CONSUMER HEALTH PERSPECTIVES

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A HEALTH SYSTEM IN CRISIS

New York City 1979

Most of our readers are no doubt aware that New York City is in the grip of a major crisis affecting the future of its hospitals and hospital-related health services. In December of 1978, the Mayor of New York, Edward Koch, let it be known that up to half of the city's 17-hospital municipal system could be closed or given away before 1981. The city's fiscal crisis was given as the reason; the city could no longer afford to provide health services. A short time later, it became known that the state, too, had a "hit list" of hospitals slated for closure, including city voluntaries and proprietaries as well as municipals. Meanwhile, throughout the past year, emergency, clinic and inpatient services in all sectors had been subject to innumerable piecemeal cutbacks at individual institutions. Several voluntaries were in bankruptcy and near-bankruptcy.

Most of these cutbacks or plans for cutbacks in the health system had been discussed and adopted outside of the federally mandated health planning structure and without the knowledge or input from the affected communities. There was outraged response from many quarters. The New York Chapter of the National Association for the Advancement of Colored People charged that the Mayor's plan to close municipal health facilities was racially discriminatory, since blacks and Hispanics were the major users of the public system. The NAACP charged that such closures would amount to a violation of Title VI of the 1964 Civil Rights Act and requested a federal investigation of the impact of the closures on minorities. The local HSA stepped into the fray by asking for a nine-month moratorium on closings and cutbacks until the agency could assess the effect of any and all changes on New York's total health system. The Committee of Interns and Residents (the labor organization representing the medical house staff in the city hospitals) staged a one-day strike to publicize its concern over deterioration in patient care conditions caused by staff and equipment shortages in the public hospitals. A broad spectrum of community groups, consumer health and provider organizations, and health workers began forming the Coalition for a Rational Health Policy for New York City,

IN THIS ISSUE

DON'T CLOSE THE MUNICIPAL HOSPITALS!

CITYWIDE HEALTH DEMONSTRATION, CITY HALL, MAY 1, 1979 — 12 NOON

All Health Advocates Invited to Join the Thousands Who Will Be There!

and have called for a moratorium on closings and a restoration of services until the city has adopted a system-wide health plan addressing community health needs. Consumer groups such as the Coalition to Save the Public Hospitals have also responded to the crisis by organizing workers and consumers and community board members at the affected hospitals.

Most of the critical response from consumers and concerned providers had two common themes: they objected to the fact that health planning was being replaced by administrative fiat and that the medically indigent were, to an inordinate degree, being made casualties of service cutbacks.

The Consumer Commission is devoting this issue to the New York City story not only because of its importance to the fate of the health services of the nation's largest city—although that would be sufficient reason—but because the issues raised in recent months in New York have direct relevance to the future course of health care and health planning throughout the United States. Political and economic pressures in New York have accelerated events and are forcing important (perhaps drastic) choices about health services. The way the city experiences and resolves its problems will doubtless be instructive for all those who are working to improve the health system in this present environment of urban fiscal crisis, taxpayer revolt and the pressure on states to retrench on human services.

Unfortunately, human services like mental and physical health care have been the first targets for fiscal managers who are casting about for a way to balance the budget with least offense to politically powerful groups. As we have said many times on these pages, health consumers are often in a very poor position to exercise their power and are rarely organized as a distinct interest group. When a health constituency is composed of minorities or of people without money, their interests are even less likely to be consulted in "crisis" decision-making.

Another factor in the current environment which affects the way health-planning decisions are made in New York and elsewhere, is the overall focus of the federal government on containing the cost of health services. As the federal government has become the single largest purchaser of health care, and as modern health care has become an increasingly costly service, we have seen an increasing preoccupation with cost-effectiveness and cost-cutting strategies and a corresponding and temporary (we hope) de-emphasis on providing care and determining needs. Unfortunately, federal resource distribution guidelines and standards can be used as ends in themselves, and cost-cutting techniques can become convenient rationales for making politically expedient decisions to cut back services.

The New York situation has brought to the surface many problems common to the nation's approach to health planning and its priorities for the provision of health services. In the following pages we intend to discuss the crisis in New York in the light of the following broadly applicable problems:

* the possibility that major health decision-making will take place outside the state and national planning structure and without attention to the impact of such plans upon the affected population or on the total network of health services within the affected geographical area.
* *de facto* consolidation of the health system in the hands of the most politically influential (but not necessarily the best or most needed) health institutions.
* inappropriate use of nationally promulgated health resource guidelines and numerical standards as rationales for arbitrary or unexamined cutbacks in the health system.
* inordinate cutbacks in services in the least influential communities, resulting in harm to the health status of minorities and the indigent.
* legitimizing the notion that health planning is synonymous with cost-containment rather than active planning to fill service needs.

QUERY

A future Consumer Health Perspectives will explore the future for consumer participation on health facility boards. Does anyone know if any HSA outside of N.Y.C. requires facilities to have community advisory boards to fulfill the requirement for community participation in planning? Please notify the editors of Consumer Health Perspectives, 377 Park Ave. So., NY, NY 10016. Tel (212) 689-8959.

CRISIS HEALTH PLANNING: A Test for P.L. 93-641

Donald Rubin
President, Consumer Commission on the Accreditation of Health Services

The New York City crisis could well be a watershed for the City's HSA and a test case for all the federally created planning agencies operating in the current climate of local and national fiscal austerity.

Mayor Koch's decision to close or give away about half of the municipal hospitals was essentially unilateral—the only outside input at the time being that of his health advisor, Dr. Martin Cherkasky, President of Montefiore Hospital, a major city voluntary. Such decision-making amounts to circumvention of the federal law regarding health planning, which places such responsibilities squarely in the hands of the Health Systems Agencies created by Public Law 93-641. Under federal law, all planning decisions—including the expansion or reduction of hospital facilities and services—are subject to review and approval by the HSA. The New York City HSA, therefore, is the proper agency to decide which hospitals, if any, should be closed. Governor Carey, who at first backed Mayor Koch's health plan, has come round to this view and now has publicly endorsed the HSA and the state planning agency as the proper province for health decision-making.

