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# Rethinking Private-Public Partnership in the Health Care Sector: The Case of Municipal Hospital Affiliation

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**SUMMARY:** By the late 1950s, New York City's public hospital system—more extensive than any in the nation—was falling apart, with dilapidated buildings and personnel shortages. In response, Mayor Robert Wagner authorized an affiliation plan whereby the city paid private academic medical centers to oversee training programs, administrative tasks, and resource procurement. Affiliation sparked vigorous protest from critics, who saw it as both an incursion on the autonomy of community-oriented public hospitals and the steamrolling of private interests over public ones. In the wake of the New York City fiscal crisis of 1975, however, the viability of a purely public hospital system withered, given the new economic climate facing the city. In its place was a new institutional form: affiliation and the public-private provision of public health care.

**KEYWORDS:** urban health, New York City, protest, hospitals, health services, health care, public health, public policy, private-public partnerships, academic medical centers

How much “private” should there be in a “public” good?

This is a question that has loomed in health care, long before the term “private-public partnership” appeared on the public policy horizon. But it is a challenging one to answer at the outset, beginning with the ambiguity of the core terms of debate. Social welfare provision, after all, has persistently defied a clean demarcation between the “public” and the “private.” Health care was and is no exception. Indeed, it might well be the most prominent exemplar of the rule. Each day, for example, gov-

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ernment dollars pour into public and private health care providers via reimbursement programs like Medicare and Medicaid. Academic research institutions, public and private, depend on billions of federal grant dollars.<sup>1</sup> Nominally private social service agencies are heavily subsidized by governments, whether through direct grantsmanship or preferential tax treatment. And many private benefits to employees are mandated by public law. One could go on with examples. But each underscores how “private” and “public” are best viewed as poles on a continuum in classifying components of the American welfare state, with the private and the public assuming relative proportions of responsibility depending on the case in question.<sup>2</sup>

This article explores these questions at the on-the-ground regional level using a less examined but highly consequential private-public fusion that has come to predominate the health care landscape: municipal hospital affiliation. By “affiliation,” I refer to the practice whereby the public pays private nonprofit institutions to help administer public facilities, provide staffing, share equipment, and make available other material resources for public hospitals.<sup>3</sup> It is essentially a subcontracting arrangement between city governments and private institutions, typically academic medical centers.

1. Recent documentations of flows of funds are *The Budget and Economic Outlook: 2018 to 2028* (Washington, D.C.: Congressional Budget Office, 2018); Office of Management and Budget, *Historical Tables* (Washington, D.C.: Office of Management and Budget, 2018).

2. The literature on the liminality of—and relationship between—public and private welfare states is vast and variegated, but excellent starting points are Michael B. Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America* (New York: Basic Books, 1986); Katz, *Improving Poor People: The Welfare State, the “Underclass,” and Urban Schools as History* (Princeton: Princeton University Press, 1997), chap. 1; Jacob S. Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits* (New York: Cambridge University Press, 2002); Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America’s Public-Private Welfare State* (Princeton, N.J.: Princeton University Press, 2003); and from a cross-national perspective, Melani Cammet and Lauren M. MacLean, eds., *The Politics of Non-state Social Welfare* (Ithaca, N.Y.: Cornell University Press, 2014). On the American health care sector specifically, see various essays on institutional flows of financing in Rosemary Stevens, ed., *The Public-Private Health Care State: Essays on the History of American Health Policy* (New Brunswick, N.J.: Transaction Press, 2007).

3. A third class is the for-profit hospital, neither public nor private nonprofit (“voluntary”). I do not discuss these proprietary hospitals because they did not play a large role in the events described here; indeed, they have yet to fully exert the impact on the health care landscape that some predicted. When I use the term “private,” one can assume I am writing about private nonprofit hospitals. On terminology, see Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989), 5–6; Sandra Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900* (New York: Oxford University Press, 1999), 9–10.

Affiliations existed throughout the twentieth century. But they had formed on a largely ad hoc basis, usually when a public hospital faced a crisis that required a private institution's rescue—for example, the filling of a staffing deficit. It was not until New York City adopted a comprehensive set of affiliations in the 1970s—as a sweeping and blanket policy covering almost all of its municipal hospitals—that the practice became less impromptu and more systematized, both in the city itself and elsewhere. Because of the New York City municipal hospital system's unmatched scope—both then and now—it is the most effective site for examining affiliation's genesis and the ramifications that arise out of it. What follows is the story of how the program came to be, the bitter battles that arose around its early implementation, and the vehement debate over alternative models of health delivery from which it emerged victorious, an outcome hardly foreordained. In the end, the pro-affiliation and anti-affiliation tendencies were competing planning philosophies, together a critical fork in the road. In one vision, large private nonprofit medical centers would assume enormous control over the public system. In the other, the status quo ante, public hospitals would continue operating as neighborhood institutions with their own governing boards, not private administration from afar and from without. After a period of uncertainty about the policy's survival, affiliation won out. I argue that it was ultimately larger political-economic shocks that made affiliation the most viable policy option by the late 1970s as the era saw new budgetary parameters forced onto almost all, especially city, governments.

