify petroleum and petroleum products as hazardous waste. It cited a “typical comment” from—who else?—Exxon:

> Perhaps the most fundamental misinterpretation contained in this rule is the inclusion of petroleum and petroleum products in the definition of hazardous substance....

> It is Exxon's understanding that a situation is not an emergency response...unless there is a release of "hazardous substance." Therefore it is essential that the definition of "hazardous substance" be accurate and correct.

> The proposed definition of "hazardous substance" [includes] petroleum and petroleum products...; and related spills may be subject to the burdensome requirements for emergency response operations. [Federal Register, March 6, 1989, p. 9301.]

On March 24, 1989, the ink scarcely dry on these “burdensome” emergency response requirements, the Exxon Valdez tanker ran aground, causing the greatest oil spill disaster in U.S. history. It took Exxon 14 hours to get the first full emergency crew to the ship and another 21 hours to surround the hemorrhaging vessel with floating oil-containment booms.

The battle to contain the oil was lost before Exxon’s effort began. Exxon’s unwanted burden thus became the United States’ tragic loss.

—David Kotelchuck

**Mystery in Mayaguez**

A succession of mysterious gas leaks from the Industrial Park of Guanajibo in Mayaguez, Puerto Rico, is suspected of causing at least 36 deaths, mostly from respiratory and cardiac failure, and scores of illnesses. Despite the gravity of the problem, there are no indications that the current government of Puerto Rico is moving toward the solution it promised during the election campaign in 1984. Six years and half a dozen government reports have brought no definitive answers, only more questions and the specter of more deaths.

Among the companies in the industrial park are international textile, plastics, electronics, and pharmaceutical firms such as Propper International, Transworld Industries, Productos Westinghouse, and Bristol Laboratories Corporation.

The first identified leak at the industrial park was reported by the news media on March 23, 1983, and prompted the evacuation of dozens of people and the hospitalization of many others. That particular toxic leak came from an overpressurized valve in an ammonia gas tank. The source and identity of the escaping substance were known and reported in the media’s account of the accident. But over 50 other gas leaks have been reported since that incident, most of them of unknown origin and composition.

Hundreds of people have been affected by the vapors released into the environment from these unknown sources, and at times entire facilities and sections of the surrounding communities have been evacuated. Symptoms such as depression of the central nervous system, loss of memory, and numb-
ness of the extremities lead experts to believe that one or more organic solvents are involved. Residents of adjacent communities claim the leaks occur much more frequently than reported by the press. A committee of concerned citizens, Comite para el Rescate de Nuestra Salud, was organized in 1983 by 40 workers and community residents, mostly women, and has led the struggle to get the government to act on the problem. They are also convinced that the release of gases began well before it was first reported in March 1983. Health problems associated with environmental contaminants were common among workers in the industrial park long before that. According to one worker who suffered permanent nerve damage, most affected workers ignored their symptoms out of fear and lack of information until the committee brought the story to the public's attention. Despite the committee's efforts to focus media attention on the situation, no end to the leaks or the deaths is in sight.

—Graciano Matos

An Issue of Tissue

A recent interest in research using fetal tissue has nudged its way into abortion discussions. It has raised a difficult quandary for even pro-choice feminists to answer: namely, should a woman's right to an abortion be absolute?

The question hinges primarily on the methods that researchers and clinicians might use to obtain fetal tissue. For the past two years, scientists have begun to seriously investigate the possibilities of using fetal tissue to treat a whole host of health disorders—including Parkinson's disease, Alzheimer's disease, Huntington's disease, childhood diabetes, and potentially many more. Although the results have so far been inconclusive, as research continues and if fetal tissue transplants later prove to be viable, a market for aborted fetuses could develop. And with that demand comes the possibility that women might have abortions merely for financial remuneration.

Professor Nadine Taub, director of the Women's Rights Litigation Clinic at the Rutgers University Law School, has compared this scenario to debates surrounding surrogacy. Indeed, selling fetal tissue seems to fall under the heading of a rather long-standing feminist concern—the implications of a woman's selling her body, in general. On the one hand, many would argue that a woman's body is her own and that she should have a right to do whatever she wants with it. On the other hand, the contexts in which such a transaction usually occurs—prostitution and surrogacy—often exploit women both emotionally and financially. And there is no reason to rule out the possibility that the same situation would occur if fetal tissue were to become a commodity.