Why the HSA is Needed

The overwhelming need for a systematic and rational health policy is best illustrated by the contradictory plans being contemplated at different levels of government. The Koch-Cherkasky edict called for the closing of seven municipal hospitals, the "transfer" of the $150 million North Central Bronx (NCB) facility to Montefiore (Dr. Cherkasky's hospital) and the opening of the new Woodhull facility as part of a consortium of public and private hospitals. The State Health Department, meanwhile, is recommending that three municipals, seven voluntaries and five proprietaries be closed, that Woodhull be opened as a public, municipal hospital and that Montefiore be cut by 250 beds to make the operation of NCB more viable.

The HSA has stepped into this environment of confusion and rash actions and asked for a nine-month moratorium on all closings and cutbacks pending a study of New York City's system-wide institutional resources. Now that the HSA is involved, should we stop worrying? Not entirely. Consumers and providers should continue to be active in steering HSA activities in the months to come. The HSA, like city and state government, can be susceptible to political pressure and special interest, especially if it fails to develop *independent criteria for planning, based on community need.* Without such criteria, by what yardstick will the HSA judge which services are needed by the city and which, if any, are dispensable? Without information on the community's health and on the condition of the facilities involved, the future of each facility may depend upon its relative political power rather than its quality or utility to the community.

By What Yardstick?

The question of *how* decisions are to be made is as critical as who should be making them. How should the local planning body go about setting criteria for making judgments about possible cutbacks in services, alternative services, or restoration of services already cut back?

First, the ten National Health Priorities, as set out in the National Health Planning Act, should be consulted by the HSA in all planning decisions. For instance, the first National Health Priority is the "provision of primary care services for medically underserved populations." The extent to which a health facility is fulfilling this and other Priorities is a valid criterion on which to base decisions to convert or retire facilities, to reduce bed capacity, or to approve proposals for expansion and modernization. Institutions which provide primary care services for underserved populations (as do our municipals and many of the voluntaries), those with outreach and home care services, with appropriately categorized walk-in and emergency facilities, and so forth, should not be retired but rated well and favored for improvements and modernization. Conversely, hospitals not providing such services and which are not responsive to community health needs, may be rated vulnerable for retirement or targeted for addition of services presently not supplied.

Waste versus Service Expenses

When looking at the health system's fiscal problems in the light of the Priorities, some useful distinctions can be made. The Executive Director of the New York City HSA, Anthony Watson, has made the point very clearly:

> A significant part of the deficits—both of the Health and Hospitals Corporation *[*the municipal system*]* and of some voluntaries—arises from provision of unreimbursed services, rather than from excess capacity, underutilization or inefficiency. *These are two very separate and distinct problems. It is one thing for the city and state government to seek savings by eliminating waste and another thing to do so by denying services to the medically indigent.*

Governor Carey has vowed to continue to seek state subsidies for the financially ailing voluntary, Brooklyn Jewish Hospital, because that facility is "indispensable to the health needs of Crown Height and Bedford Stuyvesant." If such consideration of public need had been consistently applied, the "hit lists" drawn up by the City and State might never have appeared.

Watson has also stressed the importance of making a study of the system-wide impact (in terms of services and cost) of closing particular hospitals, because "unless these effects are studied on a system-wide basis, it is not possible to determine whether the proposed cuts in funding will actually save money." If the consequence of closing a hospital is that patients seek care at a more expensive facility, what have we accomplished? The City will still pick up a very large proportion of the additional cost; and in shifting costs to other governmental auspices, we are not making a "saving" in terms of the overall system, although we may have lengthened the fuse on some local fiscal time bomb.

In calling for a nine-month moratorium on closings and cutbacks in New York, Watson has mandated the HSA to do two short-range studies: one a review of each individual institution and the other a system-wide review. The study of each institution would include an assessment of each institution's fiscal viability, its reimbursement problems, and the health care and financial implications of reduction of services or closure. The second study would include 1) the need for hospital beds and services in New York City as a whole; 2) an analysis of system-wide costs and the respective contributions of state and city government; and 3) an analysis of the provision and financing of free care in the city as a whole.

continued on page 11

THE MYTH OF EXCESS BEDS

by Zita Fearon

Coalition to Save the Public Hospitals

There is no evidence that there are any excess hospital beds in New York City. Since the figure of 5,000 excess beds was first circulated in 1970, more than 6,000 beds have closed. At the same time, others have opened, so that there has been an overall reduction of more than 3,000 beds since the 5,000 figure was first mentioned. Yet the 5,000 figure is still being used. There has never been any study done to support the figure, and those who claim there are excess beds have no documentation to support their contention.

The Occupancy Rate Argument

Some people argue that occupancy rates which fall below certain levels prove that there is an excess of hospital beds. But occupancy rate is not a reflection of need; it is more appropriately a reflection of hospital admission policies, need for teaching and research patients and the mix of emergent and elective cases. Until recently, the optimum occupancy rates for certain services have been determined to be: 80% for medical/surgical beds, 70% for pediatric beds and 60% for obstetrical beds. The variation in these three rates has been due to the recognition that there are definite variations in the number of children admitted, that there is a wide fluctuation in the rate of admissions of women in labor and that these are necessary, non-elective admissions.

Unfortunately, there has been little recognition that public sector hospital admissions are almost all through the emergency department and that there are very few elective admissions, with the result that there is a wide fluctuation over a year in the rate of admissions, and thus in the occupancy rate. Many of the municipal hospitals have days when their total occupany is near 100 percent, and often some services are more than 100% occupied.