Hospital affiliation should be viewed as a major episode in an ongoing dialectic between society and institutional form. From its origins in the almshouse, the American hospital has continuously transformed, redefined by changing patient composition, the emergence of new technologies, the onset of financing streams, and expanding American social welfare provision. Focusing on the late nineteenth century and early twentieth, David Rosner and Charles Rosenberg have analyzed the transition of the hospital from an institution predominantly used by the urban poor to one with a broader clientele. Each identifies distinct catalysts for this transformation; Rosner emphasizes the working-class immigrant influx into cities and the strain this placed on charity institutions, necessitating a search for paying patients.<sup>4</sup> Rosenberg, meanwhile, examines the rising cultural esteem toward the hospital and its destigmatization, as patients of higher social echelons increasingly used hospital services outside of the

4. David Rosner, *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885–1915* (New York: Cambridge University Press, 1982); Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987).

home. Joel Howell, writing on this time period as well, points to the uptake of new diagnostic technologies that coincided with the social legitimacy that the hospital was accruing.<sup>5</sup>

Rosemary Stevens and Sandra Opdycke shift to later twentieth-century developments. As does Rosner, Stevens analyzes the tension between private “voluntary” hospitals’ commitment to larger social missions on one hand and the constraints posed by finances on the other. Stevens, however, incorporates additional midcentury developments: the rising power of physicians and hospital lobbies and, most importantly, the emergence of new revenue streams from both private insurance and, later, government reimbursement from Medicare and Medicaid.<sup>6</sup> Where Stevens views hospitals at the national level and focuses largely on private institutions, Opdycke moves to a city- and institution-specific level, adding public hospitals to her analysis. Using New York Hospital and Bellevue Hospital as respective private and public foils, she explores how public health care institutions have become critical instruments for inclusive care “available at all times and under all circumstances, no matter how institutional goals or teaching needs or funding policies changed.”<sup>7</sup> For Opdycke, local particularities, especially civic charity and social-democratic traditions of twentieth-century New York City, explain the city’s deep commitment to public medical care into the early post–World War II period.

My account of affiliation incorporates the interpretive lenses above, analyzing how a confluence of forces first gave rise to affiliation and its eventual entrenchment. Like Opdycke, I also show how city politics played a critical role in shaping hospitals’ futures. I caution against the temptation to read affiliation as part and parcel of broader political shifts toward privatization and wider marketization that culminated in the Reagan administration in the 1980s. The truth about affiliation’s rise was more mundane. Far from being the health care piece of a larger conservative political strategy, hospital affiliation grew out of a midcentury public policy crisis that required immediate solving. It engendered reactions rooted as much in the cultural meanings and symbolism attached to public hospitals as empirical realities about patient needs and how to best respond to them. It is this multiplicity of forces that is the subject of this article. Affiliation was a complex organizational form—not purely private, not purely public—initially pushed by policy entrepreneurs but whose ultimate fortunes were determined by historical circumstance.

5. Joel D. Howell, *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore: Johns Hopkins University Press, 1995).

6. Stevens, *In Sickness and in Wealth* (n. 3); Opdycke, *No One Was Turned Away* (n. 3).

7. Opdycke, *No One Was Turned Away* (n. 3), 15.

Michael B. Katz has written that “organizations mediate between social structure and social change,” taking on new forms in the process.<sup>8</sup> What follows is an interplay among intellectual history, the history of medicine, and urban history. To understand it fully, we need to return to post–World War II New York City and explore affiliation’s origins and rationale.

## The Origins of Affiliation

Historian Joshua Freeman has characterized midcentury New York City as the embodiment of a municipal social democracy, one marked by a robust public sector and set of social services, all shaped by the power of organized labor.<sup>9</sup> One manifestation was the city’s eighteen public hospitals, anchored by a powerful principle: that each “[was] expected to take in every New Yorker who applied to them for help,” especially indigent patients who looked to them as medical safety nets of last resort.<sup>10</sup> By the end of the 1950s, however, there were signs that this era of robust social welfare was fraying, public medical care included. In 1959, New York City mayor Robert Wagner appointed a commission with a charge: investigate the city’s beleaguered municipal hospitals and issue recommendations for what to do about them. A year later, the so-called Heyman Commission—named after its chair, investment banker David Heyman—recommended a sweeping program of affiliation. It called for ceding administrative control and staffing of public hospitals to the city’s private medical centers, most attached to medical schools. It would amount to nothing less than a wholesale reshuffling of control.

But what exactly was the problem that confronted municipal hospitals and for which a solution was so urgently needed? The biggest short-term impetus for the Commission revolved around personnel. By the late 1950s, with few exceptions, most of the municipal hospitals were failing to attract both permanent staff and interns and residents. By one estimate, the city was relying on nine thousand volunteer physicians to cover a recurrent

8. Michael B. Katz, *Reconstructing American Education* (Cambridge, Mass.: Harvard University Press, 1987), 57.

9. See Joshua B. Freeman, *Working-Class New York: Life and Labor since World War II* (New York: New Press, 2001), 55–71. Mason B. Williams identifies another catalyst in municipal spending during the Great Depression, as part of New Deal recovery efforts. See Williams, *City of Ambition: FDR, La Guardia, and the Making of Modern New York* (New York: Norton, 2014). For another city with similar dynamics rooted in particularities of a local political regime, see Judith Walzer Leavitt, *The Healthiest City: Milwaukee and the Politics of Health Reform* (Princeton, N.J.: Princeton University Press, 1982).

