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THE FISCAL CRISIS OF NEW YORK CITY: The Conflict in Allocation of Resources To the Public and Private Health Sectors

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Dollars from the public purse underpin both the public sector and the private sector health care services of New York City. Two of every three dollars in revenues for all the city's acute care institutions are public monies. Nevertheless, in spite of the public financing of both the public and private systems, nowhere is the evidence of discrimination against the public sector institutions greater than in cities such as New York.

The money for both the private and the public hospitals now comes basically from the public purse, but the public hospitals have been undercapitalized, underfinanced, understaffed, and with insufficient cash flow compared to the private hospitals, which are also basically dependent on public sector dollars. At the same time, the public sector hospitals have not had access to the research, philanthropic, and related dollars which have helped to create the city's huge and powerful specialty-oriented entities.

In the following, we focus on the conflict in allocation of resources to the public and to the private health sectors.

We give a historical overview, present our interpretations of a succinct amount of relevant data and then discuss the realities associated with the fact that the public sector hospitals and a substantial minority or even a majority of the private sector hospitals in New York City are currently in critical fiscal condition.

Finally we review strategies for getting out of this critical condition and focus, in particular, on the necessary changes that need to take place in the behavior of our elected officials at city, state and federal levels and their associated health advisors.

Historical Overview

Historically both the public and private hospitals in New York City were institutions which mainly provided food and shelter for the impoverished sick; the well-to-do were treated at home by private doctors. It was not until well into the 19th Century that the private charity hospitals began trying to attract middle-class patients. With the advent of anesthesia and antisepsis, work could be done in hospital settings that was not possible before; the private hospitals began to attract middle-class patients by providing services and amenities which distinguished between paying and non-paying patients and by making the hospital a

desirable place for private physicians to treat their own patients.

Revenues from private patients soon became an important supplement to philanthropic support. Paying patients became more necessary for the survival of such hospitals. As the number of beds in wards for nonpaying patients decreased, the charity hospital moved into the era of the voluntary hospital. The public institutions then tended to become the principal source of care for those who could not pay for their own services. By the end of the 19th Century cities were reimbursing private voluntary hospitals for the care of "some" indigent patients, but it was now the public hospitals that provided care for those who could afford to go nowhere else. Since the public hospitals were totally dependent on tax dollars for their support, their viability was inextricably tied to the local economy.

Insuring the Differences

These relationships became further entrenched when private health insurance plans guaranteed the voluntary hospitals a regular source of income by providing those who could pay the premiums with purchasing power to pay for private hospital services; financial success within the system soon depended on the ability of these hospitals to increasingly restrict themselves to patients who could generate revenue. *Therefore, the public hospitals were critical to the survival and growth of the private hospital sector since they provided the source of care for those patients from whom the private hospitals could not generate revenue.* The new insurance schemes simply reinforced the existing distinctions in financing and in functions between the private and the public hospitals: privately insured patients tended to use the private hospitals and uninsured patients tended to use the public hospitals. In addition, the public hospitals tended to concentrate on the so-called 'stigma' services and also developed a greater concentration on the provision of emergency and outpatient services.

While over the years many public hospitals became major respected centers for teaching, research, and the delivery of medical care, after World War II there was a tremendous influx of federal money into the private medical schools and into the hospitals associated with these. There was an even more dramatic expansion in the voluntary insurance mechanism sponsored both by the so-called Blues and the commercial insurers. The private medical centers were also afforded great access to research dollars as well as to philanthropic supports. This enabled expansion which attracted high quality administrators, physicians and researchers, as well as growing numbers of patients. These private institutions with their relative autonomy—the ability to appoint their own trustees, develop their own capital, control their own budgets, apply for grants, and purchase equipment, supplies, and services on the competitive market—absorbed greater resources and increased the public hospitals' problems in attracting highly qualified research, medical, administrative and other personnel.

Thus, the mainstream of health care became more firmly established in the private medical centers. And, with the growth of the private insurance plans to pay for this care, the public hospitals became a dumping ground for the medically indigent and for those with stigmatized conditions. The financial imbalance between sectors gradually became more firmly set.

Dumping on the Publics

Medicaid and Medicare reinforced the unequal status of the public hospitals. Since third party payers cover only certain categories of patients and services, and since Medicaid eligibility and coverage have been on shifting sands, public hospitals were left to treat patients with no insurance, and to provide services which were unreimbursed or poorly reimbursed.