For example, Greenpoint Hospital in Brooklyn (174 beds) has about 75% of its admissions coming through its modern, highly adequate emergency department. Greenpoint's occupancy rate ranges from 65% to 97%. In February 1979, there were two days when occupancy was over 100%. (More beds were added to the wards.) Likewise, in January, Coney Island Hospital (449 beds) had five days when the occupancy rate fell below 89% and 12 days when occupancy was at 93%-97%.

If a hospital is at 60% occupancy half the time and at 100% or more half the time, there will then be an average occupancy rate of 80%. Or, 50% half the time and 100% half the time will result in a 75% occupancy rate. Does this really mean that these are excess beds? Not at all, since public hospitals must be there to serve the community, enough beds must be always available to care for emergency cases. The periods of low occupancy could be used to take elective admissions, but the City has tried to force the Health and Hospitals Corporation to turn away all elective patients who do not have cash or third party coverage. To this end, the City has forced staff cutbacks on the public hospitals, so that there are insufficient staff to care for elective patients. Everyone rises to the emergency situations, but staff cannot work at that pitch 100% of the time, covering for jobs that require two or more people.

In the voluntary sector, there are some community hospitals which have a substantial percentage of their admissions coming in through their Emergency Departments, also bringing about a fluctuation in the occupancy rate. On the other hand, there are some voluntary hospitals, like Montefiore, which have eliminated services with fluctuating occupancy rates. Montefiore eliminated its Obstetrical Unit some years back and has recently eliminated its Emergency Department, thereby assuring that it would not be called upon to reserve beds for these services. A hospital following this course of action can fill its beds 100% of the time with elective admissions, which are quite easy to schedule and control.

Ironically, the "excesses" which are often pinpointed in the public and community hospitals represent the total system's flexibility in dealing with emergent and non-paying patients. The "efficiency" in the hospital which has eliminated its "extra" beds ends up being reflected in the slack which must be maintained elsewhere in the system if all citizens are to get hospital care.

CUTTING BACK ON HOSPITAL BEDS—WHAT WORKS?

In New York (as elsewhere) the issue of bed reduction is a controversial one, and there has been considerable debate on the consequences of reducing hospital capacity. In this issue, Zita Fearon and Alan Brownstein have developed two points of view on the problem of bed reduction, and we hope that their presentations will promote further discussion of this subject. Articles of about 1000 words will be welcomed and considered for publication. Send to *Consumer Health Perspectives*, 377 Park Avenue So., 3rd Floor, New York, N.Y. 10016.

The Economics of a "Bed"

In the arguments over "excess beds" there has been little understanding of what a bed really is. A bed, besides being a place to put a patient, is used as a unit measure of the cost of a hospital. The bed itself does not generate any costs. Well over half of a hospital's costs are fixed, non-salary costs, such as oil, electricity, depreciation, debt service, maintenance, et cetera. In addition, a large proportion of the salaried personnel (the hospital administrator and assistant administrators, their secretaries; the department heads and their staffs, housekeeping, emergency room and outpatient clinic staff) remains constant, regardless of the number of beds.

When a few beds are eliminated—perhaps even as much as a 35-40 bed nursing unit—the only savings are for the nursing staff and for the food, supplies and medications which would have been used for the patients. These are all reimburseable items and fully covered. This may, for example, constitute a "saving" of about $150,000 per year. Unfortunately, the closing of a few beds has no impact on the cost of running the hospital, and the "saving" of $150,000 is the amount the hospital loses in reimbursement. Far from generating costs, the bed functions primarily as a generator of reimbursement. So what really happens when some beds are closed within an institution is that the costs of running the hospital are spread over a smaller base of beds, increasing the unit cost, or in other words driving up the daily rate for the use of a hospital bed. The net effect is to make health care more costly.

continued on page 10

REDUCING BEDS: A GAINSHARING OPTION

Alan P. Brownstein
Assistant Director
Department for the Community
Community Services Society

Overbedding in New York City

Hospital care is too frequently considered as if it were synonymous with health care. There is a level of beds required to meet the health needs of the community, and beyond that level the community is no better off, even though it has more hospital beds. In fact, it is often the case that a hospital, in its desire to provide all services and procedures, will do so, even when staffing, equipment, and low utilization do not measure up to quality standards. Hospitals are the most costly segment of the health care system (45.2%, or $6.74 billion in New York State in 1977). New York has more hospital beds per capita than are needed—25% more than California, for example. The relationship between New York's excess beds and hospital utilization (as compared to other states) is demonstrated by Table 1. New York's average length of stay is about 30% above the national average. Many experts attribute some of this high utilization to the fact that we have so many beds available—it is said that the supply of hospital beds generates its own demand, or a "built bed is a filled bed." The availability of excess hospital beds has resulted in New Yorkers overusing inpatient services instead of using more appropriate, less costly alternative services. Despite the overutilization of hospital services, every day there are over 5,000 empty beds in New York City. Because of the fixed costs of a hospital bed, it is estimated that the cost of maintaining an empty bed is about 60-70% of a filled bed. The cost of empty beds being absorbed by occupied beds is one of the reasons why a day in a New York hospital bed costs 25% more than the national average.

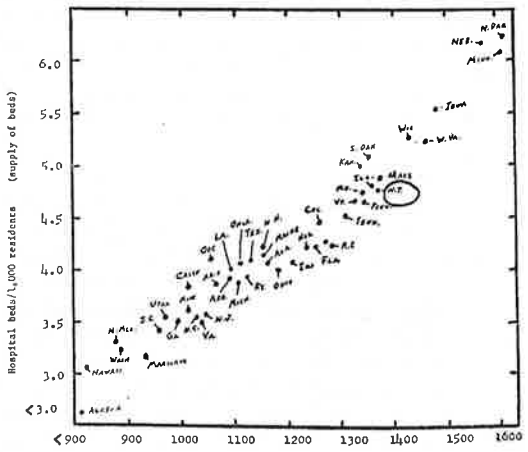
Estimates of how many beds in the City are "extra" vary widely, but we do know that the City has about 4.9 beds per thousand people. This 4.9 figure is a very large one, even granting that New York has a higher than average proportion of older people and poor people, who undoubtedly have higher rates of hospitalization and longer hospital stays than the population as a whole. (However, it should be said that hospitals in New York City serve a great many people from other states, and even other countries. An assessment of the effect of this patient in-migration to our hospitals on the total of needed beds has not been carefully studied.)