10. Opdycke, *No One Was Turned Away* (n. 3), 14, 55.

staffing shortfall.<sup>11</sup> The state of the postgraduate programs proved most dire and embarrassing. In one year, no American interns were matched to unaffiliated municipal hospitals, and a stream of foreign medical graduates (FMGs) took their places. The concern over their presence was tinged with more than a whiff of nativism. But there was also no doubt that because of training under different sets of standards and expectations, FMGs often floundered.<sup>12</sup>

The personnel problem was rooted, above all, in economics. Into the early 1950s, municipal hospitals' average wage had been close to that for house staff nationally. But by the end of the 1950s, that was no longer the case. The city's own data showed that average monthly pay for interns in its hospitals was \$125, compared to a national average of \$189 in all American hospitals.<sup>13</sup> Beyond sufficient material incentives for potential residents, unaffiliated institutions increasingly lacked equipment, adequate infrastructure, and strong teaching programs that existed at voluntary hospitals and their academic medical center counterparts.<sup>14</sup> In short, with public hospitals not being what they once were, and in some places, literally beginning to crumble, they became harder and harder to staff as talent went elsewhere. These personnel pressures cascaded and led to other problems. On an impromptu charity basis, private voluntary hospitals and academic medical centers were shouldering some of the patient load that their public counterparts could now no longer manage fully on their own. In the late 1950s Mayor Wagner had promised to raise by four dollars the per-patient amount that the city paid to voluntary institutions per day, though the city admitted that this would not outpace inflation.<sup>15</sup> Something more structured, it seemed, was needed.

11. Commission on Health Services of the City of New York, organizational meeting minutes, March 19, 1959, box 504, Folder "Commission on Health Services Minutes 1959," Records of the Columbia University Medical Center, Office of the Vice President for Health Sciences, Dean of the Faculty of Medicine [semi-processed], Archives and Special Collections, Augustus C. Long Health Sciences Library, Columbia University Medical Center, New York (hereafter CUMC Papers).

12. Commission on Health Services of the City of New York, organizational meeting minutes, March 19, 1959, box 504, Folder "Commission on Health Services Minutes 1959," CUMC Papers; Ray Trussell to George Armstrong, November 16, 1959, box 504, Folder "Commission on Health Services Gen. Corres. 1959," CUMC Papers.

13. Subcommittee on Coordination of the Medical Services, October 28, 1959, box 504, Folder "Commission on Health Services Gen. Corres. 1959," CUMC Papers.

14. Committee of Interns and Residents of the New York City Municipal Hospitals, "The Crisis in the New York City Hospital System," October 1959, box 504, Folder "Commission on Health Services Gen. Corres. 1959," CUMC Papers.

15. Commission on Health Services of the City of New York, organizational meeting minutes, March 19, 1959, box 504, Folder "Commission on Health Services Minutes 1959," CUMC Papers.

Then there were problems with bureaucracy. A recurrent complaint came from the commission members with experience in city government, and it concerned “duplication” of un-needed services, which contributed to needless rising costs and poor coordination.<sup>16</sup> One source of that problem was indiscriminate, even unnecessary, hospital construction. It was no small concern, given that the city had scheduled construction of several new facilities over the next decade. But given the problems with the existing hospitals, their sustainability was questionable, to say nothing of the question of their actual necessity. For the Heyman Commission, all these problems required more than just tweaks to a broken system. They required a pause, followed by an overhaul.

Affiliations would solve these issues. By coupling with private academic medical centers, public hospitals could leverage the former’s recruiting power and prestige to solve the staffing problem. They could benefit potentially, too, from private infrastructural resources—for example, the sharing of supplies or help with building maintenance. And finally, affiliations would create a network of public hospitals—locked into relationships with private institutions—that in the long run would allow more effective planning and operation. These were all a contrast to the scattershot approach that then prevailed when it came to everything from ad hoc payments for public patients to construction of new hospitals.

A system of affiliations, administered via contractual payments from the city to private medical centers, would represent a substantial commitment of public funds. But the benefits would far outweigh the costs, the Commission argued, as it completed its report in July of 1960 and released it confidentially to Mayor Wagner. Its members did not intend for their work to sit on a shelf, and they declared themselves an “‘action’ group” whose suggestions required “dynamic follow-through.”<sup>17</sup> The city, the Commission urged, “should vigorously implement the established policy of affiliating as many municipal hospitals as possible with medical

16. Commission on Health Services of the City of New York, organizational meeting minutes, March 19, 1959, box 504, Folder “Commission on Health Services Minutes 1959,” CUMC Papers. The theme is discussed also in Ray Trussell to Commission on Health Services of the City of New York, Technical Advisory Committee, memorandum, April 30, 1959, box 504, Folder “Commission on Health Services Gen. Corres. 1959,” CUMC Papers.

17. “Excerpts from the Opening Remarks of David M. Heyman at the Final Meeting of the Commission on Health Services,” July 20, 1960, box 504, Folder “Commission on Health Services Gen. Corres. 1960,” CUMC Papers; “Report of the Commission on Health Services of the City of New York,” July 20, 1960, box 504, Folder “Commission on Health Services Gen. Corres. 1960,” CUMC Papers.



schools or with voluntary hospitals having strong teaching programs.”<sup>18</sup> Mayor Wagner did not disappoint, accepting the recommendations fully.

