REPORT
HEALTH TASK FORCE
HON. ABRAHAM BEAME

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Institute of Rehabilitation Medicine
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October 18, 1973

My dear Mr. Sutton:

In your capacity as Chairman of the Beame campaign Task Forces, I am submitting the final report of the Health Task Forces, with appropriate supplements representing significant position papers and comments submitted to our committee. The task force met five times with an average of 18-22 participants at each session.

Attached to this report is a complete list of all those persons who gave freely and willingly of their time either as direct participants or contributors of substantive recommendations. It is my suggestion that the paper or parts thereof which are used in the campaign not be accompanied by a listing of all task force members, since several participants represent groups which would prefer not to be openly identified with a political campaign.

Should you or Mr. Beame wish to meet with members of the Task Force this certainly can be arranged. My associates in this endeavor, Martin Begun and Richard Nathan who greatly assisted in pulling this report together, join me in thanking all the members of the Task Force for being so cooperative. It has been my pleasure to be of assistance to Abe Beame and his campaign.

Sincerely yours,

Howard A. Rusk, M. D.

HAR:ph
Attachment
cc: Martin S. Begun
Richard W. Nathan

Hon. Percy Sutton, President
Borough of Manhattan
2050 Municipal Building
New York, New York 10007

ABRAHAM D. BEAME
COMPTROLLER

THE CITY OF NEW YORK
OFFICE OF THE COMPTROLLER

November 1, 1973

PERSONAL AND
UNOFFICIAL

Martin S. Begun
Associate Dean
New York University School of Medicine
550 First Avenue
New York, New York 10016

Dear Martin: Marty

I want you to know how much I appreciate your efforts in my behalf and your contribution to our Task Force.

I am running for Mayor because I believe I can manage the City of New York. I also believe that effective management of New York will require the continued contributions of people such as you who have served on these Task Forces.

I look forward to working more closely with you in the future.

Sincerely,

Abe

Abraham D. Beame

Statement

STATEMENT OF THE BEAME TASK FORCE ON HEALTH

The City of New York has striven over the years to improve the provision of health care to its residents. The City has developed a broad range of ambulatory health services for which it remains directly responsible. It operates the largest municipal hospital system in the nation. It is the only city in the nation to support a major health research program and the only city to provide significant support for the development of vitally needed health manpower.

The City has done a great deal; we believe it must do much more.

We believe that the new administration must make clear its intention to give high programmatic and fiscal priority to meeting the health needs of all New Yorkers. It must give new and perceptive attention to how it can best respond to these needs. With the help of those most directly affected, it must examine the role of the City in the delivery of health care.

We believe that the new administration must also live by its conviction that provision of improved health care can only be accomplished by the combined efforts of the City's public and private providers of care, the recipients and all health workers.

We believe that the new administration must make clear its recognition that sound organization and management are essential to the effective provision of health care. Organization should be structured according to identified health care needs and to the relative merits of different approaches to meeting those needs. Priorities should be set by the relative severity of identified needs, the expressed demand for specific services from those principally served, and the relevant scientific knowledge.

We believe that the City should establish and enforce high standards of performance for those who provide health care in its name.

We believe that the City should insist that care provided in its name be truly humanitarian and consistent with the ideas long established by the City health community.

We believe that the City, as a major provider, should recognize its great potential for creating important precedents in the field of health care and for becoming a leader among other communities across the United States.

We believe that health care services should be planned and operated for the benefit and the convenience, primarily, of the patients.

Accordingly, we recommend that as one of its first initiatives in the health field, the next City administration should undertake a thorough review of the health services -- a review taking into account the scope, quality, accessibility, cost and financing of the services now provided, the distribution and efficiency of facilities where care is provided, the present health manpower situation, and the detailed organization and management of health care services.

Based upon the results of this review, we recommend that the next City administration:

- Develop a rational assignment of responsibility for provision of health care among City health and health-related agencies.

- Consider the elimination or consolidation of agencies no longer adequately serving their original purposes.

- Pay particular attention to program goals and organizational structures through which responsible officials can be held accountable for achievement of the defined goals.

- Explore ways to

    - Reduce overutilization of inpatient services and encourage greater reliance on ambulatory and home care.

    - Increase accessibility of health care by making it available at locations and times, and in ways convenient to those needing care.

    - Improve recruitment, training and utilization of allied health manpower.

- Monitor and evaluate the performance of individuals and institutions providing health services supported by City funds and seek ways to achieve improved quality and greater cost-effectiveness from their efforts.

- Reconsider present program priorities and relationships with increased emphasis on

  - Improving and expanding provision of primary health care to all residents.

  - Strengthening providers of primary care including particularly private practitioners working in groups as well as those who continue to work individually.

  - Providing services for mental health and mental retardation.

  - Expanding preventive care, home care, and rehabilitation care for children and adults.

  - Alleviating major public health problems such as arteriosclerosis, alcoholism, destructive drug use, hypertension, stroke, venereal disease and lead poisoning.

- Coordinate City-wide health planning activities.

- Develop effective organizational and programmatic ties between health programs of demonstrated efficiency and related programs on housing, environment, transportation, recreation and education.

- Place increased emphasis on development and utilization of less costly convalescent and long-term care facilities and on improvement of procedures for movement of patients to such facilities from acute care facilities.

- Encourage decentralization of decision-making within the City's health care system.

- Seek ways to make more personal and more compassionate current provision of care through well designed intake and triage procedures, increased continuity of care to the same patient by the same medical personnel, increased integration of specialty care into comprehensive units,

integration of ambulatory care services provided by emergency rooms and hospital outpatient departments.

- Develop new ways to upgrade and create new career opportunities for the City's health workers.

- Establish a mechanism for screening nominees for all high level health appointments.

- Develop a capability for articulating the City's interests and views concerning national health policy.

- Seek increased Federal and State financial assistance for local provision of care, and expand City financial assistance for delivery of health care.

- Support a well designed, comprehensive, and adequately financed national health insurance program equally beneficial to all citizens.

- Consider ways by which the City can strengthen and coordinate inspection and enforcement authority.

- Undertake a feasibility study of establishing a City-supported medical school.

Through the next administration's implementation of these recommendations, and others likely to evolve from the recommended comprehensive review, the ultimate goal we seek is provision of health care to all New Yorkers in accordance with a uniform standard of excellence.

Abraham Beame has the foresight, the experience and the skill to accomplish these objectives.

In his pursuit of these objectives, we pledge to him our full cooperation and support.

Howard A. Rusk, M.D.
Chairman

Martin S. Begun
Coordinator

Richard W. Nathan
Recorder

Supplement

COMMUNITY COUNCIL OF GREATER NEW YORK

225 Park Avenue South · New York, N. Y. 10003 · (212) 777-5000

October 2, 1973

Dr. Howard Rusk, Director
Institute of Rehabilitative Medicine
400 East 34th Street - 6th Floor Suite
New York, New York 10016

Dear Howard,

As per your discussion with Elly Bernheim yesterday, I am enclosing a set of position papers on health services in New York City which were prepared by the Action Committee of the Health Task Force of the Community Council. They were approved by the Council's Board of Directors on September 25th.

These papers are being sent to all the candidates for Mayor with the expectation that health care needs of New Yorkers must assume the high priority in their platforms that our Health Task Force believes they should have.

I would like to highlight just a few of these positions which we feel are most important and hope that your Task Force will include them in your own position paper to Mr. Beame:

1. The Mayor should open the programmatic and fiscal activities of the Health and Hospitals Corporation for public scrutiny and discussion; he should support legislation to restructure its Board of Directors to make it more responsive and publicly accountable (p.3 of Position Papers);

2. the Affiliation Contracts between the Health and Hospitals Corporation and voluntary hospitals must be available for public review and reaction; these contracts should be geared to performance, with specifications for quantity and quality of services and procedures for strict contract compliance instituted (p.7);

3. the Commissioner of Health should serve as Health Services Administrator and should be responsible for carrying out all the activities of Health Services Administration (p. 17);

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4. the Mayor should direct his health agencies to design, develop and implement a rational plan for decentralized, city-wide ambulatory care services in the public and private sector (p.11);

5. the Early and Periodic Screening Diagnosis and Treatment Program for the medically indigent children in New York City should be moved into high gear; first step is the appointment of a program administrator to whom the Departments of Health and Social Services will be accountable (p.11);

6. the Mayor should organized an emergency Task Force of City and State and public representatives to develop community services for the care of persons being discharged from state institutions for the mentally ill and the mentally retarded (p.4);

7. the Mayor should encourage citizen participation (including the actual consumers of services) in the planning and operation of health services receiving public funds (p.24).

We look forward to your response to these proposals.

Sincerely,

Frank van Dyke
Chairman, Health Task Force
Community Council of Greater New York

FVD:SH:ta
Enc.

cc: Mrs. L. Bernheim
Bernard Shiffman
Mrs. M. Ascoli

COMMUNITY COUNCIL OF GREATER NEW YORK

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HEALTH TASK FORCE

Frank van Dyke, Chairman
Mrs. Max Ascoli, Chairman, Action Committee
Sylvia Hunter, Staff Director

POSITION PAPER

I. Health and Hospitals Corporation

The Corporation was established in 1970 as a means of bringing strong, flexible and efficient management to the nation's largest system of (19) public hospitals. Among its central purposes were: (1) to overcome the serious problems of unstable and inadequate financing; (2) to eliminate duplication and waste in such hospital management procedures as purchasing, personnel and accounting; (3) to free the hospital system from the bureaucratic control of the City comptroller's office, Bureau of the Budget and the Civil Service; (4) to decentralize control; (5) to raise the quality of care, and (6) to strenghthen consumer participation in the governing councils of the hospital system. Such measures were seen as necessary conditions to the improvement of patient care in the City's long-beleaguered and off-criticized hospital system.

Three years later, many of the same problems remain. In addition, the very nature of the Corporation as a public benefit corporation has given rise to new problems of un-responsiveness and lack of public accountability which demand urgent personal attention from the incoming Mayor..

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Community Council of Greater New York
Health Task Force - Position Paper
Health and Hospitals Corporation (Cont.)

