# THE MUNICIPAL HOSPITAL AFFILIATION PLAN IN NEW YORK CITY

## A Case Study and Critique

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### THE CHALLENGE TO THE CITIES

John V. Lindsay, Mayor of the City of New York, has stated:[1]

> We need help from the federal government and—as the emerging centers of an urban nation—we are entitled to it. Obtaining fresh revenue, however, may depend on our willingness and ability to reorganize, improve and reinvigorate city government. It is not an easy task . . . but it is one which is terribly important both to our cities and to our country.

A 1966 *U.S. News and World Report* cover article asked the haunting question: "Does New York City Have a Future?"[2] Ghetto violence and metropolitan government fiscal and organizational decay in most cities have led to the more general question: "Do any of the existing American cities have a future?"

More particularly, a revolution in expectations concerning the pattern of health services in the United States is pressing on the metropolitan areas. Here increasingly are located most of the people in society and at least the potential resources to meet such expectations, although the traditionally defined medical services are often the least resourceful means for achieving health in the metropolis.

In recent years the federal government has launched historic programs intended to assure a high quality of medical care for the elderly and for all persons without adequate private resources to cover their health services needs; to provide wider and more effective regional

distribution of scientific breakthroughs against heart disease, cancer, stroke and other dread diseases; to establish more effective state and local health services planning processes; and to bring new approaches and organization for comprehensive health services into neighborhoods and regions with high concentrations of the poor and deprived. The New York State Health Department has been strengthened, legislation to require regional hospital and health facilities planning has been passed and a liberal state program of coverage for the medically needy (Medicaid) has been created.

The new federal and state government commitments converging on a major metropolis such as New York City provide the opportunity for public health officials to move beyond their traditionally residual and narrow responsibilities to induce and coordinate the entire pattern of health services. Almost all private profit and nonprofit elements of health services are now dependent to some degree on public tax fund support. The present publicly underwritten "medically needy" category in New York City involves, at least theoretically, more than half the population. Placed in the hands of the medically needy is an effective demand to crack through the traditional separate-and-unequal welfare medical pattern to achieve more individual choice of and recall over services and more general expansion of services to reach the most neglected, if public officials effectively utilize the potential collective leverage of that buying-power.

At least a potentially new political and professional setting is seen in the health sector nationally. Scientific, technological and information systems advances might provide the basis for more rational organization of health services and for achievements undreamed of before, although these bump squarely against the institutional obsolescence, social disorganization and anomic environment of today's cities. The new quest for community control of all community services is altogether healthy, especially those programs that affect peoples' very lives and particularly on the troubled turf of low-income, inner-city neighborhoods. The root illnesses are anomie, helplessness and powerlessness. The root issue is new indigenous control and creativity, which leads to demands for decentralization of delivery system control and more sensitive adaptation and correlation of all service program operations. Also, concern is growing, especially in the face of rapidly rising health services costs amid startling disorganization, for more public planning and accountability of community health services.

> In New York City there are few issues in medical care which do not exist and about which we are not trying to do something. Because of the ethnic and economic complexities in New York and its importance as an international cross-roads, if we here cannot solve the intense problems which exist, the world will view us with skepticism.[3]

New York, center of national financial and corporate power as well as crucible of poverty, is a national city. It reflects some of the most troublesome problems of society. Exhibited in its confines are some of the most striking demographic and health trends.[51]

New York City possibly gives an advance look at the future course of national health problems and policies, as the brunt of the supply and demand challenges undoubtedly will be found in the metropolitan areas. These trends include:

1. The shortage of adequate medical care for the indigent minority and the medically needy majority in the core city; the acute shortage of well-trained physicians devoted to such service and a decreasing number of physicians trained and financed to provide a personal integration and access to such service.

2. Skyrocketing hospital and medical care costs; most new public medical insurance and prepayment programs are subject to great inflationary pressures without adequate public regulation.

3. The retreat of voluntary (private, nonprofit) hospital and medical care prepayment and insurance plans from "community" coverage to "experience rating;" the rise of national policy to fill some of the gaps, especially for the aged, but most such programs are still lacking in adequate, comprehensive coverage, accelerating the scatter of fee-for-service practice and generally leaving the actual delivery pattern of service as unsatisfactory as ever—in many cases moving much more slowly than the forces of impoverishment, social dislocation and medical ghettoization and abandonment.

4. Fragmented, discontinuous non-systems of hospitals, nursing homes, health centers and clinics, physician offices and scattered categorical health agencies that make comprehensive coordination and general public accountability virtually impossible.

5. The sharp need for leverage over the extreme variations in the

quality and availability of health care and for bold efforts to rationalize, integrate and regionalize health services.

6. An increasing reliance on medical schools, university medical centers, and major teaching hospitals, which frequently find themselves, as neo-colonial islands in the heart of impoverished ghettoes, unable to provide the leadership for improving the vital and viable hospitals, for delivering comprehensive care, for guaranteeing high standards of care and for bringing the latest developments in medical knowledge, technology and practice for the benefit of all.

Compared to the nation's other largest cities, New York City government provides the most hospital beds per capita and the greatest public financial contribution per capita for private hospital care. New York City is unique in the extent of its traditional commitment of public funds to personal health care and of direct public leadership to shape the pattern of hospital and health services.[4]

The clinics, emergency rooms and wards of the municipal and voluntary hospitals are the "family doctor" for most of the Negro and Puerto Rican population. More than 60 per cent of the hospital patients from these groups are treated in municipal wards. Most of the remainder are "city-charge"—medically indigent—patients at voluntary (private nonprofit) hospitals. Ninety per cent of their hospital care is ward care, compared to 30 per cent for non-Puerto Rican whites. On a per capita basis, outpatient departments are used 3.5 times more in New York City than the national average; emergency departments are used 2.3 times more. Forty per cent of the hospital beds in the city are owned and operated by the city, as are about 25 per cent of the general care beds.[5]

New York is a city of giant control of resources. A larger share of the total hospital bill than in all other United States cities is paid by the more aggregate sources in New York City: municipal government, private philanthropy and Blue Cross.[6] That consolidation of assets makes planning and control of the hospital ssytem at least potentially more streamlined, although the scope, scale and scatter of programs, institutions and agencies makes coordination difficult and complex.

Yet, despite these resources and commitments, one finds great inadequacies in the quality of treatment, diagnosis and prevention for most persons of low income and of deprived minority group status. During the past 15 years a rapid immigration of low-income Negroes and Puerto Ricans and a rapid emigration of middle-income whites

has raised new challenges to New York City's economic and services system. Now, almost 20 per cent of the population is either Negro or Puerto Rican, more than 12 per cent of the former and seven per cent of the latter. Southern New York increased more than 50 per cent in Negro population between 1950 and 1960, more than twice the national rate.[7]

The city of New York has the formidable task of governing and providing services for a jammed and diverse population of eight million. More than 25 different public agencies—federal, state and city—are concerned with the provision of health services in the city.[8]

The New York City Hospitals Department was founded in 1929, from a part of the City Health Department and some independent municipal hospitals with a history stretching back to the founding of Bellevue Infirmary in 1736. In 1966, the 21 different Hospitals Department institutions included seven major hospital centers, which incorporated some special institutions within them, seven individual general care hospitals, three separate special institutions (cancer, chronic care, nursing) and Gouverneur Ambulatory Care Unit. Departmental responsibilities included inpatient care (about evenly divided between general care and chronic care beds); a rapidly expanding census of outpatient care—including a growing amount of psychiatric care in cooperation with the Community Mental Health Board; control of city ambulance service; emergency service (about half of the inpatient admissions enter through emergency rooms); home care and nursing education.