Because private hospitals had a greater ability to exclude whom they wished, they were more able to adjust to the changing requirements of third party payers. *This ability to adjust services to that which was reimbursed depended on the existence of the public hospitals to pick up the rest.*

With the changing nature of New York City—the massive influx of black and hispanic populations, white flight to suburbia, and the shrinking tax base—the public sector became

ever more dependent on the private sector for its resources, and in particular for its manpower. This trend led in the late 1950's to mid-1960's to the so-called Trussell solution: the medical schools and their teaching hospitals in New York City adopted municipal hospitals through the affiliation agreements which are the current hallmark of the staffing patterns of the public general hospitals in the city. This was based not simply on an altruistic desire to bail out the public system, but on the reality that the medical schools and their teaching hospitals needed the money and the patients involved because of the changing composition of their own service population.

The Crisis Hits the Voluntaries

The virtually continuous economic crises of the past decade, with their profound impact on local government treasuries, have produced an even greater continuing crisis in public general hospitals: inevitable progression of traditional functions; even greater dependence on private hospitals and medical schools; and an historically inadequate and inequitable health care financing. It is really quite ridiculous to attribute this crisis primarily to management inefficiencies and sloppiness; this explanation represents both distortion and disregard of history.

During the past decade, there has been a simultaneous growing crisis in a great many private voluntary hospitals in New York City. This crisis has precisely the same roots as the longer term crises in the publicly-operated hospitals and can be laid at the doorstep of federal policy which has failed to develop universal, rational and equitable health care financing mechanisms that do not throw undue burdens on local municipalities. In cities like New York, where the federal government has calculated that there are 2.3 million persons, including perhaps as many as one million undocumented immigrants, who live in medically underserved areas, we have a veritable health care financing wasteland amidst plenty. We have the incredible spectacle of millions of New Yorkers uninsured, underinsured, or excluded from insurance for various conditions or services, and circumstances where the private voluntary hospitals have had to accumulate exorbitant deficits as the result of this defect in our financing mechanisms.

This has led a substantial minority of the private voluntary hospitals, and in particular those in poverty and relatively underserved areas, to be in *exactly the same fiscal jeopardy* as are the public municipal hospitals. For many years the administrators of the public hospitals were fair game for ridicule and were readily fired. The same fate has now befallen many voluntary hospital administrators, and for the same reasons. While these administrators are accused of mismanagement and injudicious decision making, absorbing the blame for fiscal instability, the heart of the problem is the inability to maintain an adequate cash flow in the face of underinsured or uninsured populations on the one hand, and sky rocketing inflation in the health sector on the other.

Interpretations of Data

1. New York City has eliminated 4,600 hospital beds since 1976, and 25 hospitals have closed.

2. In 1950 there were 170 hospitals, now there are 89.

3. Big fish eat little fish: hospitals have become much bigger, and much bigger hospitals realistically, are more costly to operate than are more modestly sized hospitals.

4. The preponderant number of closed hospitals have been in or near poverty communities.

5. The cutbacks in services to save the remaining hospitals and the threat of further closures led HEW as long ago as last winter to indicate that the city has potential violations of Title VI of the Civil Rights Act. At that time, HEW civil rights experts expressed concern that minorities would be adversely affected by hospital closures or shrinkages in a way that would violate Title VI. This finding, at that time directed at municipal hospitals, would be equally relevant for many voluntary hospitals as well.

6. The financial conditions of a great many New York City hospitals indicates serious trouble: almost all are less well off than they were in 1974. In addition to the municipal hospitals, in 1978 at least 50 voluntary and proprietary hospitals had operating deficits, and between 15 and 20 of these are close to insolvency.

7. Many of the hospitals (at least 43 including the municipals) have no debt capacity, even though estimates, which admittedly may be high, suggest that

$3 billion is needed to recapitalize the city's hospitals in the next five years.

8. It is not true that New York City has a great many more municipal hospital beds than have the other of 25 largest cities in the country.

9. New York City has startlingly *lower* hospital admission rates than the average for the 50 largest cities: 22.8 per 100 population for the others, 15.6 per 100 for New York City.

10. This in part explains the longer lengths of stay for those who *are* admitted in New York City than for the country: people are poorer, sicker, older.