Problems

1. Payments from third party sources were over-estimated, resulting in underfinancing and overdependence upon that part of the Corporation's budget which comes from city tax levies. The results have been budget cuts, personnel freezes and regressive management controls.
2. The consistent failure to make available to the public the information necessary to evaluate the Corporation's performance (and actual financial condition) has led to a serious crisis of credibility in the Corporation's operations.
3. Composition of the Board is overly narrow, for example, it has no representation from among those who use the services of the Corporation hospitals. There is no public knowledge of its actions or opinions.
4. Problems of waste and inefficiency persist. A recent study by Arthur Anderson and Company revealed $1.4 million in payroll spending unaccounted for; inadequate payroll and time records; and failure to exploit the potential of large-volume discount purchasing. Moreover, these management studies suggest that the top-heavy central staff could effectively be reduced by half.
5. The system remains over-centralized with too little attention given to establishing the proper balance between central office leadership and coordination, and local initiative.
6. Scant attention has been paid to improving the quality and modes of delivery of patient care. Overspecialization in ambulatory care clinics plague the municipal hospitals. Plans for comprehensive

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personal care, with a continuum of ambulatory, in-patient, long-term and home care services, have not been implemented.

7. Despite initial promise of the development of a network of Neighborhood Family Care Centers, there has been little evidence of overall policy or adequate planning for the three that are currently being completed, or the others which are supposed to be constructed.

Position

The Mayor, who appoints all members of the 15-member Board (five are recommended by the City Council) who, in turn, elect its President, is ultimately accountable to the public for the performance of the Corporation. So long as the City has a role in health services and contributes almost half of the Corporation's funds, he and his key staff must devote much more attention to Corporation activities.

Therefore, we urge that the Mayor give high priority to resolving some of the problem areas which impede the functioning of the Corporation, and to seek legislative changes, where necessary. For example:

1. the Board of Directors should be re-structured to make it more responsive and publicly accountable; it should provide for consumer membership;
2. the system should be open to public scrutiny, particularly with regard to budgets, affiliation contracts, operating statistics, etc.;
3. greater autonomy and decentralization of authority should be granted to individual hospitals to serve community needs. At the same time, the calibre and efficiency of central office staff

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should be improved;

4. comprehensive and coordinated ambulatory care programs in all municipal hospitals must replace the pattern of excessive specialization clinics;

5. long-range policy planning and innovative experiments in providing health care services must be developed; plans and timetable for construction and operation of the Neighborhood Family Care Centers should be formulated and made public.

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COMMUNITY COUNCIL OF GREATER NEW YORK
HEALTH TASK FORCE

POSITION PAPER

I. Health and Hospitals Corporation

Ia. Affiliation Contracts

The system of affiliation agreements between City hospitals and the major teaching hospitals of New York was developed in the early 1960's in response to the deteriorating quality of care and the chronic shortage of American-trained house staff in the municipal institutions. Under these agreements, the medical staff of the teaching hospitals provide supervision, at City expense,[1/] to the medical care programs in the municipal hospitals. In some respects, the result has been a considerable upgrading of the quality of care. However, along with the recognized benefits of this program, serious questions have been raised about the provisions of the contracts, the performance, and the cost/benefit of this program.

Problems

1. There is secrecy surrounding the provisions and specific budgets; they are unavailable for public scrutiny.
2. No statistical data are available upon which the program can be evaluated. Contracts are not geared to performance.
3. Some of the affiliated hospitals, themselves, are still unable to attract graduates of medical schools which meet acceptable

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1/ Approximately 20% of the Corporation's expense budget.

professional standards.2/

4. Questions have been raised, but unanswered by the Corporation, regarding the actual amount of supervisory time being provided by the teaching staffs of some of the voluntary hospitals.

5. Considerable confusion, inefficiency and inequities arise from the dual system of administration (physicians, and some ancillary and and administrative staffs of the affiliation program are employees of the voluntary hospitals; nurses, social workers and clericals are employees of the Corporation).

Position

We recommend that, since these agreements are currently being reviewed:

1. the findings of the Corporation's Affiliation Review Committee, which is studying these agreements, be completed as rapidly as possible and made public;

2. provisions of all proposed new contracts should be available for public review and reaction prior to making them final;

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2/ The number of foreign-trained house staff has increased since the onset of the affiliation contracts: 46% in 1962 compared to more than 50% in 1972; In 1962, of the 10 municipal hospitals with approved post-graduate teaching programs, six had over 85% of house staff positions filled by foreign-trained physicians; in 1972, the same situation obtained in these six hospitals.

COMMUNITY COUNCIL OF GREATER NEW YORK
HEALTH TASK FORCE

POSITION PAPER

II. Ambulatory Care

The people of New York City are entitled to high quality ambulatory care health services. For too long, emphasis has been placed upon high cost, in-patient care to the detriment of ambulatory and preventive health services. Unnecessary hospitalizations occur when such services are inaccessible, of poor quality or of prohibitive cost.

The City has a key role in guaranteeing an effective system of ambulatory health services to all its citizens: to include those whose private health insurance has inadequate ambulatory care coverage; for those who have no health insurance at all; for those just above the Medicaid line, as well as for those on Medicaid. This care should provide comprehensive services within or outside a hospital setting; it should provide continuity and consist of a system of preventive, diagnostic, therapeutic and rehabilitative services, either in one location or available through an effective mechanism of linkages and referrals.

Problems

1. Given the chronic shortage of private physicians in many areas in the City, emergency rooms and out-patient departments of public and voluntary hospitals have become the main source of primary care for almost four million New Yorkers. Yet these services are overcrowded and lacking in dignity for the patient. The medical service is often impersonal, and for the most part, episodic and discontinuous. The reimbursement for such care ranges from $35-95 per clinic visit;

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emergency room reimbursements are in the $35 range.

2. The availability of comprehensive, high quality ambulatory care outside hospital settings is seriously lacking. Where it exists - through Federally-funded, categorical programs now almost limited to Medicaid-eligible persons - it is subject to chronic financial instability, and precarious legislative existence.

3. The Ambulatory Care Programs of the Department of Health (formerly known as the "Ghetto Medicine" Program) though designed as a means of improving the availability and quality of ambulatory care services in the voluntary hospitals in underserved areas in the City, has become instead a mechanism for bailing these hospitals out of their financial distress.

   Periodic site visits by the Department of Health reveal that many participating hospitals fail to meet standards established by the Department, four years after operation. Little attempt is made to track down exactly where and how the money is spent in each institution. Staff support to community advisory boards for training and assistance is woefully inadequate.

4. The number of children in New York City who have not had adequate well-baby care or who come to school without necessary immunizations is increasing. Thousands of children in New York City whose medical care is paid for with public funds are still receiving fragmented and episodic care. Given New York's large transient and deprived population, many families fail to bring children for essential

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preventive health services or to follow up on recommended treatment.

New York City, under the federally-mandated Early and Periodic Screening, Diagnosis and Treatment Program, now has a unique opportunity to change and upgrade the child health delivery systems - especially for those whose health care is dependent upon public funding. This program has the potential to reach all poor and medically indigent children and to get them into the health system in an orderly way. Its potential service population is 850,000.

The federal regulations require that full medical screening, diagnosis and where necessary, treatment (including dental care) be provided for each Medicaid-eligible child under the age of twenty-one. Federal penalties for states failing to comply have been established.

But this promising program is now stalled. Its implementation is beset by many real as well as bureaucratic complications. At a time when most federal health programs are being cut back, this comprehensive ambulatory care program, about which there is little public knowledge, assumes even greater significance.

Position

The City Administration, responsible for directly providing, or paying for, the care of millions of medically indigent New Yorkers, and for purchasing health insurance for hundreds of thousands of City employees and their families, must take the leadership in guiding the planning and development of a rational system of ambulatory care services for the City of New York.

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The Mayor should:

1. immediately direct the Comprehensive Health Planning Agency (the City agency composed of consumers and providers), to develop a plan for decentralized, city-wide ambulatory care services in the public and private sectors which will:
   a) guarantee high quality, accessible, non-fragmented, sensitive services to all who need it;
   b) place emphasis upon the development and coordination of non-hospital based primary care services;
   c) tie-in the federally-funded programs and make financial provision for their continuance where necessary;
   d) assure strong consumer representation on governing boards of these services.

A time-table must be established for the development of this plan, and the Health Services Administrator and the Director of the Comprehensive Health Planning Agency must be held directly responsible for adherence to this timetable.

2. enforce compliance with standards for ambulatory care in voluntary hospitals receiving City and State money through the "Ghetto Medicine" program;
3. immediately implement the E&PS&D Program, by directing the Commissioners of Health and Social Services to assign a highly-qualified, full-time administrator with public health experience

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backed up by a strong inter-agency team, to get the program going;

4. exercise the leverage of the City's purchasing power (as major contractor) with all health insurance plans to improve their coverage for ambulatory care services.

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COMMUNITY COUNCIL OF GREATER NEW YORK
HEALTH TASK FORCE

POSITION PAPER

III. New York City and Medicaid

Medicaid is a costly program for our City even though the State pays 25% and the Federal government 50% of the total bill. In Fiscal Year 1971, 1.5 million persons (almost 20% of the population) were covered by Medicaid. In the month of February of 1973, the City spent $27,779,000 for its share (25%) of the Medicaid program. During this month more than half of this expenditure was for hospital care, including voluntary, proprietory and municipal hospitals. Other payments went to private practitioners and other covered services.

The State alone sets the reimbursement rate for all hospitals, although its financial contribution is no more than the City's. A sample of these rates are provided in the following chart:

	Per Hospital Day Semi-private	Emergency Room per visit	Clinic visit
Municipal Hospital	$ 129.62	27.44	35.88
Cancer Memorial	226.89	-----	94.30
Columbia	143.00	37.65	31.29
Swedish Hospital	64.31	10.47	-----
Flower-Fifth Avenue	160.84	38.59	67.55

Problems

New York City spends a great deal of money for health services for its indigent population without adequate control over the nature, quality, or cost of the care, and certainly without any influence on the way these services are being delivered.

Although the State has the legal responsibility to set rates and

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make policy, it has done so unilaterally, without input from the City, an equal payor in the program. The City Health Department has a system for flagging the most flagrant abuses by private practitioners, but little information is available on the hospital ambulatory care component of the Medicaid program. It is impossible to determine how many patients are going to private physicians and hospital clinics for treatment of the same illness, or whether patients are asked to return for unnecessary clinic visits.