More generally, the matter of obtaining fetal tissue points to an ethical dilemma that pro-choice advocates have so far avoided addressing—specifically, whether it is acceptable for a woman to become pregnant with the intention of aborting. A panel representing several sides of the abortion controversy, in fact, indirectly pointed to this question when they met to discuss whether fetal tissue research should receive federal funding. Although the panel, which was convened by the National Institutes of Health, decided that such funding was acceptable, they recommended certain strict regulations on obtaining fetal tissue. One is a required separation of the abortion procedure from the clinical or scientific use of the tissue. A primary intention behind it is to diminish the possibility that a woman would become pregnant merely to abort—for example, to donate tissue to a family member.

The issue is certainly a hot potato for pro-choice advocates. When the right to end an unwanted pregnancy is so tenuous, no pro-choice group can afford to take an official position on whether women should be discouraged from aborting deliberate pregnancies.

—Careti Teitelbaum
Media Scan

A Tale of Survival


by Louanne Kennedy

Community health centers have not fulfilled the hopes of those of us who, in the 1960’s, saw them as the vanguard for the reorganization of the U.S. health care system. Yet that they have survived at all, especially in the era of moral poverty that constituted the Reagan years, is a tribute to advocates, voluntary associations, bureaucrats, and legislators and their aides who fought over more than 20 years to keep the dream alive.

The story of this struggle for survival, as Alice Sardell chronicles it, is one of two competing scenarios. The tension was between those individuals and groups who saw the community health center movement as a new form of organization, radically different in structure and practice from traditional medicine, and those who saw it merely as an auxiliary model of care for the poor.

The first scenario, constituting the original motivation behind the community health center movement, was to create a new paradigm for primary care that would serve as the model for reorganizing the entire health care system. Community health centers were intended to provide comprehensive, continuous health care to a population in a designated area—care of such high quality that the middle class would press to have similar care available for themselves. This vision challenged existing power relationships, hoping to go beyond the dominant private fee-for-service system of American health care. It would do this by combining health care with community empowerment and broadening the definition of health to include improving the social and physical environment through economic development.

The second scenario was the product of the struggle of community health centers to survive. Although they viewed it as a model for change, the founders of the community health center program also understood that health services could not be provided to the poor without subsidy. When, beginning in the 1970’s, such subsidies were virtually eliminated, centers were closed or nonmedical services, such as outreach, were reduced, and the medical care they provided was limited to the poor and underserved. The result was the persistent tension between meeting the original mission of the community health centers and survival.

Significantly, though, the gradual and insistent modifications of community health center programs did not permanently undermine the policy that the poor should receive health care in an atmosphere of quality comparable to that of mainstream medicine. If the original progressive vision has been limited by the political realities, community health centers still provide the best medical care a poor person can receive.

Making Policy

As political climates shift, innovations in health care delivery are often aborted in the womb of time. Sardell shows how this happened in the case of the community health centers, describing in some detail the policymaking process. The expansionary ideology of the 1960’s provided a supportive climate for the community health centers; the conservatism of the following two decades produced an environment in which the original model was consistently restrained.

The tension between the two views of the program was played out in each administration, from President Johnson to President Reagan. Following the passage of Medicare and Medicaid in 1965 and the subsequent development of the War on Poverty programs, energy was harnessed to provide accessible, comprehensive health services to the poor. Yet there was little consensus on how these services were to be provided. Some policymakers believed that covering the old and poor through Medicare and Medicaid would solve the problem of access to health care through increased utilization of the existing hospital-based system. Others felt that access to existing institutions was inadequate for these especially needy populations. It was the latter group of policymakers, trained in public health and viewing health care as just one of a variety of social needs, who created the community health center ideal. These creative
and progressive individuals both in and outside of government were able to capture the special feeling of the time.