In 1965, about 5.2 million patient days were spent on the wards in 18,373 hospital beds and about 750,000 patient days of home care. More than 3.2 million clinic visits were recorded. The more than 36,000 full-time and part-time Hospitals Department employees make up 17 per cent of the total of the city government's employees, excluding house staff, pupil, professional and practical nurses, and those physicians employed on a fee basis. Physicians and surgeons on hospital staffs numbered about 9,000.[9]

## BEHIND THE AFFILIATION PLAN

Problems: In the late 1950's, widespread professional and public concern was expressed about the problems of city hospitals in New York. Once the proud expression of the city's historic role of providing decent medical care for the needy, once a favored assignment of in-

terns and residents from throughout the nation seeking a superb training experience, and, after World War II, the recipient of a major new construction program, they were by the late 1950's the object of scorn. Some municipal hospitals were threatened with loss of national accreditation and training approvals unless medical staff and general conditions and operations improved. In particular, those municipal hospitals without full academic ties were almost entirely without any American- or Canadian-trained medical graduates as house staff and were losing attending staff. Facilities had become obsolescent; clinics and emergency rooms were disgracefully jammed; nursing staffs had dwindled; supplies and equipment were totally inadequate.

Private Priorities: In 1959–1960, key concerns of the "Health Establishment" of New York City were reflected in reports of a special Mayor's Commission and of the Hospital Review and Planning Council of Southern New York.[10] Not only were the physician staffing crisis and the general deterioration in many municipal hospitals stressed, especially in those hospitals not associated with medical schools, but also great concern was voiced about how to provide large infusions of capital funding, greater patient care reimbursement and more teaching and research access to ward patients for the sagging private voluntary hospitals.

The Plan: A so-called "Affiliation Plan" proposed to solve these problems and priorities simultaneously by bringing many municipal hospitals under the professional wing of voluntary hospitals and medical schools primarily under full-time hospital-based medical chiefs of service for a high tax-supported price.

> A charter amendment cleared the way for the city to "enter into contracts with any university, medical school, or non-profit hospital . . . to provide and supervise . . . all or part of the professional and related staff in the operation of any institution or service under the jurisdiction of the Department. The personnel so provided . . . shall not be deemed to be employees of the City of New York."[11]

The plan had emerged by 1961–1962, under the leadership of Commissioner of Hospitals Ray E. Trussell, as the solution to be applied across the board as basic city hospitals expenditure and administration policy. It reflected a "system ideology" antagonistic to public sector planning, direction, management and provision of health services, and reflected a quest for placing all health facilities under the control of existing private voluntary hospitals and medical centers.[12]

## END OF IDEOLOGY?

Predictions have been made by some pundits that, as the technical area of judgment in medical care is broadening with new capabilities of measurement and analysis, the "ideological gap" among different professional and institutional health forces will be substantially narrowed.[13] Interviews in New York City, however, did not indicate any decrease in ideological conflict. Most parties involved appeared to see the struggle to determine the "ideology" of the municipal hospital system as an exemplary struggle for setting the path of health services social change throughout New York City.

For the protagonists the battle appeared to go much deeper than matters of technical judgment. Four loose, professional, ideological groupings might be categorized as involved either openly or behind the scenes in the struggle over the Affiliation Plan over a period of almost five years.

*The Corporate Voluntarists,* in this case headed by the Hospitals Commissioner and private voluntary institutional forces (certain private voluntary medical centers and hospitals, Blue Cross and other insurance plans) that backed the Commissioner's affiliation policy, favored partnership, as David Heyman, Chairman of the Mayor's task force in 1961, said: "relegating government participation to providing the money but not the management."[14] They generally saw little hope for government directly carrying out effective medical programs, they said, because of political meddling and over-caution, civil service and red tape rigidity and inadequate public finance. That was the local equivalent of the national professional and institutional "Medicare coalition," the primarily voluntary "organizers of medicine" who were engaged in a national battle with the more conservative elements of "organized medicine." They felt that the "voluntary sector" should be paid full-cost-plus by government to take responsibility for insuring and providing health service on terms favorable to the existing pattern of voluntary institutions.

*The Practitioners* were fighting, they said, to maintain the hospital as much as possible as a "community workshop" for solo practitioners, to emphasize the importance of the solo practitioner and practitioner-teacher as opposed to the researcher-teacher, and to preserve the fee-for-service private pattern plus volunteer charity care against a generally hospital-based system.[15] They included by no means all the private fee-for-service practitioners, many of whom have increasingly favored

part-time appointments with academically controlled teaching hospitals or medical schools and have not concerned themselves about practitioner independence. Of course, many of the voluntarists were not against fees, either; they just did not go that far in fighting for the dominance of the "independent" part-time attendant within the hospital. Ironically, the city government hospitals, before affiliation, afforded solo practitioners the opportunity for part-time, responsible positions on medical boards much more so than did the voluntary hospital system.

*The Patricians* were certain elite medical school scientists and leading clinicians who saw medical quality as a very scarce asset that could not be expanded too rapidly. They opposed the medical school devoting too much attention to the "social" problems of medicine at what the patricians believed to be the expense of their teaching and research programs. They were often sympathetic with the practitioners' complaints against the middle-level exclusivism of teaching hospitals. Their essential view of medical practice was that the medical school teaches and develops medical breakthroughs in the capstone centers for the solo-practitioner who carries the load in the community hospital and in the broader community. They were cautious and critical of "downtown" schemes to integrate all parts of the medical system too quickly under the private command and responsibility of a few medical centers.

*The Progressives* were in favor of moving in the direction of publicly guaranteed health insurance and a more socialized health service and favored a cumulatively stronger role for government as regulator, demonstrator and at least compensatory deliverer of medical care as well. They opposed government serving only as a finance agent for private institutions and programs. Their emphasis most often was on community service, social medicine and ambulatory care, as well as on the core in-hospital setting. Their view was that the public sector was too weak and rigid then, but that it should be thoroughly developed to assure a publicly-accountable, single-high-standard system of care for all, and not be abandoned to totally private control. Their vision was of an increasingly integrated system under general public authority. Some might have countenanced delegating more responsibility for the delivery of care to nonprofit hospitals if it meant that those hospitals effectively became closely regulated public utilities. They staunchly opposed, however, simply applying public investment to the loose support of voluntary hospital domains and of increasingly relying on voluntary or private insurance "intermediaries" for social insurance.