The National Guidelines for Health Planning, issued last year by the Health Resources Administration, set 4.0 beds per thousand as a maximum which regional health planning agencies should not exceed when reviewing requests for hospital construction in their health service areas. The four-per-thousand hospital bed figure should be easily sufficient to any area's health needs, since many well organized health systems (including the British National Health Service and some prepaid health plans in the U.S.) seem to be able to provide excellent health care with many fewer beds per thousand people and an 85% occupancy rate. In fact, the literature on the subject indicates that the bed ratio can be as low or lower than 3.0 (provided other health service supports are in place; e.g., home care, primary and preventive services) with no demonstrable effect on the health of the population. Even granting the City's special health problems, 4.9 beds per thousand seems out of line.

Overbedding has a price tag, not only in dollar terms, but also in human terms. The emphasis on excess highly technological inpatient hospital care has the effect of draining limited dollars that are becoming increasingly scarce (especially during this prolonged period of "fiscal crisis" for New York City), that might otherwise be used in other areas (e.g., primary care) where health services are woefully inadequate.

TABLE 1

SUPPLY OF HOSPITAL BEDS AND HOSPITAL UTILIZATION 1970
New York Compared To Other States



Total patient days per 1,000 residents (hospital utilization)

Source: data computed from American Hospital Association statistics, and *Statistical Abstract of U.S.*, 1972

Each dot represents aggregate data from one state (several states have been omitted because of inadequate data, or because "spillover" effects to other states distort data—i.e., Connecticut is omitted).

The Complexities of Bed Reduction

There is justification for reducing the total hospital bed complement in New York City, although there is, of course, no excuse for using the concept of overbedding as a rationale for the kind of arbitrary hospital closures which deprive vulnerable groups of citizens of their health services. To

continued on next page

trim waste from the system without disrupting services, it is necessary to outline some of the complex problems that must be considered.

The first problem is to determine how many excess beds are in the health care system. In New York City, although there is considerable disagreement, 5,000 excess beds is the number that has been most frequently cited for the last few years. During this period, 25 hospitals have closed and New York City's acute bed inventory has been reduced by over 2,900—yet it is still said that there are 5,000 excess beds! The basic consideration in developing the original estimate of overbedding involved the notion of a desirable bed/population ratio and an analysis of utilization data for the city as a whole. Clearly, there is a problem with retaining the same estimate of excess after there has been a major reduction of beds. What is lacking is a revised estimate of overbedding based on objective health status and needs criteria as part of an overall health services plan. It is well documented that different population groups have different needs for inpatient care. **These criteria should be developed by the HSA, and no beds should be closed until they are developed.**

A citywide estimate of excess beds (based on the 4 beds/thousand population standard mentioned above) is not always workable at the borough (county) or sub-borough (regional) level. A recent analysis (Buxbaum and Brownstein) of the community impact of closing Hospital "X" (a hospital in New York that is actually being considered for closure) demonstrates some of the defects of applying an aggregate citywide number to a regional/community level. Although Hospital X had a 75% occupancy rate (1975), surrounding hospitals had occupancy rates between 93% and 104%. Hospital X provided 150,000 patient days. Given the prevailing occupancy levels in the surrounding facilities, it would be impossible for them to absorb the increased demand for inpatient care if Hospital X were closed. Even if the 150,000 figure is partially inflated, the result would be that patients would have to travel considerable distances to be treated, postpone care, or not receive care at all.

Closing Hospital X would have additional major consequences for the community. One-quarter million OPD (outpatient department) visits and 100,000 emergency room visits would have to be absorbed by a community ill equipped to do so. And lastly, the community impact of the displacement and the loss of jobs for 2,000 employees would be profound. **Whatever happens to inpatient beds, provision must be made to preserve needed outpatient or emergency services, and to develop humane methods of meeting the needs of displaced hospital workers.**

Another problem in reducing the number of hospital beds is that the greatest savings are realized if entire institutions are closed, somewhat less in closing units, and minimal in decertifying individual beds. The example of Hospital X presents **the conflicting goals of maximizing savings** (i.e., closing the hospital) **versus meeting community needs** (i.e., keeping the hospital open but reducing unused beds). In sum, reducing hospital beds needs to be done on a regionalized basis in relation to the needs of the community, which, in many instances, will not support the closing of hospitals (with the possible exception of certain small facilities) no matter how desirable from a fiscal point of view.

The most basic and most complex aspect of closing hospitals or reducing beds is that the hospital's patients, trustees, operators and employees all view the hospital as "their own." These groups frequently represent a solid wall of resistance to reducing the number of beds—not without some good reasons. It is unreasonable to expect health consumers, many of whom receive inadequate health services, to support the closing of beds, even if need for those beds is undocumented or marginal, without getting something in return. Similarly, it is unreasonable to expect a health provider, whose hospital requires major modernization, to support closing of a hospital wing, without getting something in return.

Gain Sharing: Trading Off Excess Beds for Better Services

Richard W. Nathan has calculated "conservative estimates" of savings that would be derived from eliminating excess hospital beds in New York City. The range is from $95 million (based on individual bed reductions) to $279 million (based on hospital closures) each year. When needs-based criteria are established, that would enable us to identify the excess supply of hospital beds, and such beds should be removed from the system so that savings can be realized.