Although the City Health Department is charged with maintaining quality standards in the Medicaid program, the Health Department does not have sufficient personnel or administrative committment to carry out its regulatory and monitoring role effectively. Because of the lack of leadership, Medicaid funds have not been used creatively to promote the development of alternate health delivery systems such as HMOs and pre-paid group practices.

Position

We recommend that the Mayor should:

1. expand and strengthen the Health Department's program of surveillance for all institutions receiving Medicaid funds to maintain the quality of care;
2. encourage the use of Medicaid funds to develop innovative approaches to delivery of medical care, such as HMOs and pre-paid group practices;

...

3. insist that the City be represented (as an equal payor) in making policy with regard to setting rates and developing rules and regulations. (This is particularly pertinent in the event of a State take-over of the Administration of the Medicaid program; the City Administration must protect the rights of its medically-indigent citizens to obtain the medical care to which they are entitled.)

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SFH:ta
Dept. 610/150cc
July 26, 1973

COMMUNITY COUNCIL OF GREATER NEW YORK

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H E A L T H T A S K F O R C E

Frank van Dyke, Chairman
Mrs. Max Ascoli, Chairman, Action Committee
Sylvia Hunter, Staff Director

POSITION PAPER

IV. Inter-relationships and Coordination Among City Health Agencies

The present City Administration has undertaken three major organizational changes in the City's official health establishment: creation of a "super-agency" (Health Services Administration - HSA) to administer a wide range of City health programs including the Addiction Services Agency; creation of a public benefit corporation (Health and Hospitals Corporation - HHC) to operate the 19 municipal hospitals; and creation of a planning agency (Comprehensive Health Planning Agency - CHPA) to conduct city-wide health planning under the Federal Partnership for Health Act.

The purpose of these undertakings was to have improved the coordination and accountability of the planning, execution and evaluation of public health services. In practice, not all of these goals have been achieved.

Problems

1. Those City agencies which have the responsibility for articulating and implementing the City's health care goals have not carried out this responsibility to its fullest extent.

Community Council of Greater New York
Health Task Force - Position Paper
Inter-relationships and Coordination Among City Health Agencies (Cont'd.)

2. There has been lack of clarity and overlapping in the respective roles of Health Services Administration and the Health Department.
3. The Health and Hospitals Corporation has operated in a no-man's land of public accountability. Operations have been overcentralized and at the same time sheltered from public scrutiny and even of its own Board of Directors.
4. The Comprehensive Health Planning Agency has not done its mandated job: planning: It lacks the authority and the capability to perform its role with full effectiveness.

Position

1. The Health Services Administration and the Health Department should be merged, with the Health Services Administrator clearly established as the City's Chief Health Officer. The Health Services Administration would supervise and coordinate public health activities with those of the Department of Mental Health and Mental Retardation, Addiction Services Agency, Comprehensive Health Planning Agency, and the Health and Hospitals Corporation.

Health Department

would set standards, evaluate, monitor, conduct program audits, epidemiological investigation and surveillance over the effectiveness of public and private health programs, and continue with the development of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) for

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Medicaid-eligible children;

Health and Hospitals Corporation

would eventually carry out operational functions of unifying and delivering preventive and treatment services and bringing them into the community through a network of ambulatory care centers;

Comprehensive Health Planning Agency

should be firmly established as the planning arm of the Health Services Administration/Health Department with its long-range planning capability strengthened; authority to approve capital outlays for health facilities; development of a hierarchy of planning objectives from the city-wide level through to local districts. Objectives should be set area by area, by specific age groups and specific disease conditions. District health officers should be used actively in local district Comprehensive Health Planning Agency programs.

2. The Mayor should be clearly seen as accountable for the activities of the Health and Hospitals Corporation. To facilitate this, his HSA/HD Administrator should cease to be Chairman of the Health and Hospitals Corporation's Board of Directors, but instead, adopt an independent posture. The post-audit and surveillance activities of his agency re: the Health and Hospitals Corporation should be significantly increased.

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COMMUNITY COUNCIL OF GREATER NEW YORK
HEALTH TASK FORCE

POSITION PAPER

V. Mental Health and Mental Retardation Services

Since its establismment in 1969, the New York City Department of Mental Health and Mental Retardation Services has achieved some significant gains - strengthening its central planning and evaluation capabilities, developing constructive arrangements for collaborative services with other public agencies and departments of the Health Services Administration, and initiating development of a city-wide "Master Plan". Several advisory "federations", at borough and local levels, have been established in an attempt to achieve public accountability.

All of these efforts are sound and reasonable if the City is to move toward a city-wide system of comprehensive community-based program of mental health and mental retardation services, but serious problems remain. Among these, the most serious are: inadequate funding, uneven quality of services, and inequitable distribution of these services.

Problems

1. A two-class system of mental health care exists in this City, care that is available to those dependent on public facilities, and care that is available to the more affluent. Psychiatric services in Corporation hospitals are subject to the same shortcomings of obsolence and the lack and inadequacies of materials, amenities and manpower that affect all municipal hospital services. In addition, there are remarkable differences in the quality of care and in the funds allocated among the several municipal psychiatric services. ...

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2. Certain categories of persons - for example, children under care of public agencies or courts, the older poor with mental disabilities, drug addicts, alcoholics and the chronically unemployed - are isolated from the referral channels that would bring them to the attention of providers of mental health care.

3. Barriers to effective collaboration among providers of service continue to persist, involving jurisdictional disputes and competition among agencies for primary recognition.

4. Serious gaps and shortages in available services remain:

   - ten years after the enactment of the Mental Retardation Facilities and Mental Health Construction Act, the City has only six community mental health centers in operation from a projected plan of sixteen;
   - inadequate preventive services in the area of mental health. School mental health services, for example, are unable to deal effectively with overt deviant behavior as well as with less manifest problems;
   - cuts in staffing which may result from recent cutbacks in the granting authority of the National Institute of Mental Health.

5. The State has released persons from mental hygiene and mental retardation institutions without adequate, available community facilities for their care or rehabilitation.

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Community Council of Greater New York
Health Task Force - Position Paper
Mental Health and Mental Retardation Services (Cont'd.)

Position

1. The City must give priority concern for mental health needs and, together with the State, provide replacement funding to make up any shortfall in mental health funds which will result form Federal cutbacks, and make a commitment for additional monies to support new programs.
2. The City must assume a more vigorous role in the search and development of facilities for housing, care, and rehabilitation of patients discharged from State institutions. The Mayor must organize a Task Force, including City and State representatives, to develop adequate programs and funding to provide after-care for these persons.
3. The City's standards for the provision of mental health services should be carefully re-examined both as to the levels of performance, and to the application of these performance standards in contracts with voluntary hospitals and agencies.
4. Mental health agencies funded by the Department of Mental Health and Mental Retardation should be subject to high standards of practice and requirements for full collaboration in the City's program.
5. New programming and budget allocations must be focused on preventive mental health services and in serving categories of persons who have been underserved - the older poor, children under care of public agencies, drug addicts, alcoholics, etc.

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COMMUNITY COUNCIL OF GREATER NEW YORK
HEALTH TASK FORCE

POSITION PAPER

VI. Citizen Participation in Health Services

In the last few years a number of different City health programs have established, or are in the process of establishing, community boards, namely, Comprehensive Health Planning District Boards, Municipal Hospital Community Boards, HEW Neighborhood Health Center Councils, Ambulatory Services Advisory Boards to the "Ghetto Medicine" Program, and Mental Health and Mental Retardation Sub-regional Planning Boards. These Boards were created by federal or state legislation in response to a growing national concern for consumer participation in health, education and welfare services and in community development. With greater emphasis on decentralization of service delivery, the concept that consumer representatives of local interests should share in local decision-making is becoming accepted by many people in our City particularly in the public sector.

The voluntary sector is also beginning to respond to the need for consumer participation because it, too, receives substantial amounts of public funds and because it recognizes the positive contribution made by consumers towards improved delivery of services. Heretofore, voluntary organizations have only involved those lay persons who could raise the money for an institution or assist in building expansion programs, but have not included the actual consumers of the services, especially the medically indigent and middle-class persons. Now, when the major portion of the operating budgets of voluntary hospitals comes from Medicare, Medicaid and health insurance and only a small percentage from philanthropic contributions, there needs to be some re-consideration of the composition of policy-making boards for these institutions.

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The rationale for involvement of consumers is to insure that the services provided will be relevant and responsive to the needs of those for whom they are intended. Community participation in health services also serves to raise the consciousness of what good health care is, and how to get it. On the other hand, those providers who oppose consumer involvement fear that it would mean "control" over technical questions of diagnosis and treatment and thus hamper the delivery of care.

With the growing consumerism movement in American life, it becomes imperative to expand the involvement of lay persons in the delivery of health services, particularly those who have been traditionally excluded from this process. The issue is no longer whether consumers should have input, but how to define "consumer" or "community" and what would be an appropriate, productive and non-adversary role.

Problems

1. Lack of clarity, consensus or consistency around the definition and role of "consumers" or "community" in relation to health services.
2. In the public sector, guidelines vary, according to funding source, as to responsibilities[1/] methods of selection and extent of consumer membership on community boards. Potential danger of overlapping exists due to plethora of facilities and satellites with differing guidelines.

...

1/ e.g., NIMH mandates policy-making role; Health and Hospitals Corporation says "advisory", Comprehensive Health Planning Agency District Boards say "review and comment" on applications for funding.

There is no overall coordinated policy among City health services about geographical or functional jurisdictions.

3. In the private sector, despite the fact that local people and indigent persons are usually the primary users of out-patient services, there is no provision for representation on policy-making boards.

4. City health agencies have been slow in carrying out their responsibilities to establish viable local boards where these have been mandated. On a central level, the Health and Hospitals Corporation Board has no representation from among the users of the municipal hospitals and the Health Services Administration has never appointed its 15-member Advisory Board (with a majority of public-interest laymen), as provided by the City Charter.

5. There are insufficient City programs to educate the consumers on the boards of municipal and voluntary hospitals about the complexities of health services, or to educate the providers about consumer concerns, thus resulting in frustrations and confrontations.