Drawing on the literature of political science, Sardell describes the role of the behind-the-scenes actors—the so-called subgovernments—in shaping the destiny of the community health center program. These “subgovernments,” defined as “clusters of individuals that effectively make most of the routine decisions in a given substantive area of policy,” might be the “members and staff of the committees or subcommittees with jurisdiction in that policy area, government officials from the bureau or agency that administers (or would administer) policy in that area, and representatives of interested private organizations.” Sardell uses this perspective to explain how subgovernments shaped community health centers into “a social welfare program with a low-income constituency” rather than the challenge to traditional medicine that was originally envisioned. Using this same perspective, she shows how subgovernments protected the centers when powerful interests in the government aimed to destroy them. These subgovernments succeeded in blocking the inclusion of community health centers in health services block grants administered by the states. When cuts were demanded, the Bureau of Community Health Services (the federal agency funding the centers and part of the subgovernments) decided to back off from overt confrontation in favor of more limited skirmishes and offensives that allowed the bureau to determine how and where the cuts would be taken.

Sardell highlights the role of the National Association of Community Health Centers, an independent agency formed by the centers to provide technical assistance and lobby on their behalf. Funded largely by government, the association organized its constituency to fight for continued appropriations and battled selectively for its programs. During the Reagan years, the Heritage Foundation, a right-wing think tank, and the Reagan transition team compiled a list of groups that received federal money and also did advocacy work for social program constituencies. Grants were no longer to be given to groups perceived as “fighting the administration,” and the National Association of Community Health Centers was on that list. Acknowledging that the association could not benefit from direct confrontation with the administration to achieve its aims, the group sought support from the Robert Wood Johnson Foundation to become less dependent on government monies for organizational activities. The association’s strategy was to develop networks at the state level to reduce dependence on federal funding and to provide technical assistance to centers to generate more secure payments, for example, through prepaid financing.

The Costs of Survival

The survival of the community health centers, given the demise of many other poverty programs of the 1960’s, makes for an enlightening case study. The literature on progressive agendas in health care has generally focused on failure and on the unequal relationships between powerful interest groups and those for whom health care is just one of many social needs. But in this instance, the forces in the subgovernment were able to shield the program from destruction, even in the absence of strong support from presidents and Congress. Sardell emphasizes the ability of these subgovernments to know when to push for change and when to lay low. But survival did have its costs. The centers were not able to serve nearly as many people and offered reduced services to those they did serve.

Community health centers are now expected to be competitive with other service providers. Cost-effectiveness is the primary concern—a concern that has no meaning when revenues cannot be generated from nonpaying patients. Sardell describes somewhat uncritically the pressure on community health centers to adapt to the new competitive ideology surrounding health
care. Without comment, she reports that the Bureau of Health Care Delivery and Assistance recommends participation in prepaid plans as one of the competitive strategies the centers should be moving toward. The bureau views this as a reasonable course of action for centers in states where "Medicaid programs are aggressively encouraging or mandating recipients to enroll in prepaid, capitated systems" and community health centers could otherwise risk losing their Medicaid patients.

The notion that the centers should compete with hospital clinics and other community health centers for limited Medicaid dollars by developing strategic-planning mechanisms and marketing devices gives us reason to question whether mere survival of an organization is enough. There is no doubt that competition has become the dominant ideology of the health care arena and marketing to capture the best-paying patients a sine qua non of "good" practices. But surely an analysis of successful competition among community health centers deserves more than the one paragraph Sardell devotes to it:

One of the central questions about the future of health centers is whether it will be possible to compete effectively for "new markets" and at the same time to deliver comprehensive primary care to low-income populations—to provide "community responsive practice." The Community Health Center program's future, like its present, will depend on a constellation of forces in the larger health policy and political arenas [p. 199].

To make the community health centers competitive requires eliminating many of the primary care services that make them unique. Dependence on Medicaid limits the possibility of caring for those working poor who are unable to pay. Dependence on reimbursement also limits services, thus reducing the social dimensions of the original program mandate, such as outreach workers. The pressure to incorporate Medicaid patients into managed-care programs is simply the latest manifestation of pressures placed on community health centers to compete as part of mainstream medicine in opposition to the social medicine model of its earlier proponents.

Doomed from the Start

Sardell points out quite cogently that the notion that the community health center movement would result in a restructuring of the American health care system was doomed from the start. The program has succeeded as well as it has because it does not have a direct impact on traditional forms of care. At each point in its history, where it has constituted any sort of threat to organized medicine, it has had to back away. Advocates for the community health centers in Congress and in the bureaucracy had to guarantee that only the poor would be served and that services would not compete with traditional providers. But limiting the population and services to the most vulnerable members of our society also limited the mobilization of additional groups to pressure for systemic change.