Current efforts to "shrink" the health care system are aimed solely at the reduction of costs, without incentives to improve health care. However, derived savings should not be removed entirely from the health care system, but rather, any reduction in inpatient services should be accompanied by *prior* commitments to specific plans to divert a proportion of the savings into the development of other kinds of needed health services, including modernization and other purposes (see below). It is important to emphasize the need to establish—not only in principle but in terms of specific plan development—gain-sharing *prior to* bed reductions. (The term "gain sharing" will be used throughout the remainder of the paper to denote the redistribution of excess hospital resources to other areas.) Too often the promise is made (or strongly implied) by public officials that closing hospital beds will permit the reallocation of wasteful hospital dollars to provide other needed health services, but it rarely happens, for a variety of reasons.

A Gain Sharing Strategy: The State's Role

Only the state has the regulatory ability to directly and indirectly effect the redistribution of health dollars through its certification of need, licensure and rate-setting authority. To date, this approach has been piecemeal, without adequate planning and coordination. Further, even if regulatory functions were to be coordinated to achieve specific health system goals, it is questionable whether the state has sufficient reimbursement leverage to create the financial incentives to bring about desired changes. The state's proportion of direct savings derived from bed closings is primarily from its contribution to Medicaid, or less than 20% of total savings. In other words, for gain sharing to work, the state must commit itself to the principle of gain sharing and coordinate all of its regulatory functions, including insurance regulation (so that insurance rates and reimbursement can be applied to gain sharing). In addition, to increase the gains and strengthen the incentives, it is essential that federal and city governments be plugged into a gain sharing strategy. Because the basic tenet of reimbursement programs is to provide funds for costs incurred, funding based on reduced reimbursement due to declining hospital costs (resulting from bed reduction) would require special Medicare and Medicaid waivers. *Only with federal, state and local participation,* can a substantial portion of derived savings be used for these purposes.

For gain sharing to succeed it must be done in a political context considering the legitmate concerns of all parties who would be affected by bed reductions and gain sharing —consumers, hospitals, employees and their unions. The following hypothetical Gain Sharing Distribution Formula (GSDF) is a conceptual outline for discussion purposes that incorporates political considerations, health status and system needs, based on the assumption of $100 million of sav-

continued on page 11

CONSUMERS ORGANIZE TO SAVE VOLUNTARIES, MUNICIPALS

Neighborhoods where individual hospitals are located are beginning to organize to save their health facilities—whether municipal or voluntary—from cutbacks in vital services; and they are learning that by joining together, they can prevent being played off against one another when the City targets particular hospitals for closure.

More than 160 community organizations in Crown Heights, Bedford Stuyvesant and Fort Green have organized to make sure Brooklyn Jewish Hospital, a voluntary, stays open. Block associations, tenants' groups and civic organizations have come together in a remarkable display of unity over the threatened closing of the financially troubled hospital, which has not been able to survive without state subsidy.

According to Robert Speaks, Chairperson of the **Community Coalition to Save Brooklyn Jewish Hospital,** the Coalition is unique because just about every ethnic segment of the Black, Hispanic and Jewish area is taking an active part in its work and because it has managed to "defuse" suspicions between the public and private hospital constituencies. The Coalition has been lobbying in Albany and at City Hall, staging demonstrations and meeting with state legislators and Congresspeople over the Brooklyn Jewish issue.

Another group, the **Coalition to Save the Public Hospitals,** was formed in 1978. The Community Boards of the municipal hospitals had been struggling against cutbacks and threats of closings at their facilities for several years and many temporary coalitions had been formed at different stages of the crisis.

However, as it became clear that Mayor Koch was going to fulfill his campaign promise to make drastic reductions in the HHC, and as his health advisor began to release the details of such proposals to the press, the Council of Community Boards saw the need to bring together all the community boards, community organizations and health workers affected by public hospital closings.

The Coalition is organizing caucuses of health workers, patients and community members at each municipal hospital, planning mass demonstrations to keep each hospital open and in the public sector, as well as fighting for whatever other resources are necessary to provide good health care for the community. The Coalition has also circulated petitions to Governor Carey and Mayor Koch in support of public hospitals, is assisting community boards in gathering data and technical materials, and is developing legal strategies to keep the public hospitals open.

Housestaff Doctors Fight Service Cutbacks

Along with consumer and community groups, New York's housestaff physicians—interns and residents—have been organizing to call attention to the effect of proposed service cutbacks on patient care.

The Committee of Interns and Residents (CIR), bargaining agent for housestaff in many New York hospitals, had been attempting since last summer to get the New York City Health and Hospital Corporation to engage in talks concerning the deteriorating quality-of-care in municipal facilities. Failing to get the City to negotiate on these "non-bread and butter" matters, many CIR members staged a "paper slow-down," in which housestaff deliberately failed to sign hospital Medicaid reimbursement forms.

Then, on January 17, in response to City Hall's announcement of further cutbacks in the health facilities, the CIR called a one-day strike to protest withdrawal of needed public sector health services. The housestaff union has been one of the major provider groups to join the Coalition for a Rational Health Policy for New York City (see pages 8-9) and has called for a moratorium on proposed hospital and health service closures and reductions.

Like housestaff in Chicago and Los Angeles, New York's CIR has been working to incorporate minimum hospital quality standards into its collective bargaining agreements.

THE DEVELOPMENT OF THE COALITION FOR A RATIONAL HEALTH POLICY FOR NEW YORK CITY

Samuel Wolfe, M.D. Dr. PH
Professor of Public Health
Head, Division of Health Administration
Columbia University School of Public Health
Chairperson, Pro Tem, Coalition for a Rational Health Policy

In mid-December of 1978, New York City officials began to leak rumors of massive cutbacks in public health services. It was claimed that the City could no longer afford to serve the medically indigent—the no fewer than 1.4 million New Yorkers who are not covered by either Medicare/Medicaid or private insurance plans. Up to one half of the municipal hospital system was rumored to be slated for closing or transfer to other auspices. At the same time, the financial problems of many voluntary hospitals, especially those serving poor and minority communities, were serious and a number were near bankruptcy. Arthur C. Logan Hospital—the only Black-operated voluntary hospital in New York City—closed its doors on January 11, 1979.