Position

1. Definition of "citizen" should be broadened to include both the actual consumers of service and representatives from the community in which the service is located, or from city-wide organizations for city-wide programs.

2. Although the methods of selection and specific functions should be flexible enough to conform to local needs, any operational health

...

service, public or private, should have a community board whose responsibilities would include:

a) assist in establishing priorities in provision of health services, including which services are most needed by the community and innovations in delivery mechanisms;

b) participation in allocation of funds within the health service's budget;

c) assessing the performance of the health service in meeting the recipients' needs;

d) participation in selection of the health service's administrator;

e) deciding how best to broaden community participation in health services, whether this be done by patient education or patient advocacy;

f) determination of location and hours of service, to assure accessibility and availability.

3. These boards should have available to them full program and fiscal data in order to carry out the above functions.

4. In the voluntary sector, these community boards should be adequately represented on the policy-making boards of the respective institutions.

5. The Mayor, in carrying out the City's commitment to citizen participation in the delivery of health services, should:

a) guarantee that all City health agencies immediately comply with mandated requirements for establishment of representative community boards (Comprehensive Health Planning District

...

Boards and Department of Mental Health Planning Boards, Municipal Hospital Boards);

b) in order to assure their effective functioning, city-supported programs should be instituted to educate board members and the public in complexities of health service delivery; funds should be allocated for staff support to these boards as well as for carfare, baby-sitting expenses, etc.;

c) where there are conflicting, overlapping or vague guidelines, the City should assume responsibility for specifying, rationalizing and coordinating them, and if necessary, negotiating changes with federal and state agencies to make the guidelines workable;

d) appoint the Executive Committee (consumer majority) of the Comprehensive Health Planning Agency's Board of Directors as the Advisory Board to the Health Services Administration; its responsibility will be to recommend service priorities and overall program plans, allocation of resources and discretionary budge funds;

e) institute legislative changes to enlarge the Health and Hospitals Corporation so that consumer representatives from the Community Boards of the municipal hospitals can serve on the central Board of Directors; in the meantime the Mayor should fill vacancies on this Board by such representatives until the law has been changed;

f) establish an "ombudsman" service in the Mayor's Office to investigate consumer complaints in both private and public health services in New York City.

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SFH:ta/Dept 610/200cc/October 1973

New York City Chapter
National Association of Social Workers

79 MADISON AVENUE • NEW YORK, N. Y. 10016 • MURRAY HILL 3-4612

September 28, 1973

Mr. Martin Begun
Associate Dean
N.Y.U. Medical School
550 First Avenue
New York, New York 10016

Dear Mr. Begun:

I want to express my appreciation for your suggestions in response to our mutual concerns pertaining to the delivery of health care and services to the people of New York City who are in need. In response to your suggestion, we have briefly outlined a statement of some of the basic issues.

The admission and discharge of patients, particularly the aged, is dependent upon coordination of efforts between the hospitals and the Human Resources Administration Department of Social Services. The current lack of coordination results in unnecessary hospitalizations and delay in the transfer of patients to nursing homes and other community facilities, as well as to their own homes. The patients are therefore unnecessarily occupying expensive hospital beds when, in fact, they are medically ready for discharge to less expensive facilities. For example, the average cost of a hospital bed is $129-$180 per day as opposed to a nursing home bed with an average cost of $30-45 per day. People are often admitted to expensive hospital beds from the community rather than to nursing homes or other community facilities due to inadequate and unwieldy administrative procedures and regulations utilized by HRA. These procedures unnecessarily delay the financial approval essential for institutional and/or community placement of patients. The HRA system is unresponsive to immediate requests for community services such as homemakers, housekeepers, etc., which would enable patients to recuperate at home rather than in an acute care hospital bed. The attached article from the New York Times best illustrates the concerns of our committee.

The NASW Ad Hoc Committee has developed a working relationship with the Director of Income Maintenance, Mr. Charles Morris, and are working toward resolving some of these problems. Many problems remain in the system. Local Income Maintenance Centers are unable to coordinate with Chelsea Medicaid office, thereby delaying financial approval. The staff in the Centers are either unable or unwilling to follow regulations and procedures as required, resulting in massive delays in meeting people's needs.

The computer system has failed to be responsive to the human needs that HRA is mandated to meet and a system must be devised where accountability for the delivery of services can be identified. The City's efforts to meet the new state regulations for Public Assistance and Medicaid are woefully inadequate and must be reviewed with more allocation of manpower to this new demand. These and many other problems are still awaiting resolution. The Ad Hoc Committee has been encouraged by the response of the current HRA administration to our concerns, and we are looking forward to furthering our working relationship with the new administration. At this time we are apprehensive as personnel changes are already in effect, but trust that the remaining staff will follow the present direction of cooperation with the hospitals and health related agencies.

I hope this information can be of some use to you in furthering the delivery of health care and services to the citizens of New York City.

I welcome your suggestion that I participate on the task force and look forward to hearing from you if I can be of further assistance.

Sincerely,

Louis Kerdman

Louis Kerdman
Director, Social Services
Fordham Hospital

Member, NASW Ad Hoc Committee of
Bronx Professional Social Workers

LK/rmc
encl.: N.Y. Times article
Press Release

JANE C. MC CONNELL BEAME'S HEALTH TASK FORCE

Beginning in the 1960's several organizational changes were instituted in relation to New York City's municipal health delivery system with the intent of improving the organization, quality and accessibility of health care rendered to the consumer.

The first major change was the implementation of the affiliation contracts that city hospitals developed with the area's medical schools and teaching centers as a means of providing comprehensive professional services within the municipal hospital system. In 1967 the Health Services Administration, a new organizational superstructure was formed with the purpose of improving and coordinating health planning, evaluation and policy formation among the municipal health and health related agencies in New York City. By 1970 the Health & Hospital Corporation, a quasi-public agency was established to free the municipal hospital system from a centralized organization heavily dependent upon other centralized agencies into a self-sufficient organization decentralized to make every city hospital responsive to local needs. It also was to integrate all municipal health delivery services within its structure and by working in close cooperation with the voluntary institutions to provide for a planned network of community health services.

Although these changes have resulted in some improvements within the health care system, the progress made to date has been too slow and in certain instances an actual deterioration of services has occurred.

Overlapping, fragmentation and gaps in services plus increased consumer frustration still exist. Long range health policies, plans and manpower needs for New York City as yet have not been formulated. Just as before two segregated systems of health care remains with no significiant improvement in the quality of the municipal health services as yet apparent.

RECOMMENDATIONS

Since the present health organizational structure has not achieved its purpose, in order to determine the facts and future action to be taken, it is recommended that a committee be established with consumer representation which will address themselves to specific questions and will report to the Mayor within a specified period of time their recommendations for improvement in health services and programs (Several open meetings should be held in order to obtain more consumer imput).

1. What mechanism can be instituted to provide for better coordination between health and health related agencies within New York City since the Health Services Administration has not succeeded in this task?

2. Review the functions, performance and accomplishments of the Health & Hospital Corporation and make recommendations for improvement.

3. Review affiliation programs for level of performance and cost.

SPECIFIC POINTS

HEALTH & HOSPITALS CORPORATION

1. Since the central office has been expanded considerably the reasons for this should be explored, as well as, a review of the background and qualifications of the new executive personnel hired by the Corporation.

2. Analyze the degree to which the local hospital management has had a say in the institutions' budget and in determining how it is to be spent.

3. What is the cost per patient day in each hospital and the reasons for substantial differences? What local incentives for fiscal management have been instituted?

4. What is the actual improvement in nursing hours per patient day? Even though 1,000 Registered Nurses have been hired, what percentage of them now staff new intensive care units and additional expanded services. What percentage of them are additional staff to the existing general patient care units. Why is the percentage of staff nurse turnover at the 90% level. Why has the number of Licensed Practical Nurses and aides been decreased? What innovative changes in nursing practice in light of the technological changes have been implemented or planned? Why has the Department of Nursing managing approximately 40% of the personnel within the Corporation, providing patient care, no place or voice within the top executive management of the Central Office.

5. What steps have been taken to reduce Emergency Room and Out-Patient Department waiting time and to improve services? Has the triage system been effectively implemented? Are clinics still functioning in rigid specialized areas with no specific appointment times or physicians assigned.

6. Why does the ambulance response time still remain 20-30 minutes? Even though more extensive training is now being given to ambulance technicians, what are the requirements for completion of the course?

Why do the ambulance drivers still receive more pay then the ambulance technicians even though they are not trained to assist in immediate emergency care?

7. Why has the Corporation failed to meet its own timetable in developing comprehensive child health programs within the existing child health stations?

OTHER SUGGESTIONS

AGED

Our health care system must address itself to the unique needs and problems of the elderly which now constitutes 13% of the population of New York City. Methods should be explored to develop a program of providing health screening and maintenance within new and expanding senior citizen centers. Also day hospitals for the frail elderly can be implemented within some existing hospitals and nursing homes. Transportation problems to and from hospitals and social service agencies need to be reviewed on a city-wide basis.

Statement on needs of the mentally retarded in New York City.

The shame of Willowbrook exposed by the media has focused attention on the inhumane conditions in the state institutions in which thousands of mentally retarded citizens of New York City are forced to waste their lives. These conditions have struck a raw nerve in the conscience of the people of the city and created a demand for an end to the shameful conditions that prevail in the large state institutions that warehouse and dehumanize the mentally retarded.

"No More Willowbrooks" has become the battlecry of parents and friends of the retarded. The City of New York must accept its share of blame for the consequences of its neglect of the mentally retarded residents of the five boroughs. For too long the official attiude of the city has been a callous indifference to a major public health problem involving approximately 3% of its population.

The parent organizations have been forced to carry a major share of the financial burden of organizing educational programs for school children excluded children, for diagnostic and treatment clinics, sheltered workshops, activity centers, and other pilot programs. The parent groups have played the pioneering role in advocacy, legislation, direct programs, and support for research.

Until recently the city completely ignored pleas by the parent organizations for city tax levy funds. In the year 1972-73, community agencies in

contract with the city Department of Mental Health and Mental Retardation Services contributed about $4,500,000, while the city itself contributed only about $500,000.