11. The voluntary and proprietary hospitals of the city get more public funds (federal, state and city) than do the municipal hospitals. This began to be true in the early 1970s, and is even truer today.

12. While there has been glib talk about substituting ambulatory care for beds, the fact is that ambulatory and preventive services have been cut back and have declined as the result of the policy of the city with respect to both its Health Department, which has been decimated, and its municipal hospitals, where eligibility criteria have become harsher and service and staffing cut-backs have been very marked.

13. There has been only a very slow development of moves to cut back on tertiary care services such as cardiac invasive procedures and neurosurgery, and to consolidate these through regional arrangements in a limited number of hospitals.

14. If there still *are* excess short term beds in the city, they are few in number. A good many solid arguments are being made that suggest we have now gone to the extreme of having too few short stay beds in parts of the city. Closing beds in Manhattan does not improve the bed situation in Queens or Brooklyn. The rapidly changing nature of the population, particularly the increases in elderly, will justify the few surplus beds since they will require more beds years ahead. Also, flexibility in shifting from short term beds to long term or extended stay beds within or across institutions requires greater priority.

15. The relatively low level of productivity of the teaching hospitals and medical schools in their performance under the affiliation agreements with the municipal hospitals has been documented; it can also be noted that similarly low productivity levels exist in the performance of the professionals across the entire system. While part of this can be explained on the basis of the massive amount of teaching that goes on within the New York health system, part of this represents sloppy organization and delivery of services and maldistribution of costly resources. The most glaring examples are the way in which a great many of the hospital-based outpatient clinics in both the municipal and voluntary hospitals are organized and staffed. The subject of more efficient productivity across the work force within the health sector, while it is sensitive and controversial, begs for detailed analyses. We have talked about it a lot but have not done much about it.

16. There is no evidence whatever that turning over public hospitals to the voluntaries or to the teaching institutions reduces the cost of care. The savings of Mayor Koch's so-called "plan," now largely discredited, which proposed closing some municipal hospitals, cutting services in others, and turning still others over to voluntary institutions in order to cut costs, have shown to be illusory, and likely to inflate costs. Several groups in New York City working independently of one another have come to this came conclusion in recent months.

Therapy for the System

We have a very serious problem in New York City with respect to the financial underpinnings for health services and the structures that originally were intended to support those underpinnings. We went through a period of time with excess production of tertiary care resources. There was and may still be a preoccupation among the major medical schools and their teaching hospitals to compete with one another for power, prestige and resources.

Primary, preventive and ambulatory services were at the same time being starved and were of low priority to the medical schools. Inflation in the health sector was imposed on the general high levels of inflation. Defects exist in the mechanisms for reimbursement to institutions by the major private and public insurers. The extremely high level of medical indigency in New York City is a critical problem. Taken together, these have seriously exacerbated our present critical condition.

When a patient is in critical condition, heroic but

HRA Head Issues Warning on Hospital Service Cutbacks

Hospital beds and services should be reduced only if reasonable alternatives exist for the provision of care, especially to the poor, Dr. Henry A. Foley, Administrator of the Health Resources Administration (HRA), stated recently.

"In some cities," he wrote in a November 2 letter to directors of State and local health planning agencies and chairpersons of Statewide Health Coordinating Councils and local agency Governing Bodies, "reductions have taken place with only vague discussion of where the people who have been receiving care through affected institutions are to turn." In time of fiscal constraint there is a danger that State and local health planning agencies "will become unwitting accomplices to closures, conversions and mergers which end up making services unavailable to those who are most in need," Foley warned.

HRA policy, he stated, "is that hospital beds and services should be reduced or eliminated only if reasonable alternatives for providing care, especially to the poor, are in place and that binding commitments have been made to deliver needed services." Provisions should also be made for the retraining and relocation of hospital employees consistent with the 1979 amendments to the Health Planning and Resources Development Act, Foley noted.

Even if a certificate of need is not required for a reduction in beds or services, he explained, "your Health Systems Agency or State Health Planning and Development Agency can serve as an essential community forum in which interested parties can address the availability and accessibility of appropriate and needed services through alternative sources and the need for retraining and relocation of affected workers.