Trussell's candid antipathy to "rigid civil service staffing" and

"bureaucratic red tape" led him to savor particularly the "necessary budgetary flexibility" of the affiliation contracts. "The city," he said, "is purchasing a total service . . . and the budget allowed is to be spent according to the prevailing practices of the affiliating institution."[16]

It is important to note in considering the actions of such a noted liberal public health leader as Trussell that his "voluntary ideology" runs much deeper than tactics. A strong thread running through his social analysis and strategy was a contempt for government "entanglements" (as deep as his opposition to proprietary hospital profits).[17] He borrowed some of his Affiliation Plan approach from the national Veterans Administration hospitals policy of affiliating with medical schools and using "deans' committees" for staff selection, but he trimmed away the strong public administration aspects of that policy and added greatly to the private institutions' affiliation responsibilities and authority. He asserted in one interview: "Spare me from the government system." He predicted the Veterans Administration hospitals would never be able to survive their civil service restrictions; he said they could not "meet competition."[18]

That, he said, was the special value of the lump-sum budget spent in the voluntary sector. He criticized the managerial inability within the public service to raise staff positions selectively that were in scarcity and to organize institutions internally in a flexible, directive way.

A basic breakdown of trust in professional and political circles in New York City thus threatened to paralyze the municipal health services pattern. Underlying these conflicts were deep-seated ideological notions of what should be happening to the system that made the attainment of one particular path of development most difficult. Systems do not easily lend themselves to multiple paths in the basic ideological sense because, if they did so, they would break down as systems.[19] Deals and trade-offs can be made about the location of hospitals and who gets to be on attending staffs, but the basic unitary logic and status ordering of a system cannot be so easily bargained away.

Some of the conflicts were not so much ideological as they were based on different analyses of New York City health services problems and potentials: 1. e.g., whether different persons saw the problem of municipal hospital medical staffing as due to lack of prestigious medical school or voluntary hospital ties or simply because of lack of basic public investment in direct salaries and equipment, allowance of more managerial flexibility and other basic factors (or whether it was deemed possible at all to upgrade the municipal system directly in this way);

or 2. how different persons assessed the matrix of political power and professional resource potential in the city to move in a given direction.

Closely involved in the affiliation battles were two interested groups without physicians' credentials. The municipal hospital employees viewed the municipal hospitals as a public trust and viewed basic public employee working conditions and promotional, training and compensation guarantees within them as essential. They, or at least their union representatives, saw the affiliations as an attempt to demoralize and scuttle public employment in hospitals just at the point when they had won city-wide collective bargaining for public employees.[20] Some of the people of lower-income neighborhoods, who have relied on the municipal hospitals for much of their medical care, have fought through various community organizations to keep a municipal community hospital in those areas. They wanted some concrete assurance that doctors would be nearby. Community resistance gave a new lease on life to Gouverneur Hospital on the Lower East Side of Manhattan in 1962, and brought forth a rather exemplary ambulatory care program in the interim. Such resistance also gave an interim lease on life to Fordham Hospital and probably paved the way for a pattern of guaranteeing at least ambulatory care services for all neighborhoods, even if municipal hospital services were to be more consolidated.

The Hospital Council study and the Mayor's task force report were a major display of the thinking and power of a growing coalition of voluntary hospital and insurance interests and pragmatic public health and medical school leaders. One federal public health administrator called the coalition behind the Affiliation Plan "the most powerful one in metropolitan medicine in the nation."

Trussell said that this coalition was a marriage of mutual convenience in the public interest. He said the municipal system needed the quality, recruiting power and managerial flexibility of the better voluntary hospitals, and that the voluntary teaching hospitals needed the additional financial support and expanded access to patients.[21]

According to Trussell, the affiliation plan was to assist the voluntary hospitals in two ways, in addition to the direct cost-plus financial grants to the affiliating centers: 1. "Any shift of training costs to a tax base through an affiliation automatically strengthens the survival potential of the voluntary system,"[22] and 2. "freeing up ward beds which are a drag on the financial solvency of the voluntary hospitals for private and semiprivate beds, which are in great shortage in our good hospitals

in New York City."[23] Private insurance plans, of course, favored any transfers of revenue to the voluntary hospitals that helped these hospitals to cover their costs.

## THE PUBLIC ENTREPRENEURS

Paul Ylvisaker once coined the term "public entrepreneur" to apply to a mover-and-shaker in the public arena who gets things done.[24] Harold Kaplan provided a classic study of a public housing director he called a "political entrepreneur" who worked to harness political and private power to clear slums and build new buildings and housing, working in close partnership with the mayor.[25] Students of health system social change should develop a useful schema for assessing the health services public entrepreneur, the expert in "medical urban renewal."

Trussell, as Hospitals Commissioner, provided a stunning model of a dedicated individual who used every conceivable role-aspect of political, organizational and personal leverage to achieve his particular policy approach. Using sociologist Ray Elling's list of power variables,[26] one notes that Trussell ran the scale, for example, as follows:

*Ideology-influence:* publicly released reports emphasized a particular idea of medical quality associated with a particular medical status system and system of medical organization.

*Myth-making ability:* use of a particular theme and analysis, played constantly in the press and other media.

*Technical knowledge and skills:* mobilized through university prestige and status (although the internal conflicts with the medical establishment at even his own university base gave pause).

*Control over economic resources:* entry into the Mayor's "hospital reform" post, 1961 to 1965, carried guarantees of a vastly increased budget, crucial as both carrot and stick.

*Control over organization:* within the Department attained through sheer stridency of personality as well as reference to a privileged political position, although the complaint was voiced of too much one-man concentration on individual battles and no development of general administrative strength in the Department except for perhaps a few chosen associates.

*Authority of office:* invoked as its latent powers had never been before; legal battles were fought to secure vested executive power.

*Prestige:* came rather easily in the public eye for an academic medical figure, a scientist, a crusader of sorts, although a "public health" background caused some professional difficulties.

*Political support:* flowed independently from a position as a strong figure in public health and political advisory circles, and from his regular position (on leave as Commissioner) as Director of the School of Public Health and Administrative Medicine at Columbia University; (in addition, the creation of supportive community organizations, e.g., the Harlem Health Council).

*Charisma:* a strong reputation for "drive" and single-mindedness molded in a sometimes searing, sometimes engaging, strong personality that stimulated either intense loyalty or opposition.

*Willful refusal of the will of another:* acted out in various showdowns with particular hospital medical boards over installing affiliations, particularly the climactic heading off of a "strike" at Elmhurst Hospital and the "firing" of the head of the medical board, an arch-rival, over affiliation.

## THE RESULTS

By 1965, after many battles to install costly, omnibus and loosely defined and administered affiliation receiverships, more than a dozen city hospitals were being directly and indirectly financed under the new pattern. An uneven array of private voluntary hospitals (some not affiliated with medical schools and some having weak teaching and medical programs) and a few medical schools thus were granted tax-supported working capital and facilities expansion plus patient-population control (admissions, referrals and so on) and geographical domains "to grow on." The affiliation contracts in less than five years amounted to more than $200 million in appropriations (including ten per cent payment as "managerial method") for institutional grants expanding private teaching and research programs. These were without community plans or general requirements for the pattern of service. During this period the city also increased the payment level and expanded the number of city-charge reimbursements for all private voluntary hospitals. The pattern of city tax fund subsidy to the private sector

of health services was thus greatly expanded—even for the control and operation of what remained of the public sector of services.