A massive political action compaign that included mass demonstrations by the mentally retarded was required to insure that there would be an increase in city funds in the 1973-74 budget of the Department of Mental Health and Mental Retardation Services. At no time did the city administration support the fight for more funds for the mentally retarded.

The issue before the next administration is whether the city of New York will provide leadership in the fight for the rights of the retarded, or whether the mentally retarded and their families will continue to receive the crumbs of benign neglect.

Recommendations:

1. The official policy of the City of New York should be to guarantee the mentally retarded full rights in health services, education, training, employment, legal, recreation and residential services.

2. An Assistant Commissioner for Mental Retardation should be appointed in the Department of Mental Health and Mental Retardation Services to plan and coordinate all mental retardation programs.

3. The City of New York should provide mental retardation programs with a proportionate share of city tax levy funds.

4. A Commission should be established to implement the Unified Services Plan passed by the last session of the legislature. The bill provides

for state and local community planning and funding of all mental health, mental retardation and alcoholism services to the participating communities. The Commission should prepare a plan by July 1, 1974 based on input by providers of services and community representatives.

5. The city should provide leadership in the hiring of the mentally retarded. The law permitting New York City Civil Service to provide 100 jobs for the mentally retarded should be immediately implemented.

6. That all school age retarded children be guaranteed an education. All waiting lists for admission to public school special education classes should be eliminated.

7. That all school buildings and public buildings provide for the mentally retarded.

The major thrust at present is to replace the large, isolated institutions with community based facilities, which allow the retarded an opportunity to live at home or in smaller home-like residences. The next administration can provide the leadership that will mark a new era of hope for the mentally retarded and their families and write a chapter that will bring honor to New York City.

Jack Gorelick, Ph.D.
Chairman, Bronx Mental
Retardation Council

Ernest Koller

To : MARTIN BEGUN

From: MICHAEL LANDAU

The responsibility of government for health care for everyone should be no less than the responsibility for education, police and fire protection, etc. Indeed good medical care should be provided without regard to the means of the individual in the same manner as Social Security.

The assumption of this responsibility then obligates government to make sure that the best care, the right care, and necessary care is provided in the most efficient and economic manner possible for the following reasons.

1. Tax dollars that will have many demands on them will be paying for this care, so we should make sure we are not squandering it, and at same time getting the most and the best service we can get.

2. By such prudent administration we would thereby permit commensurately more services for more people, within the practical limits of the tax dollars appropriated for health.

To accomplish these objectives two concepts are suggested:

I Cut costs, and at same time increase and improve medical care, by reorganizing the delivery of health care.

II Provide for diagnostic check-ups for everyone- on a mandatory basis- within everyone's financial reach.

I REORGANIZING HEALTH CARE

Regionalization of health facilities can begin by reorganizing services provided by the hospitals of the New York City Health and Hospitals Corporation and New York City health clinics with related voluntary hospitals and health facilities on a logical geographic and population basis. Since virtually all of the Municipal hospitals are affiliated with major voluntary hospitals which provide most of the medical services, to the tune of over $160,000,000 annually, there is sufficient financial incentive and clout to effect such an organization.

We presently have voluntary and municipal hospitals and various medical facilities situated all over the City each of which offers a multiplicity of services .

The utilization of the facilities and the services available within the hospital itself, as well as between the different institutions, can vary tremendously- and does- from 90-100% utilization down to less than 50%.

Examples of this are open heart surgery and renal dialysis units which are high-cost and may be inadequately utilized. This is clearly inefficient and certainly contributes largely to the spiraling costs of health care.

The goal of the regional administration should be to provide more care for less money by consolidation, elimination, (unnecessary, unproductive, too costly services, facilities or entire hospitals).,cost controls, and ongoing utilization reviews internally-similar to what is being done by certain government-sponsored programs like Medicaid and Medicare.

These decisions should not be made unilaterally, but in consultation with community, professional, political and union leaders.

There would also be ongoing cost audits to determine reasons or justifications for significant cost variations between the hospitals.

II DIAGNOSTIC CENTERS

It's a lot cheaper to give a person a thorough diagnostic check-up in special new diagnostic facilites to be set up either in hospitals or in separate structures, even store-fronts or mobile units, than it is to admit some one to a hospital bed first, and then do the check-up.

A diagnostic center can be manned by one doctor and nurse in charge, and supported by various technicians along with a host of the most modern and sophisticated testing equipment available . Within this center, many tests can be performed at one visit which were fromerly performed in different clinics, each staffed by doctors and nurses. Obviously, a comprehensive diagnostic check-up undoubtedly will perform far more tests, in far less time, as a routine procedure than would normally be done even if some one scheduled appointments for several clinics, spread over several visits. This will immediately save money.

There are other tremendous health and economic benefits to be derived from the diagnostic center concept. By performing a complete series of tests automatically, an ailment may be discovered which may really account for the patient's complaints, rather than referring the patient to a specific clinic based on the patient's own description of his ailment. These " routine" tests may also disclose unsuspected conditions which would benefit immesaurably from early treatment.

Not only would the individual's health benefit, but society would similarly derive great dividends. Contagious diseases, social diseases drug and narcotic addiction, alcohol addiction, heart condtions, epileptic conditions, etc. could be detected, treated and cured. Heart or epileptic conditions can be hazardous to drivers and the public, especially if the individual is unaware of his condition. Sufficient privacy for indivuals could be assured, while adequately protecting the public interest.

Prevention or early treatment, perhaps as outpatient, is far less costly than lengthy hospitalization.

DIAGNOSTIC CENTER: REPORTING AND FINANCING

(A) Reporting

A proposal to be considered by public bodies and public hearings at which the views of professional and citizen groups may be aired fully would require that the results-or perhaps a pre-determined condensation of the results of the diagnostic check-up should be followed up in a manner to be prescribed, especially where certain results mandate it as a matter of public interest.

As a prior step, however, there should be a monitoring of these check-ups. One possible method may be to require such a diagnosis once every 3 years and to show evidence of having done this, by presenting a certification to this effect-not the actual report, or even the summary-when applying for a driver's license every 3 years. After all, the eyetest is now a requirement because it is in the public interest. Similarly, certain other conditions (previously described) could be considered similarly vital.

(B) Financing

If diagnostic tests are thus mandated, it becomes incumbent on government to provide, or assist in providing, the means so that it is attainable by everyone.

1. Where to go:

Diagnostic centers will be set up in hospitals, clinics, specially constructed centers, store-fronts, or even mobile units. In addition, many will have their own private physicians do the check-up and fill out the necessary form and "certification".

2. What will it cost:

In order to put this program within everyone's reach, it is proposed that a ceiling ($35 to $50) be imposed on the maximum cost to any individual regardless of his income, unless he goes to his own private physician. Any difference between the ceiling (it may be a sliding scale within a range) and the actual cost would be subsidized by either the City of New York or by a combination of Federal, State and City governments.

Where an individual goes to a private physician for the specific purpose of complying with this check-up requirement, some form of subsidy aiding the individual could also be worked out, by utilizing certain methods such as supplying testing equipment, performing laboratory analyses, etc.

ALBERT EINSTEIN COLLEGE OF MEDICINE
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DEPARTMENT OF GYNECOLOGY & OBSTETRICS

Mailing Address:
Bronx Municipal Hospital Center
Department Gyn/Obs
Pelham Pkwy. & Eastchester Road
Bronx, New York 10461

October 3, 1973

Mr. Martin Begun
Citizens for Beame
Hotel Barclay
111 East 48th Street
New York, New York 10017

Dear Mr. Begun:

Ms. Eileen Bransten recently replied to an early letter of mine in which I urged Mr. Beame to consult with the leadership of the Society for Urban Physicians in developing realistic plans for problems with New York City's health care system. In her letter, dated September 19th, she said Dean Rusk had been asked to head a task force. I'm assuming she meant Dr. Howard Rusk who is eminently qualified.

I urge that Dr. Rusk seek data from doctors and other members of the "health team" who participate in the care of patients. This is necessary because there is a mentality which stresses cost accounting; cost benefit; and administrative efficiency. While the need for management effectiveness cannot be denied (and is desirable), there is the more important reality to identify people and programs concerned with quality of care. If desirable attitudinal aspects of all the involved personnel can be combined with technological medical advances and supported cooperatively by managerial efficiency, we will find that the overall cost, even of "quantity care", can be reduced. This presupposes that the diagnostic and therapeutic procedures preformed are necessary and accurate.

I do not think this ~~notation~~ notion is idealistic "pie in the sky". It is the result of my awareness of what is going on. In the current system, there is an emphasis on the numbers of examinations performed, including physical examinations, laboratory tests etc. The cost benefit analysis relates "total numbers" to work output per individual. It is an unfortunate, erroneous approach which fails to recognize that the more efficiently trained, motivated, and experienced individual can do a job quicker and better. While we all are aware of the dollar limitations that are

available and which require further attention, the problems of personnel performance and realistic approaches to solutions must also be solved.

I hope you will share these thoughts with the task force. If I can be of any help as you consider the important question of health care delivery in the City, please get in touch with me.

Very sincerely,

Seymour L. Romney, M.D.
Professor

SLR:amm

SR-401

M Regan

NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION
125 WORTH STREET, NEW YORK, N.Y. 10013

October 11, 1973

Dr. Howard Rusk
New York University Medical Center
Institute of Rehabilitation Medicine
400 East 34th Street
New York, N. Y.

Dear Dr. Rusk:

I very much regret that a prior commitment precluded my attendance at today's Task Force meeting. I, therefore, offer the following comments related thereto for consideration:

I concur with your viewpoint at the last meeting re the necessity that the position paper be succinct and to the point. A long narrative statement will probably appear rhetorical, and repetitive of much that has been previously said without follow-through.