"We are committed," he concluded, "to the proposition that rational cost containment can be achieved without having the effect of denying access to care for needy populations or increasing unemployment."

gentle and careful measures are indicated. The same applies to our health care delivery systems. Such measures do *not* include wild allegations by a mayor of a large city, or his systematic destruction of the capability in the leadership of the major agencies that are supposed to make policy, and plan and implement those policies. Nor is a system in critical condition treated satisfactorialy when the Mayor disregards the potential and the ability of the regional health planning authority, the Health Systems Agency of New York City and its state-wide linkage, and instead develops his own non-plan which is divisive, serves to polarize the community along racial and ethnic lines, and is proven to be *inadequate, unresponsive and even perverse* to the fiscal crisis of the city.

Planned Starvation

At the same time, one can only feel a grave sense of concern at the way in which the State has tended to sit and watch and wait as poverty area hospitals, both public and voluntary, are starved and allowed to wither on the vine. It is as though the State supports the death or attrition of such facilities.

Just a few days before Halloween, a joint federal-state announcement was made concerning help to save and, indeed, to restructure the health services for the poor in the areas of Brooklyn served by Brooklyn Jewish Hospital and certain other institutions. It remains to be seen whether this pre-Halloween announcement will turn out to be a trick or a treat in terms of providing long term stable supports to pay for health care services for the uninsured and the underinsured.

If it was possible to come up with emergency measures to save the services around Brooklyn Jewish Hospital before Halloween of 1979, it is unclear why this was not possible in the months and years before that eventful period of time. It also remains to be seen whether this is a short term gimmick or a long term effort that will restructure the services and protect the economic base and the associated jobs in a poverty community.

It is a tragedy that the Mayor of New York City, rather than creating polarization, has not himself led a coalition which would address the issue of *equitable and efficient* allocation of health resources in New York City. His preoccupation with the shrinkage of the public hospitals does not deal with the nature of the health care financial crisis of the city. In order to deal with that crisis one has to recognize the source of the problem, and the methods to begin to correct it.

At the present time, the public and the private hospitals in poverty communities are placed in a position of being allowed to fight and struggle with one another over access to dwindling number of dollars. By this strategy both of these groups of institutions run the risk of going down the proverbial tube, leaving ever larger and more expensive medical baronies, controlled by the massive teaching hospitals and medical schools, to determine health care priorities and how health care resources will be allocated. And yet it is the errors in determining the priorities and the allocation of resources by these very institutions that has been contributory to the present crisis both in cost and in equitable distribution of services.

Who's in Charge

Where is the responsible leadership? The Mayor

could be leading a coalition to deal with specific issues that have a tremendous impact on the health care crisis of our city. For example, if it is in fact the policy of the federal government's State Department *not* to police the undocumented immigrants, and if persons already in that status are to be "left alone," then surely the federal government has the responsibility to pick up the burden of their health care costs, and not impose these costs on a particular local community such as New York City.

Similarly, if a disproportionate amount of the training of highly professionalized and technical health workers takes place in the New York City area, and this training provides personnel for the rest of the world, the federal government ought to be contributing in much larger measure to the costs of producing such personnel. New York City ought not to be required to pick up the costs of those training programs through its contributions through Medicaid and through its city tax levies.

A strong case can also be made that federal policies are responsible for the unemployment rates and levels of underemployment that exists in cities such as New York; these factors are great ones in determining the level of noninsurance, termination of existing health insurance benefits, and shifts in access to Medicaid eligibility. All of these factors combine to place a disproportionate load on the coffers of New York City.

The Mayor can have a coalition to address these issues; it is unclear why he has selected a way of articulating these issues that has polarized rather than has united the community.

What is needed is a strong and diverse coalition that would articulate a need for a national and state policy that would move us away from the shameful continuation of the Elizabethan Poor Laws: then the costs of health care for the poor and needy would be shifted away from a local municipality such as New York City.

Restructuring Services

The restructuring of the health care services for the city would require in the first instance a focus on primary, preventive, and ambulatory health services in various settings, and mechanisms for reimbursing for these services that would contain costs at the same time that they would assure equality of access. Having accomplished a plan for ambulatory services restructuring, it is *only then* that one can back into the issue of short and long term beds as well as the issue of the linkage between institutional care and alternatives such as home health care services.

To pursue a preoccupation with closures, a preoccupation with the elimination of existing hospital beds, or elimination of entire institutions or parts of institutions, and to simultaneously slowly starve these same institutions is surely contrary to rational health policy and is likely to violate the civil rights of large numbers of New Yorkers.