Particularly disconcerting was the unintegrated and covert character of these moves. Massive changes were contemplated in the health care system of New York City, yet there was no public discussion on how these moves would affect the health needs of New Yorkers. Nor did it seem likely to take place. In the municipal sector, the City was allowing fiscal and political expediency to dictate its health policy. In the voluntary sector, State authorities seemed prepared to allow the bankruptcy of several voluntary institutions as the most convenient way of eliminating the "overbedding" which they claimed existed in New York City.

This "planning by decree" provoked an immediate response from those most likely to be affected by the cuts. Ranging from a one-day protest strike in the municipal system by the Committee of Interns and Residents (CIR) to a statement by the NAACP exposing the discriminatory nature of the proposed cutbacks, these individual actions played an important role in developing public awareness of the health care crisis. It became clear that the only effective weapon against capricious dismantling of the health care system would be to unite the activities and efforts of *all* the forces who would be affected: consumers, patients and providers of services.

In early January of 1979, a number of organizations and individuals with diverse backgrounds and interests began to discuss common approaches to the crisis. Out of these discussions, the Coalition for a Rational Policy for New York City has emerged.

The Coalition has been able to develop a common approach which unites diverse interests. With the participation of members of the key trade unions in the health field, professional and technical organizations (such as nurse's and physicians' groups), consumer organizations such as the Consumer Commission for the Accreditation of Health Services, various community organizations, professional associations such as the Public Health Association of New York City and a considerable number of concerned individuals, the Coalition has put forward a common demand for a rational health policy based on community needs and the rights of health workers to their jobs. In spite of the potential for conflicting analyses of multiple issues, the fact is that agreement has been reached on the principle that there should be a moratorium on any closings or cutbacks in services in the entire system until a rational health policy has been developed and publicly discussed.

The key to unity has been agreement that the National Health Priorities should provide the framework for any rational health plan in New York City. These priorities give first importance to the development and improvement of health care services to the medically underserved population. They effectively speak to the needs of the entire N.Y.C. health system and its provider and consumer constituencies.

On this basis, the Coalition is beginning to mount a broad campaign for a rational health policy. For the first time, a united effort of providers, consumers and communities will have to be reckoned with by public officials and planning agencies. By seeking to create an overwhelming demand for a rational health policy, the Coalition will act as a counterweight to the inordinate power held by large institutions and government officials acting in the name of political expediency.

The dual focus of the Coalition's work will be to educate the public and to bring pressure to bear on public officials to respond to public needs. By providing technical information, organizing public pressure and lobbying, the Coalition hopes to force the City and State to retreat from their stated goal of dismantling major parts of the hospital system and to force the various levels of government to take a more active role in health policy and planning through the use of existing legislation which will lead to the development of a rational health policy.

The Coalition will try to coordinate activities of its constituents with local campaigns to save specific hospitals

continued on page 12

☐ I am interested in the Coalition for a Rational Health Policy for New York City. Please send me more information.

☐ I/We would like to officially endorse the goals of the Coalition.

☐ I/We support the Coalition and would like to help by making a contribution. Enclosed is $_____.

Name_____

Address_____

City_____ State_____ Zip _____

Send to: Coalition for a Rational Health Policy, 377 Park Ave. So., New York, N.Y. 10016

The Coalition for a Rational Health Policy for New York City

PREAMBLE

Whereas public officials are seeking to reduce health services in the city of New York in the interest of budget economics and without rational health planning based on the needs of the city as a whole;
Whereas threatened actions against health services in the absence of a rational health policy will impact adversely upon the entire population and will discriminate principally against the poor, minority groups, and recent immigrants;
Whereas all health services including all hospital and health facilities regardless of auspices are primarily dependent on public sources of funding,

STATEMENT OF PRINCIPLES

1. **The Coalition believes in a rational health policy for the City of New York based on needs in accordance with national health priorities, as expressed in the federal health planning law;**
2. **The Coalition strongly supports the preservation of *needed* health services and an expansion of ambulatory, work place, preventive, home health and other outreach services;**
3. **The Coalition believes in the principle of public accountability in health services;**
4. **The Coalition supports the equitable allocation of resources in health care reimbursements, regulations, planning decisions and legislation;**
5. **The Coalition calls for the elimination of the long-standing discrimination in the allocation of resources to public sector institutions;**
6. **The Coalition supports the proposition that the cost of health services for non-insured persons, currently borne in large measure by the City of New York, be shared by all levels of government;**
7. **The Coalition opposes shifting control and accountability of public sector services to private hands;**
8. **The Coalition believes that the governing bodies of all health institutions be changed to conform to the requirements of the federal planning law so that they represent the community and the population served by race, ethnicity, sex, language and income;**
9. **The Coalition insists upon the equal treatment of minority, poor, alien and other disenfranchised health care consumers and the equitable allocation of health care resources accordingly;**
10. **The Coalition believes that any restructuring of the health system in New York City must be in accordance with the National Health Planning and Resources Development Act of 1974, and its ten national health priorities.**

STATEMENT OF PURPOSE

1 The Coalition proposes that there be a moratorium on proposed closings or mergers of any specific health institutions, on proposed cutbacks in services within such institutions, and on new construction or expansion of health facilities and institutions until responsible officials and agencies present to the people of the State and of New York City a rational health policy based on assessment of needs of the community, and until such a plan is followed by public discussion and debate.

2 The Coalition expresses strong support for the vigorous and early involvement of agencies representing the community in the health planning process, and strong opposition to the growing power of a selected number of large institutions to influence public officials and public policy and planning, often in their own institutional self interests.