The Hospitals Department was clearly unequipped for the great leap from direct service operations to contracting privately for most of its vital service and leadership activities. Because of the unavailability of a clear public plan or framework for evaluation, an alternative pattern for comparison and an effective public review process, the city's top health administrators, as well as the general public, were not fully informed of the irregular pattern of these arrangements.[27] They were shaken by the public exposé of these arrangements in late 1966.[28]

*Some Improvements*

Given a doubled Hospitals Department budget in about five years, some improvements were, of course, noted in institutions under the Affiliation Plan, although that was not necessarily evidence that other, more direct, approaches would not have been at least as successful. The quantity and the educational certification levels of physicians were increased at a number of hospitals, relieving some acute medical staff shortages.[29] Some new medical care programs were launched, but too often as limited "demonstration projects" for particular research interests rather than comprehensive guarantees of service to the surrounding communities.[30] Even the recruiting of physicians—the heaviest Affiliation Plan expenditure emphasis—generally lacked the needed depth and range, actual service time, appropriate integration and community medical care programs so desperately needed. The evidence regarding the change in the pattern and quality of medical care was mixed and disappointing, given the large increases in expenditure.

*New Private Control*

The affiliations generally amounted to one set of private priorities and patterns in many municipal hospitals (formerly fragmented, part-time, private practitioner-dominated medical boards and staffs), being replaced by another set of private priorities and patterns (often lowest-priority services from private voluntary hospital and medical school-based staffs in a frequently narrow, specialized, research-case-extraction setting). Academically based, associated or oriented medical institutions (medical schools and voluntary teaching hospitals), even though they usually have contained a high technical quality of professional resources, frequently have brought many unfavorable elements in carrying out medical programs to meet the pressing community needs.

These elements have included: 1. super-specialization and fragmentation of services with emphasis on the core-center activities to the neglect of general community outreach;[31] 2. overriding research and teaching-demonstration interests, which lead to medical selectivity for only "medically interesting" patients, the dumping of "uninteresting" patients, and preoccupation with episodically "interesting" procedures not always in the best interest of the individual patient;[32] 3. patrician exclusiveness from hospital experience and continuing education of community physicians who lack high credentials as specialists.[33]

Thus, although many of these institutions have been considered the guardians of medical quality and scientific advances, it appeared that without strong, countervailing community planning and surveillance and public administrative-regulatory controls, they were not likely to provide the needed continuous, comprehensive, personalized pattern of health services for the total community.

*Losses and Limits*

Some of the following disadvantages and limitations of the Affiliation Plan in actual operation were observed:

1. Benefits in the form of city financial aid were intended to accrue to private voluntary institutions. Under loose city supervision the arrangements led in some cases to highly questionable institutional and individual misallocations of funds, equipment and service operations.[34]

2. Control by city government administrators was lacking or severely weakened and no community representative controlled these affiliated institutions. In addition, dual public-private administrative patterns often led to conflict and confusion within hospitals and a severe drain on the morale and standing of city personnel. No one was clearly responsible for overall program development in most cases. Without effective public planning and review, the necessary reorganization of services was not achieved to meet personal and community health needs most effectively. Patient dumping and questionable research projects and procedures were rife without city administrative control of internal hospital operations.[35] Persons dependent on city hospitals appeared to be increasingly eligible for the world's most excellent care for the exceptional and interesting case and yet subject to the unavailability, inadequacy and negligence of medical care for the ordinary case and particularly for routine preventive and diagnostic services.

3. Planning by particular private domains with their own private priorities—reinforced by a voluntary, hospital-dominated, regional hospital planning council and passive city government deference to it—made these institutions essentially unaccountable to the publics they served, either in the immediate community or as city taxpayers. That amounted to "private government" over vital tax-supported public services. No public planning process for health services, city-wide or on the community level, was developed. In fact, that capacity was weakened in contracting with private institutions for most professional and administrative leadership. The priority of each private affiliating institution was usually for the expansion of its own particular domain without reference to general service needs. Without adequate public planning and allocation, costly and dangerous proliferation of scarce "prestige" items of equipment and medical capacity have been the result.[36] Also accelerated or continued as a result of the lack of overall planning under affiliations were patterns of maldistribution and skewed utilization of hospital beds and of obsolescence and imbalanced design of facilities.

4. Imbalances of priorities in concentrating on top medical specialists, new facilities and major equipment purchases led to the serious neglect of auxiliary staffing, of development of effective utilization of existing manpower, of routine but vital supply items, of preventive maintenance and of overall integration of programs. Those larger municipal medical centers already with affiliations arranged before 1960 (almost all with medical schools, usually more limited in nature than the Affiliation Plan arrangements and usually with only nominal public contractual costs), were generally neglected in the surge of new affiliations expenditures and were allowed to deteriorate. Such imbalances might just as well have been calculated to create a situation in which these city government programs and institutions, as well, having lost much of the capacity for direct city improvement, would have to rely on expanding private affiliations or receiverships.[37] Many of the city hospitals' problems of staffing, supply and facilities deterioration, cited in 1960–1961 as the reasons for needing a sweeping new approach such as the omnibus private affiliations, still existed in 1966–67.[38] The underemployment and improper utilization of persons on existing city hospitals auxiliary staffs were tragic losses of this period of shifting to private direction, management and recruiting.

5. Losses of great opportunities, to improve the general pattern of health services, given the great increases in city expenditures, especially for the medically needy, were particularly disappointing. Most of the difficulties remained or were accelerated—the incorrect utilization of many institutions and the gaps in appropriate facilities and services, serious lags in ambulatory care services and adequate extended care facilities, and particular health service needs that remained generally unmet (e.g., prenatal care, first-stage mental illness, geriatric problems, dental needs and even untended feet problems). Great personal and family difficulties were still encountered in the medical pattern—rejection from hospitals, jammed and fragmented emergency rooms and outpatient services, services unavailable at convenient times, perfunctory professional attention, little dignity or basic amenities for the patient, no follow-up from particular episodes of service and so on. Despite new economic entitlement under Medicare and Medicaid and the contractual purchase of new private professional resources for city hospitals, other patterns of discrimination—on ethnic, social, age and medical interest grounds, and on grounds of means of referral or entry —continued to combine with economic forces to block the achievement of medical care equity for many persons. The fiscal lag of compensatory public expenditures have been used and have done little to counter the inequities.

Certain low-income neighborhoods of the city were losing hospitals to less needy areas as a result of the affiliation arrangements.[39] Other hard-core poverty areas continued to lack comprehensive health services, despite the affiliation arrangements of the municipal hospitals serving their general areas.

Thousands of physicians (and thus their patients) lost staff connections to city hospitals as a result of the mdeical staff turnover under new affiliations. That added to the problem of more than one-third of New York City's physicians being without any meaningful hospital appointments, outside the mainstream of medical development. Ironically, a proposed city government plan for administering Medicaid required physician attachment to hospital staff duties and continuing postgraduate training to be eligible for reimbursement, while city hospital affiliation arrangements pushed many physicians out of such opportunities.