I do think the statement might highlight major problems which require attention by the City such as:

a) The need for a clear delineation of responsibility of public agencies involved with health (i.e., HSA, CHP, HHC, Health Department, Department of Mental Health and Mental Retardation, ASA, etc.), both in reference to planning and health services delivery. The best way for agencies to be held accountable is for their responsibility to be clearly articulated. The fragmentation, overlap, duplication, and lack of coordination in the City needs correction.

b) That more attention be given to evaluation of, and experimentation with, alternative health care delivery modalities, with analytic attention to cost, quality, and efficiency of service delivery.

c) Improved coordination and sharing of resources and responsibility between the various public service delivery agencies (i.e., social services, housing, transportation, recreation, etc.)

d) Increased emphasis on appropriate use of health facilities in the City, such that acute care, extended care, nursing home care, and home care capabilities supplement each other to provide total care for NYC residents as economically and optimally as feasible.

e) Careful attention to increased utilization of allied health personnel, where they can perform tasks previously performed by more scarce, more expensive personnel. Good training programs for such personnel will, however, be necessary, and delivery of high quality of patient care must remain the overriding goal.

f) The affiliation contract must be modified so as to be acceptable to all interested parties. Once accomplished, however, contract compliance must be expected from principal parties to the contract.

g) Increased focus must be given to the development of auditable guidelines and standards in the health care delivery field, and those who are to deliver the services should be consulted during the standard-setting process.

h) Since it is not feasible to do all things well in every facility, more attention must be given to sharing of service responsibilities between municipal facilities, and between municipal and voluntary facilities. Priorities in health care will probably be required, and once priorities (intra-institutional and City-wide) are set, efforts must be made by providers to focus increased attention (functionally, and via resource allocation) on same.

i) New York City can and should set examples in health care delivery for the United States,

Sincerely,

Norma J. Goodwin, M.D.
Vice President for Community Health
and Ambulatory Care

NG:fm

CITIZENS' COMMITTEE FOR CHILDREN
OF NEW YORK, INC.

777-3800

2 Park Avenue, Suite 2310, New York, N.Y. 10016

October 12, 1973

Dean Martin Begun
New York University
School of Medicine
550 First Avenue
New York, N.Y. 10016

Re: Beame Health Task Force

Dear Marty Begun:

So good to meet you yesterday.

Attached is a draft of our Position Paper on Early and Periodic Screening, Diagnosis and Treatment for Medicaid eligible children which you might wish to use as an attachment for Comptroller Beame. Henry Saltzman, our Executive Director, informs me that this draft paper along with others was sent to Judah Gribbitz who said that he would send them to the respective Task Force people. In case you didn't get this one, here it is.

I am sure that one matter came up after I left the Task Force meeting yesterday, i.e., the last two lines which endorse Mr. Beame. I certainly hope that the names of the members of the Task Force will not be disclosed and that the last two lines on the paper indicating public support for the candidate will not be included. Many of us in the civic field have long believed that it is not in our organization's interest to be publicly identified with any candidate. Ray Trussell told a group last night that he had understood that being on the Task Force in no way meant that the people would be so identified.

I will look forward to receiving the names of the members of the Task Force and the final product. I commend you and Mr. Nathan for

the excellent job you did in trying to pull together so many diverse points of view. Feel free to call if I can be of help.

Cordially,

Betty

Betty J. Bernstein, Ph.D.
Associate Director

/pls

Citizens' Committee for Children of New York, Inc. 2 Park Avenue, Suite 2310
DRAFT New York, N.Y. 10016 725-7948

EPSDT POSITION PAPER FOR MAYORAL CANDIDATES

The Early and Periodic Screening, Diagnosis and Treatment Program for Medicaid-eligible children 0-21 years of age is mandated under a 1967 Amendment to the Social Security Act. Federal regulations require that all States provide a full medical screening, and where necessary, diagnosis and treatment for all Medicaid-eligible children (those whose families receive or are eligible for Public Assistance or Medicaid). New York City has 850,000 eligible children 0-21 years of age, a figure which far exceeds comparable populations in many States. Federal and State Medicaid reimbursement is available and States failing to comply will be penalized.

Citizens' Committee for Children believes that the EPSDT program is the single most important health program ever enacted for children in the United States. It has the potential to reach all poor and medically indigent children and provide them with urgently needed comprehensive health care.

Here are the main problems delaying implementation of this program in New York City and the Citizens' Committee for Children proposed solutions which would speed up service to the children of New York City and compliance with Federal regulations:

I. Problem:

The City lacks information about eligible children (names, addresses, ages) to such an extent that in thousands of cases the Departments of Health and Social Services do not even know which children are eligible.

Solution:

Instruct the Commissioner of Social Services to see that an EPSDT Computer Tracking System is designed and completed immediately (some work is in progress) with the capability to identify all Medicaid-eligible children 0-21 years of age.

Cost:

In spite of our efforts, we have been unable to obtain a copy of the proposed and cost estimates from the Office of Management and Control, System Human Resources Administration. A large part of this activity is reimbursable.

II. Problem:

There is neither a plan for locating and reaching the eligible children (many of whose families are transient) nor assigned staff.

Solution:

Instruct the Commissioner of Social Services to insure that the EPSDT Computer Tracking System and staff maintain addresses and telephone numbers (where they exist) which are regularly up-dated for the eligible children.

Instruct the Commissioner of Social Services to assemble a staff of outreach workers and provide appropriate training to enable them to work with this program and population.

Cost:

We are informed that existing income maintenance staff are being transferred to this program. Training costs are reimbursable.

III. Problem:

A whole set of administrative problems exist because of the division of responsibility between City agencies, the lack of coordination and cooperation between public and voluntary health care providers, and the usual inter-governmental (Federal, State, City) factors.

Solution:

Instruct the Commissioners of Health and Social Services each to appoint a top-level full-time person responsible for EPSDT.

A mayoral assistant for EPSDT should be designated to work with concerned parties.

Cost:

Negligible.

IV. Problem:

At present no agency knows definitely what health care each child requires, if any, where, and of what quality.

Solution:

Instruct the Commissioners of Health and Social Services to design and maintain health information systems for these children which are interfaced with the EPSDT Tracking System.

Instruct the Commissioners of Health and Social Services to implement and coordinate the use of standard forms and charting procedures among EPSDT health providers as a reimbursement requirement.

Instruct the Commissioner of Health and other appropriate officials to provide additional professional and para-professional staff to the Child Health Stations and other public facilities.

How many additional?

Instruct the Commissioner of Health to develop specific guidelines and provide adequate staff support to monitor and coordinate patient care plans.

Cost?

Medicaid Reimbursement.

V. Problem:

There is a critical need to insure that quality and continuity of care is provided by public and voluntary health care facilities which are paid with public funds.

Solution:

Instruct the Commissioners of Health and Social Services to establish codified standards for public and private health care providers in the EPSDT program. These standards should authorize reimbursement for diagnosis and/or treatment of children with handicaps or diseases covered under the N.Y.C. Health Department Bureau of Physically Handicapped Children Program to approved

providers only.

Cost:

Negligible.

VI. Problem:

The City must meet its responsibility to inform residents about EPSDT and encourage parents to avail themselves of this service.

Solution:

Instruct the Commissioners of Health and Social Services to utilize modern techniques of mass communication drawing on all available media and using English, Spanish and Chinese to facilitate maximum participation of eligible children.

The Mayor should proclaim a special EPSDT day during which appropriate Citywide and neighborhood preventive health programs should take place.

Cost:

Medicaid Reimbursement.

COMMITTEE OF INTERNS AND RESIDENTS OF NEW YORK CITY
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SECRETARY-TREASURER

September 18, 1973

Martin S. Begun
Associate Dean
New York University School
of Medicine
550 First Avenue
New York, New York 10016

Re: Beame Health Advisory Task Force

Dear Mr. Begun:

The City faces severe problems with the delivery of Health Care to the citizens of New York. Two areas of vital concern are the following:

1) Ambulatory Care:

Development of adequate ambulatory care facilities should be encouraged, and should include the improvement of existing out-patient departments and emergency rooms. Furthermore, the Health and Hospital Corporation should encourage the development of resident training programs in family practice and emergency medicine. Should the revision of the Federal Emergency Health Care Act be passed, the City should make every effort to utilize these funds to improve ambulatory care.

2) New York City Health & Hospital Corporation Budget:

While the Health and Hospital Corporation budget is one of the largest items for the City of New York, the Corporation has become increasingly self-supporting over recent years. The City should at least provide the mandated minimum amount required by state law for the support of the Health and Hospital Corporation. The attached article from Volume 1, Number 1 of the CIR Bulletin is self-explanatory.

Presently, the City contends that the minimum annual appropriation required by Section 6-1(a) of the Act, should include appropriations for Medicaid, Mental Health and Debt Services. This is a highly questionable interpretation of the Act, since these funds are not in fact appropriated to the Corporation, nor paid to the Corporation, nor budgeted or expended for services rendered by the Corporation.

While we can all postulate as to how additional funds should be utilized at the City hospitals, at the very least, one must consider the understaffing which exists. For example, the present goals for providing nursing services on medical-surgical wards at the Health and Hospitals Corporation is 3.8 hours of nursing care per patient per day. This is well below the regional average of 5 hours per day.

The attached article from Volume 1 Number 2 of the CIR Bulletin, "Nurse's Nurse", is self-explanatory.

Needless to say, there is a strong need for the City of New York to commit itself to more than just saying that all citizens have a right to health care. The City must provide adequate health care and must support to the maximum extent, the Health and Hospitals Corporation in discharging its duties.

Yours sincerely,

Anthony Bottone, M.D.
Executive Secretary

AB:bc
Enc.

To: Health Advisory Task Force to Hon. Abraham Beame

September 18, 1973

From: Lillian Roberts, Member

PRIORITIES IN HEALTH

Concern for the health of the citizens of New York City must be a major priority in the next administration. This concern must be reflected in innovative program development and implementation, and supported not only in the budget but also encouraged through imaginative policies and program planning.

New York City can no longer rely upon a crazy quilt pattern of private institutions which supply not only some of the health manpower for New York City but also, in a major way, for the nation as a whole. As we all know, the reason for the development of the senior and community colleges in the CUNY system was to provide education for those academically gifted students who could not afford private education. It was hoped that many of these students would serve New York City after graduation --- indeed they have. One of the reasons for the creation of the City University graduate center was the need for faculty and schools who would serve in the university systems in New York City --- and this has happened. Similarly, the community colleges have educated

many of the students who have sought careers in the schools, hospitals, health centers and other city agencies and departments. It is apparent that New York City need not be dependent upon the private institutions which pride themselves on being national resources. The talent and wealth of New York must be directed toward producing health manpower to take care of the needs of the citizens of New York City. The first and most important priority in health for the next administration is the development of a system of municipal medical schools. The city medical school system would not compete with the private medical schools. Students are numerous -- applicants far outnumber those accepted. Patients are indeed numerous. Most voluntary hospitals have a long waiting list for admission, and fortunately, staff positions are eagerly sought after at the schools of excellence in New York City. It would remain for the voluntary hospitals to establish a method whereby training could be performed on their mostly middle class patients. The fact is that training is now performed on poor people who are used as teaching material by transient doctors in training supervised by part-time senior physicians. If training involved poor and middle class patients, I am certain that standards would be improved benefiting all.