Beneath the surface, however, affiliation simmered with explosive questions about power and control. One of the most contentious of these was what to do about those hospitals *not* selected for affiliation at all and instead marked for closure. In its discussion of the slapdash nature of the public hospital system, the Commission had cast long-standing local attachments to faltering health institutions as community-rooted sentimentalism that ought to be divorced from dispassionate analysis on how to “provide optimum medical care.”<sup>19</sup> Elaborating, it stated, “While it is obviously desirable to have a hospital as close to a community as possible . . . enough experience has been accumulated with municipal hospitals in locations where adequate staffing is difficult or has proven impossible to raise strong doubts as to the wisdom of building more. Good medicine is not practiced by bricks and mortar.”<sup>20</sup> Hospitals that were unneeded, then, ought to be closed. And planned closures were not just a provisional idea. At one meeting, the Commission reviewed a list of a dozen hospitals, naming three of them—Fordham in the Bronx, Sydenham in Harlem, and Gouverneur on the Lower East Side—as good candidates for closure.<sup>21</sup> It was an affiliation that would ultimately determine which facilities the city ought to continue supporting and which it should not.

Affiliation was thus no mere exercise in administrative tidying. It represented a novel power-sharing arrangement with the private academic medical centers. Some independent public facilities were placed on the chopping block and others brought—against their will—into an administrative fold that radically shrank existing autonomous institutional governance and instead bound it to private affiliates. While in theory mutually beneficial, institutionalized affiliations permanently increased the dependence of municipal hospitals on private institutions—and at a monetary cost to the city. The surface reciprocity of the relationship masked the two parties’ unequal degrees of desperation. Municipal hospitals, with their personnel shortages and infrastructural deficiencies, needed private institutions much more than the latter needed reliable

18. “Report of the Commission on Health Services of the City of New York,” July 20, 1960, box 504, Folder “Commission on Health Services Gen. Corres. 1960,” CUMC Papers.

19. *Ibid.*

20. *Ibid.*

21. Commission on Health Services of the City of New York, Technical Advisory Committee on Coordination of Medical Services, organizational meeting minutes, July 16, 1959, box 504, Folder “Commission on Health Services Minutes 1959, Archives and Special Collections,” CUMC Papers.



revenue for their charity roles, which at worst they could simply stop fulfilling altogether. And yet the Commission barely discussed mechanisms to ensure that all sides in the proposed private-public partnerships held up their ends of the bargain.

One reason for this might have been the Commission's very composition. From the outset, it was heavily influenced by physician-administrators from the city's prominent voluntary hospitals, medical schools, and research universities, including Mount Sinai, Montefiore, the Rockefeller Institute for Medical Research, and Columbia University. With such doyens dominating the Heyman Commission, it seems obvious why academic medical centers assumed the major—and largely unquestioned—role.

But the Commission's composition goes only so far in explaining the affiliation program's aggressiveness: its call for allocating budgetary resources to private institutions, for transferring governance, and for gutting some hospitals out of the equation altogether. To comprehend its radical character, one also needs to look closely at two of its driving forces: the persons of Ray Trussell and Martin Cherkasky.

### Trussell and Cherkasky: The Two-Headed Hospital Hydra

If ever there was an analogue to the much-reviled New York planner Robert Moses in the city's health sector, it would possess two heads: one Ray Trussell, the city's hospitals commissioner, and the other Martin Cherkasky, Montefiore Hospital's young chief executive. Within a decade of the Heyman Commission, both exerted more influence on the city's municipal hospital policy than any group of policy makers up to that point and since. Thus to identify the logic of affiliation, one must examine their early actions and thinking.

The roots of Trussell's thinking go back to studies he had conducted on Blue Cross of New York while director of what was then known as the "School of Public Health and Administrative Medicine" at Columbia University. Blue Cross had drawn scrutiny for its rapidly rising premiums. In his analysis of why, Trussell spotlighted poorly planned hospital construction as a major contributor to the premium problem, a consequence, in his view, of infrastructure costs passed on to consumers.<sup>22</sup> The takeaway was that hospitals had become unwieldy networks requiring far more regional planning. That insight fed into Trussell's simultaneous work for

22. Ray Trussell and Frank van Dyke, *Prepayment for Hospital Care in New York State: A Report on the Eight Blue Cross Plans Serving New York Residents* (New York: School of Public Health and Administrative Medicine, Columbia University, 1961), 269–73.

the Heyman Commission. Affiliation was one such method for the coordination that Trussell felt was so absent.

Trussell's thinking could be autocratic and oblivious. In declaring, as did the Commission, that the only necessary hospitals were those with an affiliation and proximity to private partners, Trussell relegated all other concerns to secondary status, including neighborhood ties to an institution, hospital jobs, or simple demand for services from surrounding residents. In doing so, he ignored a spectrum of other potential rationales for constructing or maintaining local medical facilities. Even more important, he discounted their immense symbolism, a blind spot that would soon become apparent with the backlash to the plan.

If Trussell's support for affiliation came mainly from the world of academia, Cherkasky's emerged from real-world practice. As the relatively new chief executive of Montefiore Hospital in the Bronx, Cherkasky had initiated a pilot affiliation of his own between Montefiore and Morrisania, a neighboring Bronx public hospital. Talk of the affiliation began when Morrisania had failed to attract a single intern from the National Intern Matching Program. Montefiore, by contrast, boasted thirty American interns, with room for an additional seventy if it had desired. Under terms of the agreement, implemented in 1959, Montefiore began sharing personnel with Morrisania, which in turn provided access to more patients for teaching purposes. Morrisania, in the process, solved its staffing problem. Soon afterward, the two institutions agreed to share technological resources, including X-ray and laboratory facilities, and planned to provide more Montefiore training for Morrisania interns, who might have been otherwise inclined to apply to private institutions.<sup>23</sup> The Morrisania pilot influenced the Heyman Commission's proceedings, serving as an example of affiliation's win-win symbiosis and offering Trussell and Cherkasky a blueprint of what ideal affiliations looked like: a public hospital bound to a strong academic medical center close to it. Beyond the Commission, the Morrisania experience also made Cherkasky a hungry and ardent proselytizer for affiliations, not just for Montefiore but for other similar institutions in the city at large. But it presaged, too, critical chatter to soon come of Cherkasky as an empire builder overseeing a rapidly growing institution with eyes on consolidating its Bronx medical hegemony.