6. Costs to taxpayers of the affiliation arrangements were increased not only by privately misallocated city tax funds, but also by the imbal-

ances in services direction and program priorities that take years and great new expenditures to adjust fully. These opportunity costs totalled at least the 200 million dollars budgeted for the new affiliations during the first four or five years. Many opportunities were also missed, because of a shortage of capable, imaginative direct city administrative capacity, for federal grants (e.g., for health facilities construction, manpower training and research)[40] and for additional private payments from patients or for federal-state reimbursement coverage, including full and speedy Medicaid and Medicare implementation. The average cost per patient day in municipal hospitals rose from much lower than the average daily cost for all patients in private voluntary hospitals in 1962, to clearly above the voluntary hospital average in just four years (although the base of these figures was not clearly comparable).[41] Thus, particularly for this level of expenditure, the results in the overall medical care pattern were disappointing. The city taxpayers had been paying millions of dollars for support, in effect, of education and research programs whose benefits were primarily national and international. Open-ended salary and fee arrangements and high contractual recruitment costs pushed the general escalation of physician costs in the city. No end was in sight to the rising inflation of city hospital costs begun under these arrangements.[42]

*One-Sided Partnership*

What was apparent in 1966–1967, as a new mayor attempted to develop a more systematic pattern of health policy and administration, was that the heralded "partnership" between city government and the private voluntary sector under the Affiliation Plan had been full of holes. Not only had it led to numerous cases of questionable private use of public expenditures and suspect medical research and admissions policies; it had also led to the deterioration of the capacity of the public sector to exert overall health policy and program leadership at a time when it was most needed. The affiliations had been launched as an intentional subterfuge of the existing city government administrative and personnel pattern, a stopgap measure primarily to solve a particular physician staffing problem. They were continued as an expedient because of drained direct city professional and recruitment capacity. The vicious cycle went on.

City hospitals were thus rarely the coordinating centers for community health programs, but, instead, were usually either the colonies of

particular private hospitals or medical centers with generally rather narrow program priorities or were hopelessly deteriorating centers suffering years of public neglect.

*A Case of Libel*

The omnibus affiliations for city hospitals thus represented another step in the continuing libel against the potential of publicly owned and controlled institutions and services because of the traditional stigma of welfare institutions, the scarcity of public finance for direct improvement of public institutions and the unwillingness to modernize directly an antiquated, rigid and strained city administrative pattern.

*A Basic Mistake*

Basic questions concern not only the way in which these arrangements were implemented and administered by the city. The whole precedent of delegating to private institutions lacking broad community accountability the responsibility for staffing, operating and, in effect, for making policy for major public hospitals and health centers was basically misguided, especially without an effective, publicly accountable pattern of planning and administration. The creation through public policy and expenditure of a scatter of particular private domains to plan and organize basic health services for the city was patently limited and precipitous; especially when most of these institutions appeared to be generally incapable of mobilizing most efficiently and effectively the total health care resources and of guaranteeing excellent, equal and appropriate health services for all citizens within a framework of clear-cut public planning and accountability and community-wide decision-making.

## SYMPTOMS OF A MORE GENERAL MALAISE

*A symptom.* Clearly the Affiliation Plan and its effects have been symptoms of the general lack of a creative, comprehensive approach to solve the basic problems of the health services pattern on the part of government, civic and professional leadership in New York City. These are symptoms of national problems, as well.

*Laissez-faire industry.* The health services industry nationally, despite its great scientific and technological capacity, must be characterized as perhaps the most primitive and *laissez-faire* organizationally. Although all health services are theoretically linked by a highly specialized

division of labor, from sub-professional neighborhood health aids to world-renowned open-heart surgeons and from storefront clinics to major medical center complexes, the actual communication and information pattern is incredibly spotty and lacking. Health services are now caught between hand and computer technologies and between styles of individual interpersonal service and mass organizational production, without a common logic or system ideology. Effective methods have not been generally accepted by either professionals or the general public to make individually directed service both efficiently organized and in a personally responsive pattern.

*Industrial revolution.* A scattered, private and corporate "industrial revolution" in health services, given a considerable boost by government financing of research, education and services, can thus be seen dawning in New York City. It is highlighted by the city's granting of great tax support and authority to private "organizers of medicine" (under private voluntary hospital and medical school auspices, endorsed by their philanthropic backers and private financial intermediaries) up and against the claims and protests of "organized medicine" (local medical societies and other professional guilds are still the voice of the solo-practitioner who is primarily based outside the hospital and medical school setting). Lack of public efforts to integrate the total pattern of health services exacerbates the loose, costly, dual economy of medical care between the corporate hospital and medical center-based physicians and the medical free enterprisers. The latter are usually either denied meaningful access to the centers with the latest scientific developments and technologies and finest staff assistance or they control the smaller community hospitals in a costly, haphazard, generally unaccountable way. Yet these practitioners and their organizations still have great financial claim to a scattered personal medical market. They are benefitting, for example, from the separate inputs of public financial coverage for personal health service on a fee-for-service basis, especially more recently under Medicaid and Medicare. That duality is perhaps more generally pronounced and divisive in the New York City core metropolis, with its most concentrated, yet uneven and diverse pattern of medical professional resources.

*Excellence for the few.* Some of the best medical care in the world is available in New York City hospitals, especially at the major voluntary hospitals, particularly through private and semiprivate room coverage. But the narrow priorities and limited range of these elite hospital and medical centers—usually accepting only the wealthiest and most

prestigious or the most medically interesting cases and offering special lines of intensive care only—generally prevent them from developing programs that provide equal, excellent health services for all citizens. The health services pattern in New York City has offered truly excellent, comprehensive care to only a small proportion of the population.

Personal health services increasingly are sought desperately in jammed emergency rooms and through distant telephone answering services. The so-called guarantee for a "free choice" of physicians is for many citizens a cruel joke. Serious maldistribution of hospital services is reflected in impossibly long waiting lists at the few truly excellent hospitals and community panic and protest at the loss of even clearly inferior hospitals in hard-core poverty areas.

By far the greatest proportion of the private hospitals, both voluntary and proprietary, are of highly questionable and uneven quality, lack continuous top physician and paramedical staffing and an adequate range of medical services and usually are poorly related to other kinds of health services and social services. City hospitals and health centers, as already emphasized, generally have been left to become dumping grounds and professional spillovers of private institutions.

*Obsolete patterns.* Several types of existing medical care institutions and patterns in this metropolis are clearly obsolete:

1. The multi-thousand-bed hospital with dozens of different clinic lines, almost always too unwieldly, distant and fragmented to be operated effectively.

2. The isolated and neglected large nursing or chronic care institution that becomes an asylum more than a medical institution, as with so many ungainly mental institutions or mammoth psychiatric wards.

3. The small hospital with less than 200 beds; fragmented and narrow ambulatory care services; lack of effective, around-the-clock internal organization and full-time staffing; and few ties, on the one hand, to major medical centers, and on the other, to health professionals, social services agencies and broad-based organizations in the community.

Most present modes of public and private financing of health services continue to encourage the institutional lag and maldistribution, professional unevenness, and cost-escalation by covering the present antiquated patterns of delivery in narrow and episodic ways.

*Origins of inequity.* The problem of great inequity in the availability of excellent medical services appears to boil down to the basic facts of medical economics and medical professional organization in the United States. Without more regulation of the range of payments bidding for physicians' and health professionals' services and access to basic and primary medical care, the social distance and the income lag (including public supplement and guarantees) of the lower-income population will almost inevitably place them in poor, second-class conditions. They are not now being granted equal access on the basis of medical need or even random access in a generally available services system. They continue to be the lowest bidders for the least-prized services—a reflection of their very low-income and low-status condition.