They are demanding their own doctors, their own children in tax supported medical schools. They want a system of medical schools and doctors proud to be in New York, -- proud to train full time salaried doctors to take care of patients in the city hospitals. New York is a unique place. Just as New York developed a pioneering health department, and the first municipal hospital system in the country, so New York must train New Yorkers for hospitals of New York to take care of the citizens of New York City and for those people tuition will be free.

The development of a full time staff of the municipal hospitals is obviously a long range and long term objective. In the meantime, we must work through the affiliates to obtain more responsive and responsible care for the people of New York City - those people who use the beds in the municipal system. Toward that objective the New York City Health and Hospitals Corporation must undertake a thorough and detailed audit of the affiliation agreements. It is not enough simply to ensure fiscal accountability of the affiliates -- although we all want to know how our tax dollars are being spent --- we also want to know what our tax dollars are being spent on. Therefore, the audit should also be a program audit conducted jointly by the staff of the Hospital

Corporation, the Health Services Administration, and members of the Community Boards of the respective hospitals. Once those houses begin to be put in order, we can concentrate on what needs to be done in the municipal hospitals. But first I want to emphasize that as important as it is to do things, the way in which things get done can be equally significant. By that I mean significant community participation in the affairs of the hospital -- and where the medical school or voluntary hospital makes important decisions relating to the municipal hospital, there must be broad community participation in the decision making in the private hospital or medical school. It's only common sense and it certainly works the other way around. When the city makes an appointment to a particularly important job, many people in the community are consulted -- that job has an impact on many people.

I'm not a doctor, and I'm not a nurse, but I do know the city hospitals inside and out. I don't know all of the different programs coming down from the state and coming up from Washington, I don't know about scholarly studies, I suspect that studies are a lot like statistics - you can always find one to tell you what you want to hear - but I do know what the people want.

They want doctors. They want doctors in their communities. They want doctors in their communities who speak English or Spanish. They want doctors in their communities who not only speak their language but also know the community and are going to settle down and stay there. They want doctors who know them and who don't look down on them. They want community doctors who will practice in the neighborhood and who can also take care of them when they have to go to the hospital. A priority in the new administration, therefore, is the development of full time pre-paid group practices involving as many of the community physicians as wish to be involved providing them with full staff privileges in the municipal hospitals.

I also know that an awful lot of people in the community, employees of the city and our members too, are worried about the kind of health care they get; the quality of health care; the need for different kinds of procedures which are done; the need to go into the hospital, or if procedures can be done on the outside. Therefore, a third priority of the new administration must be the strengthening and expansion of power within the Health Services Administration. HSA must undertake to develop once again a great health department in New York City. The HSA must ensure that it

has the capability to gather all the statistics and to do the various studies which the city very often subcontracts to various consulting firms. There is no magic in private firms doing public work. The only magic is the way in which they make the city tax dollars disappear overnight.

A fourth priority for the city in health is the development of adequate housing for hospital employees within easy access of the municipal hospitals. The city must encourage private builders and sponsors to develop such housing. That will do much more to attract doctors, nurses, aides and all of the people who work in the hospitals than all of the recruitment drives in the Phillipines and elsewhere put together.

Finally, I would like to emphasize my concern about the proliferation of a multitude of special programs supported by the city - alcoholism, drug addiction, venereal disease, mental health, mental retardation, sickle cell, and on and on. I would like to see a de-emphasis of <u>all</u> of the special programs, and the development of comprehensive neighborhood based, family oriented health centers, where all of the health problems that occur within a

family are taken care of by a health team equipped to handle the full range of human health problems. People don't come as a sickle cell disease, or a drug addict, and we have to treat people as human beings within a social context. We must gear our disbursement of funds towards the development of the programs inherent in these priorities.

A substantial period has now elapsed since the elimination of dual health care system ostensible became the established policy of the City. It is now time that real and substantial advances be made toward making the stated policy an actuality - for this is surely not now the case. The recommendations I have made are the basic steps that need to be taken to achieve equality health care for all the citizens of New York. No administration in this City could make a greater contribution to the viability of the City and the vitality of its citizens.

September 17, 973

Howard Rusk, M.D.
400 East 34th Street
New York, New York

Dear Howard:

As I see it, the position paper for Mr. Beame should stress:

- health care is a right of every New Yorker to be accorded a top priority;

- top priority attention also derives from the size of the health care industry in New York - in money and jobs;

- the concern must be reflected in leadership and guidance by the Mayor to both the public and private sectors, for both are needed to fulfill the right of New Yorkers to good health care at reasonable cost;

- he will undertake and rebuild the private-public partnership in health which has been eroded in recent years and will use the financial leverage of Medicaid, ghetto medicine, city insurance payments, and hospital affiliation contracts to get private sector cooperation in bringing about a single system for organization and delivery of health care in New York City;

- he has a specific responsibility in the public sector to rebuild the Health Department, simplify City governmental organization and responsibility for health programs and review the effectiveness and efficiency of the Health and Hospitals Corporation in meeting its legislative goals.

The increased availability and accessibility of health services and the problem of cost containment are intertwined for the former depends on solutions to the latter, which, in turn, require aggressive

action to improve the delivery system. Thus, Mr. Beame could stress two principles of organization and administration, namely,

- aggressive action by a simplified health planning structure to develop a unified plan for New York's health care system, and

- clear lines of accountability by City officials and access for the consumer to decentralized operations.

I suggest that he point to the needs in three programmatic areas, namely,

- development of accessible primary care arrangements, especially ambulatory care, at hospitals and in Neighborhood Family Care Centers;

- improved emergency rooms, ambulance service, and training of emergency care personnel;

- emphasis on preventive programs, especially maternal and child health and implementation of the child screening program mandated by the Federal Government.

These represent, to me, at least, a beginning. I hope the thoughts are useful. Incidentally, I doubt that I can make the meeting on Wednesday, September 19th, because of another commitment.

Sincerely,

Irving J. Lewis
Professor

IJL/jz

Form 90-Adm.

State of New York
Department of Mental Hygiene

BRONX STATE DEVELOPMENTAL SERVICES

MAILING ADDRESS
1410 PELHAM PARKWAY SOUTH
BRONX, NEW YORK 10461

TELEPHONES: 430-2440
-2443

HERBERT J. COHEN, M.D.
DIRECTOR

September 24, 1973

Dean Martin Begun
New York University Medical School
550 First Avenue
New York, New York

Dear Dean Begun:

Mr. Ernest Koller, the Community Relations Developer for our program, asked me to write you concerning recommendations in the area of Mental Retardation for a position paper for Mr. Abe Beame's campaign.

Since time is short, I will summarize my recommendations as follows:

The current trend in Mental Retardation programs is towards the provision of community mental retardation services. The latter should (and is) a collaborative effort of City and State and voluntary agencies. The City should play a major role in planning services and in financing new programs in collaboration with the other parties. New programs are aimed at providing early treatment to prevent unwanted and unnecessary side effects resulting from neglect of the mentally and physically handicapped. One other area that must be stressed is that the provision of effective community diagnostic and treatment programs must be in geographically distributed system of services so that almost all necessary services will be available in the local community. Finally, a key point is that new alternative programs to long-term institutional placement must be developed. These should include community residences, hostels, nursing care facilities coupled with the needed and educational programs for all needy citizens.

For details concerning any of the above, I attach a copy of my recent article on the "Treatment of Mental Retardation."

I hope this has been helpful.

Sincerely yours,

Herbert J. Cohen, M.D.
Director and
Professor of Pediatrics and
Rehabilitation Medicine

HJC:gm

cc: Mr. E. Koller

attachment

STATEMENT ON ALCOHOLISM

AS RECOMMENDED BY MR. SUTTON'S ALCOHOLIC ADVISORY COMMITTEE

The alcoholic by definition is one who has an uncontrollable desire to drink and thus is excessively addicted to alcohol. It does more damage than all other addictions put together...It touches 8 out of 10 families in one form or another...beginning with the other parent and the dependent children, affecting basic evaluations in morality, physical, emotional, spiritual, psychological and sociological factors. Alcoholism, then as a disease, is a destructive force in all phases of our society; alcoholism is recognized as a major causative factor in family disintegration, welfare, job losses, criminal activities, and other social and physical phases.

Every dollar spent for the rehabilitation of the alcoholic, there can be an expected return of $10. In New York City, there are, at a minimum, an estimated 300,000 alcoholics.

The affects of alcohol abuse have been well documented and statistics continue to be published. Most recently, the National Commission on Marihuana and Drug Abuse, established by congressional action as part of Public Law 91-513 passed in 1970, has printed their final report entitled "Drug Use in America: Problem Perspective" dated March, 1973. This commission reported the following statistics related to alcohol use and abuse:

Frequency of Use: -- 53% of adults had used alcohol within the past seven days

-- a considerable segment of our population use alcohol in combination with other drugs

Social Costs -- alcohol dependence is without question the most serious drug problem in this country today involving millions of dollars.

-- the higher the degree of alcoholic involvement, the lower the likelihood of an intact marriage

-- between 22 and 55% of the children of alcoholics have been reported to become alcoholics themselves

Economic Costs:

-- one third of all persons receiving welfare payments use alcohol excessively

-- $100 million annually spent on processing chronic alcoholics through the criminal justice system

-- 56% of alcoholics had job difficulties directly attributable to drinking

-- generally agreed that alcohol dependence contributes to increased insurance rates, industrial accidents, increased absenteeism, theft, impaired job performance, security risks, retraining costs, etc.

Crime Costs:

-- 67% of male felons were alcoholics or problem drinkers

-- alcohol was reported as a factor in 67% of the sexual crimes against children

-- alcohol was used directly prior to the crime by at least half of the offenders in cases of homicide and other assaultive offenses.