23. Commission on Health Services of the City of New York, Executive Committee, meeting minutes, April 21, 1959, box 504, Folder "Commission on Health Services Minutes 1959," CUMC Papers. A published account of the affiliation, coauthored by Cherkasky, appeared as Nathan Smith, Peter Rogatz, and Martin Cherkasky, "The Case for Voluntary and Municipal Hospital Affiliation," *Amer. J. Pub. Health* 53, no. 12 (December 1963): 1989–94.

The outsize influence of Trussell and Cherkasky was reflected in Mayor Wagner's 1961 appointment of Trussell to commissioner of hospitals, for whom Cherkasky would serve as an advisor. Trussell implemented immediately the recommendations he had pushed, initiating five affiliations for Lincoln, Bellevue, Harlem, Metropolitan, and Elmhurst Hospitals. In his view, the state of the system was far worse than he had thought, and he wrote that any delays in getting the program under way amounted to "a calculated risk" on the city's part. Emergency rooms in unaffiliated hospitals were understaffed, often compelling them, Trussell alleged, to hire unlicensed physicians. Trussell declared in August 1961 that the situation at Bronx Municipal Hospital was "desperate."<sup>24</sup>

Trussell might be suspected, with good reason, of exaggeration or melodrama. He was, after all, the intellectual architect of comprehensive affiliations and had an obvious stake in the policy's implementation. But a steady flow of public complaints substantiated Trussell's depiction of a crumbling system with poor staffing, low morale, and crumbling physical plants, all in desperate need of a sweeping fix. One city resident named Henry Herman wrote about the experiences of his mother-in-law, who had been struck by an automobile and brought to Kings County Hospital, then denied a request for a bed pan when she needed to use the toilet. "Since these patients are bedridden," he explained, "they have no alternative but to relieve themselves in their bedding and lie in urine and feces." In a public hospital, Herman wrote, "a patient cannot expect comfort and service that might be available in a private hospital, but why should misery be compounded by presence of some personnel with sadistic tendencies?"<sup>25</sup> Incidents like Herman's suggested a public that had for some time held the public hospital system in low esteem.

If there was an opportune time for Trussell to push sweeping policy changes in the health sector, this was it. Public hospitals' difficulties kept making news. In late January 1961, Harlem Hospital faced a crisis because a large number of FMGs intending to join its house staff had failed an exam given by the Executive Committee on Foreign Medical Graduates, which barred them from performing physicians' activities. The situation, particularly in emergency rooms, had grown to the point of "chaos," as one *New York Times* report put it.<sup>26</sup> The press also made clear it was on Trus-

24. Ray Trussell to Abraham Beame, August 10, 1961, box 64, folder 793, Departmental Files, Robert F. Wagner Papers, LaGuardia and Wagner Archives, LaGuardia Community College, City University of New York, Queens, N.Y. (hereafter Wagner Papers).

25. Henry Herman to Robert Wagner, September 5, 1962, box 64, folder 794, Departmental Files, Wagner Papers.

26. Morris Kaplan, "Hospital 'Chaos' Is Being Studied," *New York Times*, February 2, 1961.

sell's side. At the time of his appointment, newspaper stories portrayed him as a polymathic savior who had arrived to save a dysfunctional system, with a typical headline reading, "A Medical Dynamo Dedicated to Lifting Health Standards."<sup>27</sup>

Over the next few years, affiliations accelerated, though their scope differed from arrangement to arrangement. One of the most comprehensive was that between Montefiore and Morrisania, which ballooned from a pilot program that had started with the sharing of a single surgical resident to an "integrated" residency program, which officials hoped would soon evolve from staff swaps between schools into a full-fledged joint-residency program. In addition to house staff, six Morrisania departments received full-time chiefs. In July 1962, the city formally committed to a three-year affiliation contract worth three million dollars a year. Besides permanent staff, Montefiore now assumed oversight for Morrisania's medical care services, along with supplying X-ray and laboratory services. In a report summarizing the affiliation's progress, the authors described it as a "prototype" and went on, "Still in its infancy, the plan is only in the development stage. But it is not too soon to report that the infant is lusty and thriving. The affiliation works."<sup>28</sup> And there were plans for it to grow still more. In October 1963, the city accepted land from Montefiore, located close to the hospital, that would be used for a rebuilt Morrisania facility in a few years' time.<sup>29</sup>

Another arrangement, between Columbia University and Harlem Hospital, was less harmonious. In 1961, Columbia's medical school began supervising Harlem Hospital interns and residents, who received periodic visits from Columbia faculty in the form of regular rounds, conferences, and lectures. Columbia took part as well in a committee that advised the city on Harlem Hospital affairs, including wages and facility needs. Its most important role came with immense power: the screening of potential hires for departmental director and assistant director positions at the hospital.<sup>30</sup>

27. Barbara Yuncker, "A Medical Dynamo Dedicated to Lifting Health Standards," *New York Post*, February 23, 1961; "Doctor of Many Hats: Ray Elbert Trussell," *New York Times*, February 24, 1961.