*Leadership gap.* The greatest gap of all in health services is the lack of generally accepted leadership. The general responsibility or ability to command the whole range of resources necessary to achieve needed systematic reorganization and coordination of health services has not been assumed by public health agencies, by academic institutions, by hospitals and "organization medicine" or by general professional "organized medicine" forces. The traditional weakness, narrowness, fragmentation and residuality of public health agencies—from the federal to the local level—have led to increasing reliance on private fiscal intermediaries, medical schools, private voluntary hospitals and voluntary hospital councils, to pull together the scattered pattern. But thus far, relying simply on such private governments, as demonstrated by the results thus far under the Affiliation plan, has produced only disappointment.

What is being learned, apparently the hard way, in New York City, as well as throughout the nation, is that great institutional obstacles hamper the fulfillment of the executive promises, legislative acts and even the large public expenditures for public purposes such as the improvement of city hospitals and equal access for all persons to a high quality of medical care. Even the academic guardians of medical quality and the most progressive organizers of care among the major, private, nonprofit hospitals cannot be counted upon by themselves to deliver the needed services in the most efficient and effective way.[43]

## SOME QUESTIONS ABOUT "VOLUNTARISM"

This has been called the age of the "contract state." If "creative federalism" or "progressive partnership," those Johnsonian euphemisms, are the wave of the future, new governmental teeth and a new public yardstick must certainly be developed. Otherwise, the pluralistic social responsibility, the best of both worlds, will not arise, but, instead, the spectre of state feudalism, a mixture of loose public finance and elite private purpose, the worst of both worlds, will develop.

In light of the voluntary-dominated Affiliation Plan as a privately engineered public solution for New York City's problems, some general questions should be raised.

How accountable are these so-called voluntary institutions to the public when their planning processes and financing systems are run behind essentially closed books by the private producers? How accountable when the public sector is assigned to those jobs the private sector finds uninteresting or unprofitable and to following the lead of the elite private sector on public policy?

How voluntary is an organization dominated by the commercial and professional power structure or by a producer-dominated board of directors? How nonprofit is a large organization with large retained earnings for expansion; high administrative costs; large salaries, expense accounts and fee divisions for the staff and assured ties to more profitable enterprise?

Paradoxically, a prerequisite for adequate financing of local health services programs and adequate leverage for regionalization and coordination under present metropolitan conditions is the involvement and approval of the local economic power structure. The "power budget" of the health services system in reference to these forces must be at least at a certain minimum to be effective.[44] But, once this private mobilization is taking place, the problem of making the structure publicly responsible becomes the critical one. More than simply mindless government sanction of that private process must be involved. New variables of general public interest and concern must be brought into the policy mix. The possibility exists of inducing micro-planning, particularly within institutions, via cleverly developed hospital planning councils,[45] which can form constraints on inefficiency and irresponsibility. But still generally lacking is a broadly accountable and participatory set of social forces in the planning processes.

*Not New York alone.* Some of the national imbalances cannot be corrected by even the boldest actions of New York City government

alone. So long as such a scattered, lucrative and open-minded "sellers market" exists in physician services nationally, attempts to organize services most efficiently and effectively will be blunted. So long as such acute national shortages exist in professional health manpower, many of the gaps in staffing will be almost impossible to fill, unless sweeping reorganization of services is achieved. So long as federal and state health programs and legal requirements are so uncorrelated and narrowly designed, the city government cannot move effectively. On the other hand, until New York City and other cities attempt to establish their own unified systems of health policy and administration —from neighborhood to region—and begin demanding that federal and state programs be redesigned and financed to match more effective local patterns, requirements and specifications, the necessary national changes will likely not be made.

*Added difficulties.* Some additional factors make the general constraints within the health services sector all the more difficult in a metropolis the size of New York City. These include the scale and complexity of its services pattern and the diversity of its people in a sector of professional and scientific calling not generally known for its breadth of social vision or its tolerance of ambiguity and diversity.

*Bigger than one sector.* The extent to which New York City citizens —living in such a densely settled area with a decaying social infrastructure and an inadequate government and fiscal base to cope with its complex problems—can mold their own futures is an open question, even in a particular sector of activity such as health services. Some forces beyond the arena of health policy may have a decisive effect on what can be done for health services—for example, national priorities being shaped by the war in Viet Nam, increasing bitterness in the ghetto and backlash in the suburbs, the decline and fall of the war on poverty, increasing desperation of local governments for adequate fiscal bases and so forth. It is also difficult in a particular sector of services to transcend the general inequities of income distribution and private market distinctions, especially when the income and social structures have traditionally been so important in bidding for that particular personal service. Public services' residuality to private expenditures'; the welfare stigma of publicly provided services; the neglect, deprivation and exploitation of low-income ghettoes; the colonization of most such areas by outside-controlled economic and services enterprises— these characteristic national problems are not to be easily overcome by action in only a particular sector of services. That is especially true

when the sector has been so narrowly defined and loosely related to other social services and community activities in the past. Its practitioners usually have responded only to certain symptoms of social and personal difficulty without demanding that other actions be taken to get at basic causes.

## MODEST PROPOSALS: NEW FRAMEWORKS, NEW FORCES

Given the difficulties of reforming one services sector of a metropolis when such action has been so weak, residual and misguided in the past, the survey[51] has viewed the need for a totally new approach to health services on the part of New York City government.

It is obvious that a crisis of medical neglect and inequality and skyrocketing hospital and medical care costs exist in New York City. The only way to begin to cope with this crisis is to create a single city policy-making body for health services and a flexible and functional public agency with decentralized responsibility and capacity for public health leadership to coordinate effectively all health services at the district and neighborhood levels.

The new frontiers in public health are in developing a total, balanced system of health services with emphasis on the total environment and the health needs of all people. Assuring excellent personal health services for all citizens today is a public health function. A new public administrative framework should provide those necessary central planning, review, regulatory and contracting functions and large-scale construction and certain other staff services within the unified agency, while delegating day-to-day decisions to decentralized district, neighborhood and unit health administrators. Public health administrators should develop carefully planned and coordinated district and neighborhood health programs that blend all public and private institutions and professional services most efficiently in a teamwork setting.

Community accountability should be strengthened through establishing broadly based hospital and health center boards and district and neighborhood health planning and review councils. Metro-regional public planning responsibilities for hospitals and health services should be unified in a single city health planning and review council.

The new Medicare and Medicaid financing for personal health services makes medical equity more of a possibility, but the existing skewed availability of services and the distorted fee-for-service pattern greatly obstruct achievement of the needed comprehensive services for

all. The basic pattern of health services must be changed at the neighborhood level, along with all other community services, to be sensitive to people where they encounter programs. A complete network of comprehensive neighborhood health centers and services—controlled and planned by neighborhood residents with professionals "on tap, not on top"—should be created, especially in hard-core poverty areas. Services must be organized on the principle that much of the greatest need will not be self-delivered, but must be sought by trusted neighborhood organizers, ombudsmen and health advocates and must be convenient, attractive and in social proximity to community activities.