In spite of these statistics and studies, the public's acknowledgement of alcohol addiction as a major social problem has not kept pace with this documentation. Thus, in recent public testimony in New York City, while many distinguished and authoritative voices were raised pointing out the desperate and epidemic nature of alcoholism within New York City, there was concomitant testimony of the dearth of programs.

In light of these statistics, and in response to overwhelming need for additional government action in the area of alcoholism, it is

proposed that the following action be endorsed by the new Mayor of the City of New York.

-- Creation of a Mayor's Task Force on Alcoholism

The Task Force, responsible directly to the Mayor, would serve as a personal fact-finding body that would make recommendations to the Mayor on alcoholic programs: the goal of these recommendations would be to achieve greater coordination of all government programs. The Task Force would include professionals in the field of alcoholism, and recovered alcoholics.

-- Introduction of family centered treatment into programs for alcoholics

The addition of family centered treatment to existing programs is viewed as vital in the effort to put parents in the position to assume constructive responsibility for the family.

-- Expansion of programs for totally dependent alcoholic

The alcoholic who is totally addicted to alcohol must have comprehensive rehabilitation services for recovery to a fully independent citizen.

-- Encouragement of business and industry to establish their own alcoholism programs for employees

The Mayor would support and encourage the efforts of Health Services Administration, the Alcohol Recovery Institute, and the National Council on Alcoholism in their efforts to encourage business and industry to establish alcoholism programs.

The benefits of this proposed action is tremendous in economic and social terms:

-- re-integration and strengthening of the family as constructive units in society

-- increased economic productivity

-- lowered welfare, prison and court costs

-- lowered health costs

THE COUNCIL
OF
THE CITY OF NEW YORK
CITY HALL
NEW YORK, N. Y. 10007

CARTER BURDEN
COUNCILMAN, 4TH DISTRICT, MANHATTAN
1457 LEXINGTON AVENUE
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427-4405

CHAIRMAN, SUBCOMMITTEE
ON PENAL AND JUDICIAL REFORM

October 3, 1973

Martin Begun, Assistant Dean
NYU Medical School
550 First Avenue
New York, N. Y. 10016

Dear Marty:

Enclosed is a brief position paper on marijuana for the Beame Task Force on Health as per our conversation of Monday.

I hope that some of its recommendations will be included by Mr. Beame in any campaign positions he may adopt. Please let me know if anything more comes of this.

Many thanks,

Warm regards,

Frank

Frank R. Fioramonti
Legislative Counsel

FRF:bb
enc.

RE: DECRIMINALIZATION OF MARIJUANA FOR INCLUSION
IN THE HEALTH TASK FORCE REPORT

The National Commission on Marijuana and Drug Abuse, appointed by President Nixon, in its March, 1973 final report estimates that 16% of the adult population has at least on one occasion smoked marijuana, and about 8% of the population currently smokes marijuana on a regular basis. Thus, by conservative estimate at least 600,000 New Yorkers are today regularly engaged in an activity which under state law subjects them to prison terms of up to 15 years.

Drug use and drug abuse is unquestionably one of the major issues facing the next mayor of New York. Any hopefully effective effort to come to grips with this problem must begin with a realistic approach toward marijuana, which is now recognized as a fact of life at all levels of New York society. Use of this substance is pervasive in all sections of town and among every conceivable income, social and employment group. Despite this fact -- or perhaps because of it -- the New York City Police Department made over 6,000 arrests on cannabis charges during 1972, an increase of nearly 15% over 1971 arrest figures (copy attached). Three-fourths of those arrested were young people under the age of 24. Of all narcotic and drug arrests only arrests involving heroin exceeded those for marijuana.

We have, then, a situation prevailing in New York City where thousands of mostly young people are being processed through an already overburdened criminal justice system at an expense of tens of thousands of dollars to the city for an activity that is, by general agreement, less dangerous to health when used in moderation than the use of alcohol and tobacco.

of small amounts of marijuana has become increasingly accepted as a responsible policy for a large number of national professional organizations. Among those calling for the decriminalization of marijuana are:

National Commission on Marijuana & Drug Abuse (Shafer Commission)
American Bar Association
Consumers Union, publishers of Consumer Reports
National Conference of Commissioners of Uniform State Laws
American Public Health Association
National Advisory Commission on Criminal Justice Standards and Goals
National Council of Churches
The Governing Board of the American Medical Assn.
National Education Association
Central Conference of American Rabbis
Canadian Commission of Inquiry into the Non-Medical Use of Drugs (Le Dain Commission)
San Francisco Committee on Crime
Mayor's Advisory Committee on Narcotics Addiction (Washington, D. C.)
John Finlator, Deputy Director, Federal Bureau of Narcotics and Dangerous Drugs, 1968-1971
William F. Buckley, Jr., columnist

Locally, the Committee on Public Health of the New York Academy of Medicine in a report appearing in the Academy's January, 1973 Bulletin (Vol. 49, No. 1) urged support for the final recommendations of the National Commission on Marijuana and Drug Abuse, and added an additional recommendation that:

> " . . . an appropriate agency of government investigate the feasibility of a system of governmental control of the distribution of marihuana. Such a system should assure that the active drug content and purity of marihuana cigarettes would be compatible with its social use. The government should also provide optimal control of distribution to prevent illegal dissemination and should make advertisement of the product illegal. It also should conduct a continuing educational program to discourage the use of marihuana."

There are several important steps the next mayor of New York should take with respect to this issue. First, he should include as part of his legislative package submitted to the Albany Legislature a bill calling for the removal of criminal penalties for possession of small amounts of marijuana. He should, in addition, establish a special advisory committee to investigate the current impact of the marijuana laws on New York City, including costs associated with their enforcement and benefits, if any, derived therefrom. Similar committees in both Washington, D. C. and San Francisco have called for regulated distribution of marijuana, a position which the next mayor might eventually take, advocating same on a trial basis for New York City alone, both as a means of eliminating black market activity in this drug and as a potential revenue source through taxation.

The time has come for us to face the truth about marijuana and to abolish criminal penalties for its use. Government can play a positive role by attempting to inform the citizen, and young people in particular, about the risks of drug abuse, and by regulating marijuana traffic much as it now regulates alcohol and some other drugs. Government should acknowledge its obligation to minimize the abuse potential of marijuana by instituting strict legal controls over its distribution and use while recognizing the exorbitant cost of continuing the impractical and ineffective approach toward marijuana presently being followed.

Dismantling of Health Agency Planned; 2 Other 'Super' Units Face Shake-Up

By EDWARD RANZAL

Details of plans to dismantle the Health Services Administration, one of the nine city super agencies created by former Mayor John V. Lindsay, were announced yesterday by Mayor Beame.

The Mayor said he would ask the City Council soon to disband two other superagencies as well—Housing and Development, and Human Resources, both of which have been troubled by scandals over the years.

There are no plans to dismantle the remaining superagencies, but Sidney J. Frigand, the Mayor's press secretary, said there would be a continuing study of the other agencies "with the possibility that certain functions and operations could be reorganized."

Superagencies were established in the Lindsay administration with a view toward centralizing control, increasing efficiency and reducing costs.

The Health Services Administration presides over the remnants of the old City Health and Mental Retardation Services, the Comprehensive Health Planning Agency, the office of the Chief Medical Examiner and the Addiction Services Agency.

The proposed reorganization plan to be submitted by Mayor Beame to the City Council calls for the following steps:

¶Re-establishment of the Health Department as a free-standing agency. Incorporated in the Health Department would be the Comprehensive Health Planning Agency and the Mecical Examiner's Office, which would retain its independence in the performance of its duties.

¶Establishmen of the Addiction Services Agency and the Department of Mental Health and ental Retardation Services as separate, independent departments.

¶Creation of an interagency health council, made up of the heads of the city's health-care agencies, the Social Services Commissioner and a deputy mayor to be established by executive order. Its responsibility would be to improve coordination in the health field.

In a report called Toward More Responsive, Responsible and Accountable Government, Deputy Mayors James A. Cavanagh and Judah Gribetz said: "The superagency experiment has proven less than successful. In a number of the superagencies, particularly the larger ones, an extra layer of bureaucracy was added. These cumbersome structures have obfuscated vital department functions."

Jobs a Question

Mr. Cavanagh said he did not know at this time whether dismantling of the Health Services Administration would result in the loss of jobs. He explained that it depended on "the kind of legislation that comes out of the City Council."

Following anticipated passage of legislation, he said, the Budget Bureau will be asked to make a survey of the needs of the various new departments in terms of additional jobs.

Dr. Lowell E. Bellin, who is both the administrator of the agency and Health Commissioner, would head the new Health Department at his present salary of $45,418 a year, which all heads of superagencies get. Commissioners of more important departments (such as Investigations) get $41,500 and of less important departments (such as Addiction Services) get $38,771.

The dismantling of some superagencies to improve the effectiveness of city programs was an election-campaign promise of Mayor Beame.

Beame Comments

The Mayor has also proposed that the Housing and Development Administration be divided into four separate departments —Development, Buildings, Rent and Housing Maintenance, and Relocation.

The recommendation and plan for dismantling the Human Resources Administration is expected to be made within several weeks.

As for the Health Services Administration, MAYOR Beame said:

"The administration has emphasized the principle that heads of operating agencies should have access to the Mayor in formulating policies and priorities, and have independence to administer their day-to-day operations. Health care is too important a service to be insulated in layers of bureaucracy."

Under the proposed reorganization the Commissioner of Health would replace the Health Services Administrator on the board of directors of the Health and Hospitals Corporation, a quasi-governmental organization established by Mr. Lindsay to operate the city's hospitals.

Historically, there was always rivalry and competition, principally on budget metters, between the former Hospital and Health Departments. With the advent of the Hospitals Corporation in 1970, the quality of services provided by the agency "progressively weakened," according to the report of the Deputy Mayors.

The undesired result was not only the subordination of the Health Department to the Hospitals Department, but the severe weakening of the Health Department in favor of the superagency lawyer, the report said.

With the elevation of the status of an independent Health Department, it is anticipated [illegible] will no longer be subject to the Hospitals Co[illegible]