28. "The Montefiore-Morrisania Affiliation July, 1962–December, 1963," ca. 1963–64, box 65, folder 797, Departmental Files, Wagner Papers.

29. Ray Trussell to Robert Wagner, October 18, 1963; Leo Larkin, "Board of Estimate Supplemental Report," November 1962, box 64, folder 795, Departmental Files, Wagner Papers.

30. "Proposal by the College of Physicians and Surgeons of Columbia University to Aid in the Improvement of the Care of Patients and to Increase the Education Opportunities for the Resident and Visiting Staffs of the Harlem Hospital in the City of New York," May 23, 1961; Donald McKay, "Recommendations for Harlem Hospital—Department of Pathology," ca. April 1961, box 322, Folder "Harlem Hospital 1932–1961," CUMC Papers.

The Columbia and Harlem relationship reflected inherent ambiguities in Trussell's grand designs. From one perspective, especially when one took stock of its ability to determine hiring, the arrangement looked like a power grab at the hands of Columbia and a city hospital commissioner looking to encroach upon a public institution's autonomy. Trussell reinforced such a view by behaving with little tact. When members of the Harlem Hospital medical board balked at the level of control that both Columbia and Trussell exerted, Trussell promptly fired everybody on it, replacing them with a temporary group.<sup>31</sup> In a private memo to a deputy commissioner, written shortly before the action, Trussell had anticipated the conflict, writing that if the Harlem Hospital board "fails to place a vote of confidence and appreciation for Columbia University on the minutes of its meeting . . . I shall consider this to be inconsistent with the policy of the mayor, the Commissioner, and the Board of Hospitals."<sup>32</sup> Such a board action, he continued, amounted to nothing less than "defiance of Departmental policy and program and against the best interests of the Harlem Hospital."<sup>33</sup>

But despite such flare-ups, affiliation continued apace. Albert Einstein Medical College commenced overseeing operation of the Lincoln Hospital pediatrics department. Different sections of Bellevue Hospital affiliated with NYU and Columbia. Mount Sinai Medical School assumed responsibilities at City at Elmhurst in Queens and Greenpoint Hospital in Brooklyn, while Maimonides Hospital entered an affiliation with Coney Island Hospital in 1963, the ninth affiliation since the program formally began in 1961. By the middle of the decade, most of the city's municipal hospitals had affiliated, a remarkable development considering the plan's origins in a mayoral commission just five years prior.<sup>34</sup>

## The Case Against Affiliation

While some public hospitals eagerly embraced affiliation, others did not. Localist resistance to affiliation was protracted, part of an emerging anti-affiliation critique. Affiliation's opponents saw the program as

31. Jesse Walker, "City Fires Harlem Hospital Medical Board," *Amsterdam News*, September 15, 1962.

32. Ray Trussell to Robert J. Magnum, September 10, 1962, Ray Trussell scrapbooks, Papers of Ray Trussell, LaGuardia and Wagner Archives, Queens College, City University of New York, Queens, N.Y. (hereafter Trussell scrapbooks).

33. *Ibid.*

34. For a full list of initial affiliations, see "The Municipal and Other Health Care and Hospital Systems," in *Community Health Services for New York City: A Case Study in Urban Medical Delivery*, ed. Robert B. Parks (New York: Praeger, 1968), 302–10.

top-down incursion onto community independence and control. Many New York City public hospitals, flanked by their own community boards and civic organizations, were characterized by their advocates as integral institutional nodes underpinning—in ways both real and mythical—a social configuration where “the block and neighborhood provided the most tangible experiences and ties of daily life.”<sup>35</sup> This stood in contrast to much other government infrastructure of the era—Robert Moses’s highways, plazas, parks, and bridges, buttressed by the federal urban renewal program—that New York City residents increasingly perceived as imposed onto them.<sup>36</sup> Those who resisted affiliation believed that public hospitals, if only given adequate budgetary resources by the city, could remedy many of their flaws and thrive independently without the support of private institutions. Those like Ray Trussell and Martin Cherkasky, on the other hand, saw resisters as relics, standing in the way of necessary administrative streamlining. What vision would win out?

Neighborhood activism against affiliation mirrored similar developments throughout the nation as academic medical centers’ power increased in the post–World War II period. So-called “town and gown” tensions took many forms, as Dominique Tobbell argued in her study of rural general practitioners’ savvy professional jockeying to have “family medicine” recognized as a distinct specialty by medical schools undergoing increasing specialization.<sup>37</sup>

In New York City, such battles pivoted around a fierce defensive localism of existing medical turf. The most pitched example occurred at Fordham Hospital in the Bronx, not too far from Montefiore. In May 1961, Trussell announced Fordham’s closure, not even offering it an affiliation. Charles Scala, Fordham’s director of medical education, excoriated Trussell and the Heyman Commission, targeting their insularity. In a critical report, he decried the decision to close as “deadly,” one in a series of “fatal mistakes” stemming from “total divorce from the wise counsel that could be offered by the hospital physicians, the hospital administrators, and the leaders of the communities.”<sup>38</sup> Trussell and cronies had staged

35. On localism’s contradictions in New York City, particularly during this era, see Ira Katznelson, *City Trenches: Urban Politics and the Patterning of Class in the United States* (Chicago: University of Chicago Press, 1981), 103–7.

36. See Robert Caro, *The Power Broker: Robert Moses and the Fall of New York* (New York: Vintage, 1975); Samuel Zipp, *Manhattan Projects: The Rise and Fall of Urban Renewal in Cold War New York* (New York: Oxford University Press, 2010), chaps. 4–5.