The considerable breakdown in citizen and professional confidence in the accountability and capacity of public leadership for health in New York City must be overcome by an active new consitituency of citizens, health workers and progressive health professionals. They must demand, confront and create more effective public health leadership, city-wide and at the neighborhood level. Of special notice in the New York City setting are: 1. the rise of new neighborhood organizations concerned with health services in low-income areas, often initially to "save" hospitals in their areas or to demand a new neighborhood health center or other health services; 2. the efforts of the hospital employees' unions, even in the face of Affiliation Plan subterfuge of the city health careers pattern and discrimination against city career employees, to develop a vastly improved training program and a broader and upwardly mobile health career ladder reaching even those with the fewest previous opportunities and to cooperate with neighborhood organizations, welfare recipients' alliances and so forth in demanding improved services for all.[46]

In concert with action at the neighborhood level, however, general, systematic, city-wide efforts must be made to reform and reconstruct the health services pattern. Until a rational and responsive general system is developed, all but perhaps the very wealthiest or most fortunate citizens will suffer. Until forces are available for effective public coordination and planning on the "system" level, only piecemeal moves can be made, which do not get at basic solutions.

## POSTSCRIPT: THE LINDSAY REORGANIZATION

John V. Lindsay, in his "time for a change" campaign for mayor in the fall of 1965, promised major reforms and reorganization of the municipal hospitals and health services pattern.[47] As mayor in 1966,

he created a new Health Services Administration to coordinate all city health departments and he promised a new program of neighborhood health centers in low-income areas.[48] As many of the flaws of the Affiliation Plan noted in the survey became hot revelations in the press in late 1966 and early 1967, Mayor Lindsay promised to "tighten" and reform the loose affiliation arrangements under stronger public supervision.[49]

At one point after assuming office, Lindsay declared:[50]

> We must face the fact that the next 25 years may produce developments in social health that will outstrip in radical change the developments of the last 100 . . . for a program conceived today to be progressive in 25 years, it must verge on the revolutionary. Any planning that we do must be broadly based and as capable of growth as possible.

However, the new mayor, saddled with numerous urban services crises, was not able to devote the personal political energy and the necessary "power budget" to move toward creating the necessary broad constituency to support such "revolutionary" intervention in health services. In the first two years of his administration he was forced to rely on very much the same established coalition of private Affiliation Plan professional and institutional forces to carry out much of the city programming in health; he was unable to secure adequate new direct public leadership and staffing in the Health Services Administration to provide real direction and overview; and he was unable to muster sufficient professional and political leverage to do more than add on to the layers of "coordination" and to keep a scatter of different boards and fragmented departmental bureaucracies with regard to public policy, planning, administrative and direct service capacities. Public discussion of a new "authority" framework for all city health functions failed to clarify the issue. The distance between rhetorical promise and crying need remained almost as great as ever.

Those actions to "decentralize" the administration of city services were primarily to delegate into the hands of particular private domains, as through the omnibus affiliations, rather than to create a totally new structure of public administration and community accountability. The entire new structure of health agency coordination appeared to be more of a holding company and a collection of holding actions—clearly lacking the necessary public leadership.

It had become clear that either the jump must be made to a totally new framework, pattern and image for public services or all "account-

ability" and "tightening" efforts with regard to affiliation arrangements and other contractual or reimbursed services would end in great frustration, would further drain public service capacity and, at best, would be mixed in a swamp of narrow accounting procedures that do not go to the heart of program requirements.

At least the problems had been brought more out in the open. Even an administration that was "trying harder" and that "knew better" was up against the basic facts of systemic illness in the traditional non-system of health services in even this most progressively committed and medically industrialized of America's metropolises. Clearly the people of New York City were still anxiously awaiting the chicken-and-egg coming of both the public leadership and the activated social constituency that could demand the necessary changes that must "verge on the revolutionary" just to cope.

## REFERENCES


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[2] *U. S. News and World Report,* January 24, 1966, p. 44.

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[4] *See,* for example, Piore, N., Metropolitan Medical Economics, *Scientific American,* 4, January, 1965; and Wagner, R. F., Message of the Mayor of the City of New York to the Board of Estimate and the City Council Submitting the Executive Budget for the Fiscal Year, 1965–66, May 13, 1965.

[5] Klarman, H. E., HOSPITAL CARE IN NEW YORK CITY, New York, Columbia University Press, 1963, pp. 34, 36–37, 40, 100.

[6] *Ibid.,* pp. 433, 493.

[7] *Ibid.,* pp. 11–16.

[8] Piore, *op. cit.,* p. 5.

[9] The City of New York, Department of Hospitals, *Annual Report for the Year 1965;* The city of New York, *Report of the Mayor's Advisory Task Force on Medical Economics,* February 14, 1966, p. 9; Klarman, *op. cit.,* p. 137.

[10] Report of the Commission on Health Services of the City of New York, July 20, 1960; Hospital Council of Greater New York (now Hospital Review and Planning Council of Southern New York), *New York City and Its Hospitals: A Study of the Roles of Municipal and Voluntary Hospitals Serving New York City,* December, 1960.

[11] Charter of the City of New York, Section 585b.

[12] For a definition of a "system ideology" *see,* for example, Dunlop, J., INDUSTRIAL RELATIONS SYSTEMS, New York, Henry Holt and Company, 1958, pp. 16–17.

[13] *See,* for example, Piore, N., Rationalizing the Mix of Public and Private Expenditures in Health, in this volume.

[14] Ubell, E., A Vision to Anger Doctors, *New York Herald-Tribune,* October 24, 1963.

[15] With the rise of more universal prepayment, particularly under Medicare and Medicaid, however, many of these independent practitioners seem to be shifting their emphasis to guaranteeing favorable payments for public fees for service and to maintaining publicly owned hospitals open to all physicians for their paying patients and more under the control of independent practitioners.

[16] Trussell, R. E., personal interview; and The City of New York, Department of Hospitals, Press Release, February 21, 1964.

[17] Trussell, R. E., personal interviews.

[18] *Ibid.*

[19] *See,* for example, Dunlop, *op. cit.,* p. 17, who states that "these ideologies [must be] sufficiently compatible and consistent so as to permit a common set of ideas which recognize an acceptable role for each actor."

[20] A statement from the State, County and Municipal Employees in October, 1966, called affiliations ". . . the instrument for the destruction of the legitimate rights and interests of employees in the city's hospital system." They were joined in attacks and strike calls by the Teamsters, the Doctors Association of the Hospitals and Health Departments and the Hospital Administrators Association of the Department of Hospitals.

[21] Trussell, R. E., Interrelating Public and Private Services and Facilities, *in* THE HEALTH CARE ISSUES OF THE 1960'S, New York, Group Health Insurance, Inc., 1963, p. 147.

[22] ———, The Municipal Hospital System in Transition, *Bulletin of the New York Academy of Medicine,* 38, 232, April, 1962.

[23] *Ibid.*

[24] For example, in testimony before the Surgeon General's Advisory Committee on Urban Health Affairs, Confidential Report submitted December 3, 1965, to the Surgeon General of the United States.

[25] Kaplan, H., URBAN RENEWAL POLITICS: SLUM CLEARANCE IN NEWARK, New York, Columbia University Press, 1963.