Despite the discrepancies between what was envisioned and what exists, the community health centers have had their successes. Health status has been improved in areas served by centers. Hospitalization rates and length of stay are lower, and health centers have been able to improve patients' health outcomes even in the context of cost-effective practices. More important, they have built an important political base in communities in the South. For example, community health centers are among the core organizations in voter-registration efforts.

Sardell's book makes an important contribution to understanding why we have been unable to achieve an organized primary care delivery system through such structures as community health centers. As employers and the government place ever more pressure on cost containment and managed care for both the poor and middle class, we would do well to study her work. Cost, not quality or appropriateness of care, has become the focal point for decision making, and the unequal battle between public and private medicine continues. The results of the conflict Sardell describes constitute a benefit for the more than 500 communities where health services are improved by health centers; but it represents a net loss for a country still lacking an organized, comprehensive, publicly funded program of primary care.

Louanne Kennedy, a member of the Health/PAC board, is Associate Provost and Professor of Health Care Administration at Baruch College of the City University of New York.

The Health Care Crisis: What's a Mayor to Do?

Hal Strelnick

During the height of the drought in the mid-1980's, New York City aired a TV commercial in which Mayor Edward Koch appointed all the city's children as deputy commissioners for water conservation. Corny—yet, according to one of the mayor's staunchest critics, City Councilwoman Ruth Messinger, it was a rare demonstration of constructive leadership on the mayor's part. Water consumption not only decreased, it dropped most dramatically in the low-income and minority neighborhoods that Koch's rhetoric has so often alienated. Creative leadership made the difference.

In New York, as in other cities, the mayor's health-related responsibilities are limited to budgets and appointments for city departments. As a consequence, the politics of health and health care have been narrowly defined around the largely arcane and technical budgetary process. Simply said, health and health care have not been an issue in city politics.

Yet, the chairman of the New York City Council's Health Committee, Joseph Lisa, is predicting "a total collapse of the city hospital system in two years." New York City's hospitals are gridlocked, with 22 of them operating at over 100 percent of capacity. Emergency rooms are so backed up that, on any night in January 1989, some 600 patients could be found in emergency room holding areas, waiting for an open bed, and patients died when ambulances were diverted from hospital to hospital because of the congestion.

This is only part of the problem. The nursing shortage has led to recruitment efforts that resemble bounty hunting; fiscal crises at many major hospitals have prompted hiring freezes and major layoffs. All this is compounded by the convergent epidemics of AIDS, drug abuse, mental illness, homelessness, and growing poverty.

But the financing of most health care lies beyond the authority of the mayor. New York City's contribution to Medicaid funding is controlled by the state legislature and Congress; hospital beds by the state Department of Health; accreditation by the Joint Commission for Accreditation of Healthcare Organizations; and categorical grant programs by Washington and Albany. Environmental standards are set by the federal Environmental Protection Agency. With so much of the control in structuring, regulating, and funding the health system beyond his or her authority, what's a health-conscious mayor to do?

To start, health care must become a priority issue for the mayor and the city. According to most professional observers, this is unlikely. Despite New York's crippling health care crisis, "People don't vote about health. It's as simple as that," says Bruce Vladeck, president of the United Hospital Fund. The four reasons most often cited by health advocates for its low standing in the polls and on mayoral candidates' agendas are: people don't care; many who do care don't count because they don't vote; improving health care means more taxes; and health care, while it has severe local effects, is not merely a local problem.

Beyond the Budget

How can the mayor put health care back on the political agenda? With the public's attention increasingly turning to the city's health care crisis, a health-conscious mayor could turn this crisis into an opportunity.

Borrowing a tactic from former New York City Mayor Fiorello LaGuardia, Boston's Mayor Ray Flynn has captured his city's attention by racing fire fighters to fires and often arriving first. With substance behind them, even political gimmicks and photo opportunities can become compelling symbols. Mayors and TV crews never seem to tire of rushing to the bedsides of wounded police officers; how about rushing to the incubators of low-birthweight infants to dramatize the importance of prenatal care or the consequences of drug abuse in pregnancy? The drama of a baby's day-to-day survival could highlight hospital overcrowding, the nursing shortage, or the costs of high technology. If a mayor can race fire trucks, why not ambulances?