37. Dominique Tobbell, “Plow, Town, and Gown: The Politics of Family Practice in 1960s America,” *Bull. Hist. Med.* 87, no. 4 (December 2013): 648–80.

38. Charles Scala, *Report on Status of Fordham Hospital and Hospital Situation in the Bronx* (New York: Fordham Hospital Alumni Association, 1961), 1, 3.

something just short of a coup, working from “preliminary arrangements.” “The Board of Hospitals had already unilaterally decided to close Fordham Hospital,” Scala continued, and it had done so without any kind of open deliberation about rationales and justification.<sup>39</sup> There was some truth to these charges. Fordham Hospital, along with two other facilities, had appeared on the list of planned closures in a closed-door Heyman Commission meeting dedicated mostly to the issue, and its members had never sought outside input.

Apart from blasting the planning process, Scala defended Fordham’s existence by pointing to its heavy utilization rate (88.6 percent average occupancy), consistent certification, plus accolades for specific departments: a sharp contrast to other facilities that had failed, in recent years, to earn reaccreditation. And while staffing pressures surely existed, Scala argued that Fordham had performed far above par, considering the circumstances that all facilities faced. Noting persistent struggles to attract Bronx physicians to serve in the borough’s four municipal hospitals, Scala pointed out that Fordham had, in its most recent count, attracted 36 percent of those 481 Bronx physicians. And unlike other hospitals, it did not have any problems filling a full intern and resident class. While Scala acknowledged the high number of FMGs in the program, he suggested that its established training program, with a regular rotation of lecturers from adjacent universities and hospitals, mitigated against any training deficiencies with which they might have arrived.<sup>40</sup>

At the same time, deficiencies were real, the most glaring in nursing, where Fordham reported filling only 25 percent of its total positions. And Scala admitted, too, to severe infrastructural deficiencies. Such problems, however, needed to be viewed as the outgrowth of long-term trends that went beyond Fordham. The obsolescence of the physical plant, likewise, stemmed not from negligence by Fordham but from the city itself, which had promised in 1954 a “complete modernization” of Fordham yet to actually materialize. The declaration that Fordham’s plant was now irredeemable amounted to cover story for closure. And it was a diversion from years of city neglect. “Fully cognizant of the present desperate need to improve facilities for patient care,” Scala charged, the city still “ignore[d] completely the need to maintain well the existing institutions (Fordham, Lincoln, Morrisania) that are actually rendering such care right now.”<sup>41</sup> From this perspective, the plight of Fordham—and other public hospitals like it—was the by-product of larger city fiscal negligence. Closure and the

39. *Ibid.*, 2–3.

40. *Ibid.*, 4, 6–7, 28.

41. *Ibid.*, 11–12, 14, 19.



larger affiliation plan, consequently, missed the root causes of what ailed hospitals. For Fordham, the motives behind closure were fundamentally about politics and power, not economics and fiscal necessity. Rather, “misleading propaganda,” namely claims about the superiority of the private institutions, fueled the decision.<sup>42</sup>

Fordham’s defenders had indeed punched many holes in Trussell’s blanket depiction of isolated, unaffiliated hospitals with poor teaching programs and unneeded and redundant services with middling patient demand. Fordham’s catchment area, Scala estimated, consisted of 600,000 potential patients. He openly suggested that a regional Bronx power play was afoot and referenced a 1960 overture by Montefiore Hospital to affiliate with Fordham Hospital that the Fordham Board had rebuffed. Without naming Montefiore’s Martin Cherkasky specifically, he pointed out that Cherkasky had become Trussell’s adviser and suggested openly that Fordham’s death would pave the way for Montefiore to acquire a remaining city hospital and enlarge its regional Bronx presence.<sup>43</sup> (See Figures 1 and 2.)