[26] Elling, R. H., The Shifting Power Relations in Health, in this volume.

[27] Howard J. Brown, Health Services Administrator for the City of New York, said in late 1966, that it was virtually impossible to determine whether care had improved or deteriorated since affiliation. *See,* Schumach, M., Difficulties Cited on Hospital Data, *New York Times,* December 11, 1966. Mario Procaccino said, in January, 1967, "It becomes obvious almost immediately that the Department through ignorance or abdication of responsibility just doesn't know what is going on"; *New York Times,* January 14, 1967.

[28] State Senator Seymour Thaler was central to this exposé; *see* Tolchin, M., Thaler Gives Rockefeller His Report of City Hospital Investigation Charging $100 Million Abuses, *New York Times,* December 29, 1966.

[29] For example, the number of American-trained interns and residents at a number of the newly affiliated municipal hospitals had risen considerably by the 1967–1968 academic year, but, on the other hand, Howard Brown in December, 1966, ordered more community physicians to take responsibility for patient admissions because residents were rejecting too many patients at these hospitals as "uninteresting;" *see,* Hospitals to Ease Admission Policy, *New York Times,* December 13, 1966.

[30] The System Development Corporation study of city health services, conducted for Mayor Lindsay, although intentionally favorable to the affiliations, was critical of the general pattern and environment of care, as follows: "even the recent emphasis on affiliation contracting . . . has not significantly improved the unsystematic relationship of institutions to population;" *see,* Parks, R. B. and Adelman, H., System Analysis and Planning for Health Care in the City of New York, March 25, 1966, p. 119.

[31] *See,* for example, Weinerman, E. R., Yale Studies in Ambulatory Medical Care, *New England Journal of Medicine,* 950, May 6, 1965.

[32] *See,* for example, Howard Brown's charges of affiliated hospitals rejecting "uninteresting patients," *New York Times,* December 12, 1966, p. 65.

[33] The *New York Times,* May 9, 1965, stated: ". . . in the last decade, thousands of physicians in the municipal hospitals lost their appointments when the hospitals affiliated with voluntary institutions."

[34] Evidence of misallocated funds included cases of diversion and misuse of equipment, payroll padding and uneven excessive salary scales; luxuries and extras for affiliation-employed staff only; city funds for fringe benefits and supplements; city salaries as "seed money" for private institutions' staffs; failure to provide contracted time and services; and private use of city laboratories' research space, equipment and staff without compensation.

[35] Liver Tests Made Without Consent, *New York Times,* January 18, 1967; Test Drugs Used Without Consent, *New York Times,* January 17, 1967.

[36] *Report of the Mayor's Advisory Task Force on Medical Economics, op. cit.,* p. 25; the *Report of the Governor's Committee on Hospital Costs,* December 15, 1965, reveals that although New York State had 72 cobalt bombs (high-energy radiation therapy units), 50 could care for the needs of seven million more people than the entire state population; yet under the affiliations new units are being planned and subsidized.

[37] Appropriations for those larger municipal hospital centers already tied to medical schools before the Affiliation lagged far behind those under the new arrangements. Frustration of City hospital staffs with fiscally narrow priorities, procedurally rigid city administrative patterns and inadequate city support staffs has been growing. The Affiliation Plan approach might as well have been calculated to assure the helplessness of the city administration in these areas, as well, so that the city would be forced eventually to contract out loosely to private institutions for all its services.

[38] *New York Times,* December 25, 1966: "Certainly there is no question that the affiliation agreements did not solve some of the major problems that preceded them. Municipal hospitals still have obsolete facilities, overcrowded nursing units, lack of teaching space, crowded and poorly designed surgical suites,

inadequate toilet facilities, antiquated medical record rooms and old-fashioned emergency facilities, x-ray departments and laboratory facilities."

[39] The most blatant example of "urban medical removal" was projected in the south and southwest Bronx, where two municipal hospitals were scheduled to be moved out of areas of greatest need to new locations in the upper Bronx, adjacent to their affiliating voluntary hospitals. In addition, the primary voluntary hospital serving the ambulatory and inpatient needs of the medically needy in the south Bronx was forced to close by the Hospital Council.

[40] Administrative delays were estimated to have cost the city upwards of $40 million by early 1967.

[41] Cost comparisons between city and private voluntary hospitals are not exactly parallel because of the different scale, scope, research intensity and physician staffing patterns of the public and private hospitals. City hospital costs include more ambulatory (outpatient) care costs and these are absorbed much more by the private patients in voluntary hospitals. But municipal hospital general care unit costs per patient day, which had been considerably lower than the voluntary hospitals in 1960–1961, rose at a much higher rate than the voluntary hospitals—an average annual increase of more than 14.6 per cent from 1962 to 1965—and surpassed the voluntary hospital average cost per patient day in 1965. Based on United Hospital Fund Report, February 10, 1966, a sample cross-section of ten UHF voluntary general hospitals, 1961–1965, and Department of Hospitals Reports, 1961–1966.

[42] If municipal hospital costs continue to rise until 1970 at the 1960 to 1965 rate of increase, they will be well over $100 per patient day.

[43] "The current stresses in the adjustment of universities to their burgeoning research programs, the shortage of teachers and the traditional reluctance of many faculties (even in state medical schools supported entirely by tax funds) to project their services beyond the campus, all lend little encouragement . . . ;" *see,* Masur, J., Government and Hospitals, *in* Knowles, J. (Editor), HOSPITALS, DOCTORS AND THE PUBLIC INTEREST, Cambridge, Harvard University Press, 1965, p. 141.

[44] Elling, R. H. and Lee, O. J., Formal Connections of Community Leadership and the Health System, *Milbank Memorial Fund Quarterly,* 44, 294–306, July, 1966.

[45] Sigmond, R. M., Health Planning, in this volume.

[46] It has required the leadership and pressure of the employees' union to create the first broad-scale training program for nurses' aides to become upgraded to practical nurses as an extended on-the-job opportunity. More than 3,000 of the 8,000 aides responded by expressing intentions to apply for the new course.

[47] Lindsay placed great emphasis in his campaign on "systematizing" and "modernizing" the entire city health services; *see,* for example, Lindsay, J. V., *A "White Paper" on New York City's Crisis in Hospital Facilities and Care,* October 15, 1965.

[48] Mayor's Executive Order No. 12, on May 27, 1966, created the office of Health Services Administrator, but the City Council had to act on actual City Charter revisions creating the consolidated administration (slated for final consideration in the fall of 1967). Although a number of Health Department ambulatory units are to be converted to comprehensive care units and more health centers for low-income areas have been projected, it has been estimated that at least 100 new centers will be needed to cover the city.

[49] On January 16, 1967, Mayor Lindsay announced a series of measures to achieve "greater financial accountability" and "greater public accountability" of the affiliation arrangements, including more regular reports, better city administrator salaries, tighter and more specific contracts and broader expense item reporting.

[50] Lindsay, J. V., Government and Community Health, *Bulletin of the New York Academy of Medicine,* 43, 334, April, 1967.

[51] This summary description is based on the 700-page report of a two-year study of New York City municipal hospital policies, the forces acting upon them, their implications and their effects, sponsored by the Institute for Policy Studies and supported with a grant from the Samuel Rubin Foundation.