3 The Coalition strongly opposes the unconscionable cut backs in staff including aides, nurses, physicians, and supplies and other vital resources in certain health institutions and agencies in the City and advocates restoration of these services so that acceptable levels of care can be provided.

4 The Coalition emphasizes the need for preventive and ambulatory services, and the training and retraining of present health workers to be deployed in such primary care programs. However, we believe such programs must be open and in place before any cutbacks in existing services or institutions are carried out.

NAACP, OTHERS, RAISE LEGAL QUESTIONS

Can a Mayor singlehandedly close, reduce, or transfer into privately owned hands a city's publicly owned facilities? Can a mayor deprive a particular segment of the population of its health services by shutting down a public hospital? Can a doctor who is president of a powerful voluntary institution disinterestedly preside over the dismantling of the municipal hospital system?

These are some of the legal and ethical questions which have been raised by New Yorkers about the major changes proposed for the city's hospital system.

The most far reaching legal question was brought up by the City's branches of the National Association for the Advancement of Colored People. In a letter to HEW Secretary Joseph Califano, the local NAACP asked the federal government to conduct an investigation of the New York situation to determine whether the projected closings of municipal hospitals constitute a violation of the civil rights of the minorities who are the chief users of the public system. Califano was also asked to enjoin the city from making any further reductions in its system pending the completion of such an investigation.

In a formal statement at a February press conference, the NAACP called Mayor Koch's announced plan to eliminate some city hospitals "a deliberate and systematic policy of discrimination against black and Hispanic citizens" which would have a "devastating" impact on minorities, both in terms of health and in terms of employment. (According to NAACP figures, blacks and Hispanics constitute from 60%-75% of the municipals' patient population and 43% of the workforce in the public facilities).

As a result of the NAACP letter, the federal office of Civil Rights (in conjunction with the Health Resources Administration) has begun preliminary hearings in the city to determine whether the cutbacks may violate the Civil Rights Act of 1964.

Cherkasky Resignation

Another legal action by consumers, meanwhile, was probably instrumental in bringing about the resignation of Mayor Koch's chief health advisor, Dr. Martin Cherkasky. The New York City Coalition for Community Health, a consumer watchdog group, in a suit against the City, Mayor Koch and Dr. Cherkasky, charged that Cherkasky's simultaneous position as President of Montefiore Hospital and as the Mayor's health advisor was a conflict of interest under the City's Charter. The Coalition also asked that Dr. Cherkasky be suspended from his city post pending resolution of the question of his status. The challenge to Dr. Cherkasky was based upon the Coalition's position that Montefiore's $18 million of health contracts with the City and the projected transfer of a municipal facility (North Central Bronx) into Montefiore's hands amounted to direct business dealings between Cherkasky and the City.

Shortly after the matter was brought before the City's Board of Ethics, Dr. Cherkasky resigned his post, stating that the disputes surrounding his role had "nothing to do" with his stepping down.

Other Questions

Meanwhile, various other citizens' and health organizations have also contemplated legal actions around several questions, including: 1) Do the City or state executive branch plans to close hospitals amount to a circumvention of the National Health Planning and Development Act of 1974, which places such responsibilities with the local HSA and State Health Planning Agency; 2) Can the HSA be challenged if it gives approval to hospital closures without giving due consideration to the National Health Priorities or other standards set out in the Planning Act; 3) Has the constitutional separation of Church and State been violated if publicly owned hospitals are given to private religious auspices, as has been contemplated in the case of Metropolitan Hospital and the New York Catholic Archdiocese; 4) Do arbitrary decisions to close municipal or community facilities serving the poor violate those citizens' rights to minimal levels of care under Article 17 of the New York State Constitution?

THE MYTH . . . from page 4

The Feds Look Only at Beds

In fact, there are a number of studies which look at hospital size in relation to costs. There are some findings which indicate that a hospital is inefficient at fewer than 150 beds or more than 900 beds. The requirements for a modern hospital are simply too great for a bed base smaller than 150 beds, and the complexity of an over-large facility, the necessary duplications, et cetera, provide rapidly diminishing returns for the increased size. Efforts to reduce cost have not dealt with the internal organization of hospitals, with the requirements of Blue Cross re-groupings or with the amount of profits made by suppliers. They have only dealt with beds. The entire federal effort is directed to the reduction of beds (There shall be no more than 4 beds per thousand population!). What happens then is that large prestigious voluntary hospitals and local government, in effect conspire to close public hospitals and the less expensive competition in the voluntary sector—the community hospital.

While the closing of entire hospitals does appear to save money as opposed to the piecemeal closing of beds, a few at a time in a number of facilities, this may only be an illusion. In the last few years, as public and community hospitals have closed, we have seen the prestigious voluntaries adding on more beds. These beds are more costly than those in community or public hospitals, and the additions to the system are in usually tertiary care facilities with many services of a highly specialized nature. The argument is not that such facilities should be cheaper, but rather that they should not be the only hospitals around.

The Consequences of Closings

What happens when a hospital closes? When a hospital closes, not only do we lose the acute care beds, we also lose the beds for the treatment of alcoholics, mental patients, home care services, the Emergency Department and all out-patient services. Over 6,000 beds have closed in NYC since 1970 and there is only *one* instance of the provision of ambulatory care to the community in place of the hospital—the Morrisania Neighborhood Family Care Center in the Bronx. The record has been that other needed services which officials claim will be provided when the beds are closed, are not provided, and are in fact lost along with the beds.

What is needed is an assessment of people's needs, not based on utilization or entirely dependent on mortality and morbidity rates, both of which are too inaccurate to use for need assessment. The beds should be left alone until this need assessment has been done (See "Health Planning in Crisis," infra.) and then the beds should be converted *if necessary,* to the services which are needed, such as long term care, detox, mental health, rehab, and many more.

GAIN SHARING . . . from page 6

ings (from all sources) derived from closing 1500 beds at an estimate of $65,000 (a round figure for these purposes) savings per year per bed.