Of course, running to a hospital is not enough. A mayor could volunteer to work with AIDS patients or open Gracie Mansion to a boarder baby or homeless family as they await a permanent home. By starting at the top, the mayor could then approach physicians to offer free care through a joint Medical Society-city hotline, as was done in Ohio during the height of the 1982-83 recession. By treating from five to ten patients each without charge, New York City's 21,000 private practice physicians could care for almost a quarter of a million patients—free.

Faced, too, with overcrowded city hospitals, Mayor LaGuardia, during his three terms, doubled the city's hospital budget and in 1944 launched a then-revolutionary comprehensive health insurance program for New York's working poor. It was this health care initiative that LaGuardia himself believed New Yorkers would best remember him for. Dramatic leadership has led this city to address its past health crises. The fall mayoral election demands such innovation once again.

Hal Strelnick is a Health/PAC board member and a physician. He teaches in Montefiore Medical Center's Department of Family Medicine.
Not Yet a Wonder Drug

I have several concerns about the piece on RU-486 (Vol. 18, No. 4). From what I understand about RU-486, it is not yet a wonder drug. Many women who have used RU-486 also require a surgical abortion. There seems to be a very narrow period of time in which RU-486 is really effective. It is not at all effective for some women. While noninvasive, non-surgical options for abortion is a laudable goal, this drug is not yet ready to be used outside of clinical trials. No long-term studies on side effects have been conducted. To suggest that RU-486 could be available save for pressure from anti-abortion fanatics gives too much power to that (vocal) minority.

I believe that it is in the best interest of women that this drug be studied from a woman-centered perspective before making it widely available.

I think that the French government’s ordering Roussel-Uclaf to resume production of RU-486 so quickly after the company announced a discontinuation of that product attests to the strength of the pro-choice position and the weakness of anti-abortion crusades.

I was disturbed that Anna Reisman uses the term “right-to-life” when describing that movement. Using their words gives them power and credibility. Those people are anti-abortion or anti-choice and need to be labeled for what they are, not allowed to hide behind the untruth and hypocrisy of the terms “right-to-life” or “pro-life.”

With respect to the major drug companies not being willing to take the risk to test market RU-486, I doubt that any threat from anti-abortion activists would be a priority in that decision. Nestlé survived boycotts of their products! However, companies such as A. H. Robbins and Upjohn are still recovering from their experiences with the Dalkon Shield and Depo-Provera, respectively. I am sure that a concern about similar types of bankruptcies from lawsuits, legal liability, and insurance are of greater importance to major drug companies than the threats of boycotts from a fanatic minority.

RUTH COROBOW
Winnipeg, Manitoba, Canada

Home Care: The Struggle Continues

Congratulations to Health/PAC for its excellent coverage of the home health care field and the struggle for justice in the workplace in its Fall 1988 issue. Barbara Caress’s comprehensive article clearly delineated the issues. She accurately described the forging of the labor-management-community coalition with DC 1707 and Local 1199 at its center, and she captured the stages leading up to the dramatic and unprecedented contract victory.

Yet—as Caress noted—as significant as the victory was, it represented but one step on the long road to full justice for the 100,000 home care workers in New York City.

Despite the significant gains realized in salaries (42 percent over three years) and health benefits, home care workers still find themselves among the working poor. These women, 96 percent of whom are either Black or Latino, still lack a pension plan. This is especially significant considering that 65 percent of them are the sole income earners in their families.

Nor are these workers covered by the overtime provisions of the labor law as are home care workers in profit-making institutions. To that end, Assemblymember Frank Barbaro has introduced a bill to end the exclusion of home health care workers employed by non-profit institutions.

In introducing the bill—co-sponsored by a number of other assemblymembers—Barbaro argued that he found no rational basis for the distinction between home care workers in the voluntary sector and those in for-profit institutions. This bill, A. 5984, deserves broad support. The inadequacy of compensation for home care employees contrasts sharply with the skyrocketing need for these workers. Home care has become a key component of the entire health care system.

DC 1707 also is initiating discussions on the pension issue. The time has passed when home care retirees are forced to subsist on meager Social Security payments.

We’ve come a long way, but the future of home health care in this city depends on our ability to travel much farther.

J. J. JOHNSON
District Council 1707, AFSCME
New York, NY

The Editors welcome letters from readers. Letters should be typewritten and double-spaced, and are subject to editing for clarity and space.

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Sauer's Restaurant • 311 East 23rd Street

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