The financial crisis in health care is not unique to New York City. Most major urban areas are or will be facing similar dilemmas. To begin to confront this crisis, federal, state, and local health planning bodies must work together, *in concert*, in evolving a strategy for a more rational allocation of health resources *based on priorities that will protect the interests of those in greatest need among our population.*

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Health In the Workplace

by Frank Goldsmith
Director, Labor Safety and Health Institute

The Right to Know and the Right to Refuse Hazardous Work

An important off-shoot of the consumer health movement has been the increased pressure by workers for stronger occupational health and safety standards. While both the general health and the specific occupational movements have achieved meaningful gains, both have been frustrated by the lack of legal power to make adequate use of those hard earned rights. Weak standards, constant reinterpretation of statutes by governing agencies, and a general lack of authority by consumer and worker groups have produced maddening situations where the rights are recognized but the implementation is absent.

The 1970 Occupational Safety and Health Act and the 1969 Coal Mine Health and Safety Act were important gains for workers. Both served as the foundation upon which workers could build a safer and healthier workplace. Continually, however, this effort has been slowed by legal and bureaucratic obstacles thrown in the path. Time and time again, industry has refused to voluntarily protect workers from hazardous and unhealthy conditions, and too often the OSHA administration and the U.S. Supreme Court have weakened the workers' position by providing narrow interpretations of the OSHA law.

Weak Standards

The most recent effort to put teeth into the often listless enforcement of the OSHA law has been the "right to know" campaign by the labor movement and the regionally based Committees for Occupational Safety and Health (COSH). This campaign has begun to force OSHA to recognize the rights of workers to know the hazards they face on their jobs. Early in 1979 the Supreme Court reaffirmed this right by ruling in favor of the Oil, Chemical and Atomic Workers Union (OCAW) in a case against the 3-M Corporation, forcing the company to provide the generic names of the chemicals contacted by workers. This decision also forced 3-M to detail its employee health and safety programs, monitoring and testing systems, devices and equipment, and statistical data related to working conditions.

Indicative of the weakness of the OSHA law, the OCAW suit was won not under that legislation but rather by using the National Labor Relation Act provision that a union must adequately represent its membership. The OCAW successfully argued that to properly represent its members it must know the on the job hazards they face. This court ruling has not produced a flood of information by employers on the chemical and other hazards faced by workers, but the foundation for future legal action has been established.

To give meaning to this "right to know" victory unions must make a diligent effort to keep track of existing and new toxic chemicals in the workplace. No employer will provide continuous and voluntary information about these substances. A union committee, preferably the job safety and health committee, should make sure this is done. This can best be accomplished by writing such a clause into the contract.

This committee should regularly request that the company provide Material Data Sheets on all chemicals used in the shop. Since these forms are usually filled out by the supplier and/or manufacturer of the substance, the information is often sketchy and a follow-up is necessary to ensure full disclosure.

Protect Legal Gains

While legal recognition of worker occupational health and safety rights is important, they are always subject to weakening, rescinding, or being ignored and should not be relied on by workers as the final word. These legislative gains can be used, however, to establish strong health and safety provisions in union contracts.

Once management agrees to a safety and health committee, a set of rights for the group should be written into the contract. Such provisions are not binding to the union, but do require the company to provide information on hazards and can be helpful in grievance procedures, especially those that end up in arbitration.

Once the right to know the on the job risks is gained the next step is the right to refuse to be exposed to hazardous conditions. The U.S. Supreme Court will soon hear an appeal by the Whirlpool Corporation of a lower court decision that established this important right. If the high court upholds this decision workers will have taken a major step towards a safer and healthier workplace. But again, even if the court rules favorably it would be wise for unions to negotiate a right to refuse provision into contracts. And if the Whirlpool decision is overturned unions still can negotiate this fundamental job right for its members. The right to refuse issue will be expanded on in a future CHP.

If you have any questions about possible hazards at your workplace and what steps to take, write to the Labor Safety and Health Institute and we'll provide some practical answers.

LABOR SAFETY AND HEALTH INSTITUTE, 377 Park Avenue South, New York, New York 10016.

Health in the Workplace will be a regular feature of *Consumer Health Perspectives*. If you have suggestions for topics you would like to see us cover in this column please write to the Consumer Commission.

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