Hypothetical Gain Sharing Distribution Formula

Resource Development Fund	$25 million
Modernization Fund	$20 million
Hospital Closure Incentive Program	$35 million
Re-Entry Training Fund	$15 million
Debt Service Fulfillment	$ 5 million
State Savings (see explanation below)	0
Total	$100 million

RESOURCE DEVELOPMENT FUND (RDF). This fund would provide monies for resources that are needed, based on analysis of the health system and health status of the region. For example, these funds may be used to convert existing beds to other purposes (e.g., hospice, Health Related Facility, Skilled Nursing Facility). Expanding long-term care beds may further reduce the demand for acute care beds, as the state Office of Health Systems Management has documented (1978) 3400 patients are backlogged in acute care beds awaiting placement in Long Term Care facilities. The RDF may also be used to expand free-standing primary and preventive care services in tandem with the New York State Primary Ambulatory Care Program. Here too, such a strategy would reduce the demand for hospital care, as experts have documented that the increase in supply of ambulatory care services reduces the demand for in-hospital care. However, these are just examples of how these funds might be used. It is suggested that the RDF gain sharing funds be aggregated by boroughs (county) for borough use and administered and distributed by the state. Priorities for use of RDF funds should be based on needs identified by the HSA as recommended by the Boroughwide Coordinating Council of the HSA.

MODERNIZATION FUND. Hospitals in New York City alone need hundreds of millions of dollars of modernization. GSDF should support needed upgrading using the same method suggested for distribution of RDF funds. Although only 20 million dollars are provided in the hypothetical GSDF, one must remember that these costs are amortized over a number of years.

HOSPITAL CLOSURE INCENTIVE PROGRAM (HCIP). HCIP is an innovative New York State program that subsidizes the placement of hospital employees for a limited time period in other hospitals when beds and staffing are eliminated. This is a declining subsidy based on projected attrition at the new hospital. First attempts at implementing this program at Unity Hospital in Brooklyn were disappointing. More recently, however, HCIP was quite successful in securing employment for 400 health workers displaced from Flower Fifth Avenue Hospital in Manhattan. HCIP has the basic ingredients of a humane approach to hospital employee displacement. With earmarked GSDF funding, it may prove suitable for replication in other parts of the country. The hypothetical GSDF assumes that 1500 beds will result in 4,000 displacements (a high estimate) with 2500 employees participating in HCIP, 1,000 employees being retrained for other health jobs and the majority of the remainder seeking employment elsewhere.

RE-ENTRY TRAINING FUND. These funds would be used to re-train laid off hospital employees for health careers in services that are created by the RDF (see above). It is important to note that retraining would be quite difficult for many employees who have been displaced, especially when one considers the dissimilar nature and requirements of the new jobs.

DEBT SERVICE FULFILLMENT FUND. These funds would be used to, in effect, allow hospitals to mothball excess beds without penalty, by absorbing a portion of the cost of the debt service. Costs of the debt service include those associated with long-term loans (interest and principal) for purchase of hospital equipment, construction and renovation.

STATE SAVINGS. The state would not realize any savings during the first year. However, substantial savings would be realized for each succeeding year as the State's obligation for HCIP and the re-entry training fund is reduced each year.

The GSDF is offered for discussion purposes only. Clearly, one of the most serious flaws is that we are not really talking about "savings," but "reduced deficit expenditures" in this period of fiscal constraint. In assessing the merits of the above approach, we must consider the short-term costs and potential long-term human and fiscal benefits in reshaping the health system.

The goal is to eliminate needless expense of carrying extra resources in the most costly part of the health system—inpatient facilities—and to divert them to areas where we have visible gaps in service. More importantly, this kind of policy encourages efficient use of already built facilities, while upgrading the total system.

*The author welcomes any ideas and critiques concerning this approach from a health planning, reimbursement, or political perspective. Please forward your comments to the author at 105 E. 22nd Street, New York NY 10010.

CRISIS PLANNING . . . from page 3

What About Studying Community Needs?

While the HSA is to be supported for undertaking these needed studies of the fiscal and physical condition of the institutional system, another dimension of the problem remains to be explored. Some consumers and providers feel that the HSA must go even further if it is to develop meaningful planning criteria. According to the Coalition to Save the Public Hospitals and many other groups, the HSA should not make recommendations for change before it has assessed community need for and use of services. A genuine assessment of community need, according to the Coalition, would involve identifying and surveying sample populations in communities selected to represent a range of social, economic, demographic factors. Prevalence of physical and emotional health problems should be determined and the population queried as to whether they have (or have in the past had) access to appropriate health services when health problems arise. Institutions and facilities which are currently used should be identified. Information extrapolated from such a study would be an invaluable indicator of the probable state of the community's health, the utility of the present system and the need for alternate health resources.

Through properly conducted need studies, the service goals expressed in the National Health Priorities can be translated into specific regional programs *via* the Health Systems Plan and Annual Implementation Plan of the HSA.

The Future

The HSA has its work cut out for it. The fiscal crisis in New York has brought the major health planning issues into high relief—cost-containment versus provision of services and regional planning versus piecemeal decision-making. The actions of the New York City HSA in the coming months will demonstrate whether P.L. 93-641 can be used effectively when fiscal expediency threatens to become the major force in health planning.

COALITION . . . from page 8

and health programs. This approach will put local struggles into a citywide context and should generate wide support. The main goal is to make sure that one sector of the health care movement cannot be "played off" at the expense of another.

Finally, the Coalition will organize City-wide shows of support of its program and principles. Through petition drives, public statements, letter-writing campaigns, meetings and demonstrations, the Coalition will seek to mobilize a broad community of interests.

At this stage, it is too early to predict the success of the Coalition; however, it is clear that a coalition of usually diverse interest groups *can* be forged in the face of forces that have the potential to destroy our communities.

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