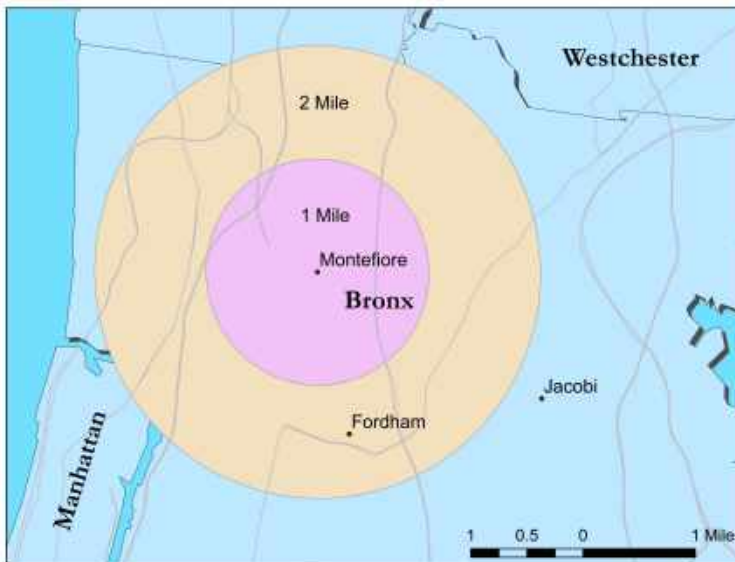
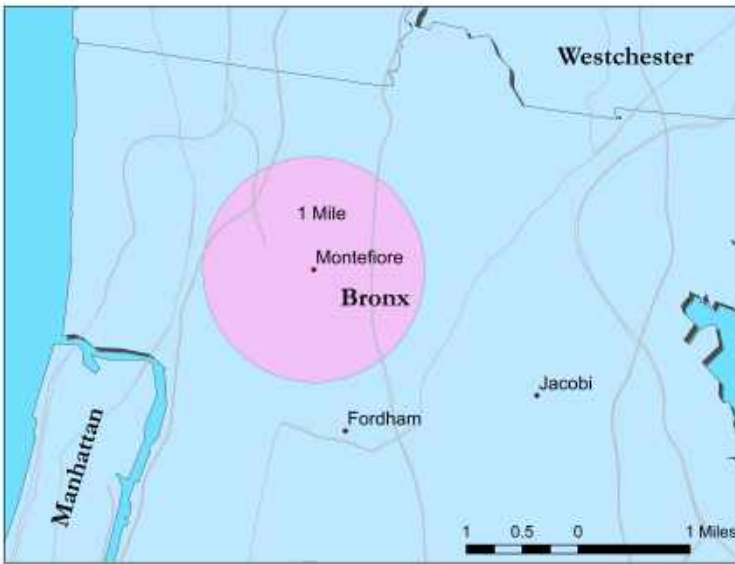
Scala’s report sparked a wave of opposition to Trussell. In May 1961, three hundred unionized Fordham Hospital employees showed up at the Department of Hospitals building in downtown Manhattan to protest the Fordham plan.<sup>44</sup> Trussell incurred the simultaneous wrath of Samuel Rubin, a member of Fordham’s Lay Advisory Committee and a mogul who had made his fortune from the Fabergé perfume line. In June, Rubin ran a series of full-page ads in city newspapers lambasting Trussell, playing up Fordham’s centrality to the Bronx. The ad recounted the hospital’s history and touted its strengths, while rebutting claims that the hospital was in unfixable disrepair. It warned that Fordham might be only the first of many hospitals to go if Trussell continued with impunity: “If Fordham—fully accredited, long esteemed, vitally needed—can be arbitrarily rubbed out of the city’s hospitals system, the question arises, which hospital is next?”<sup>45</sup>

42. *Ibid.*, 20.

43. *Ibid.*, 23.

44. “Hospital Workers Picket,” *New York Times*, May 12, 1961; “Keep City Hospitals Open!,” AFSCME Local 420 leaflet, ca. spring 1961, Trussell scrapbooks.

45. Lay Advisory Board, Fordham Hospital, “Your Hospital May Be Next to Close if the Mayor Closes Fordham July 1” (advertisement), *New York Times*, June 15, 1961; “Your Hospital May Be the Next to Close if the Mayor Closes Fordham July 1” (advertisement), *New York Times*, June 16, 1961. Rubin also wrote privately to Trussell. See Samuel Rubin to Ray Trussell, June 23, 1961, Trussell scrapbooks.



Figures 1–2. The one-mile and two-mile buffers (respectively) around Montefiore. Fordham Hospital lay in Montefiore’s catchment area and led many to claim that Cherkasky and Montefiore’s institutional self-interest was a key driver in Bronx affiliation. Source: Author’s cartography.

The groundswell against Trussell worked. In an unexpected move, he announced that he would reluctantly leave Fordham open for the time, though he maintained that he did so only because of strong outside pressures. Explaining his decision, Trussell claimed that people like Rubin had manipulatively invoked community interest in their protests: “The Fordham thing had got to the point where it was completely irrational. The community was completely confused and up in arms. I just decided there was nothing to be gained by slugging them.”<sup>46</sup> A couple years later, in 1963, the city announced an affiliation between Fordham Hospital and Misericordia Hospital, a private institution, in what amounted to a compromise between the two initial proposals. Fordham would not close and would maintain most of its autonomy, given Misericordia’s relatively minor size compared to other private institutions in the region.<sup>47</sup> But it would now be affiliated, too.

### Mounting Affiliation Critique

The Fordham episode was the beginning of many headaches for the affiliation program by the time Trussell resigned his post in 1965 and liberal Republican John Lindsay became mayor.<sup>48</sup> Lindsay’s 1965 campaign rhetoric on health had amounted to a critique of Trussell’s entire tenure. One broadside read, “Nothing has changed today. A man still can’t die in dignity at many of our city hospitals unless you consider ‘dying in dignity’ in the summer and fall of 1965, dying encased in mosquito netting to protect him from flies—flies attracted by the filth and decay and let in by lack of adequate screens.”<sup>49</sup>

Lindsay’s criticisms preceded a series of blistering reports on the state of the hospitals. The first came from Seymour Thaler, a brash state senator from Queens who served as a lead investigator for a commission on hospitals convened by Governor Nelson Rockefeller. Thaler conducted site visits to almost all of the municipal hospitals in 1966. His interim dispatches unveiled enduring problems at odds with the benefits that affiliation was

46. Barbara Yuncker, “Trussell Yields, Won’t Close Two City Hospitals,” *New York Post*, June 26, 1961.

47. City of New York, Office of the Mayor, press release on Fordham Hospital affiliation, July 28, 1963, box 64, folder 796, Departmental Files, Wagner Papers.

48. “WINS Radio 1010 NYC Hospitals Commissioner” (transcript), June 6, 1965; Ray Trussell to Robert Wagner, June 28, 1965, Trussell scrapbooks.

49. “A ‘White Paper’ on New York City’s Crisis in Hospital Facilities and Care: A Program of Positive Action and Progress (Part I),” October 15, 1965, Box 91, Folder 8 “Crisis in Hospital Facilities and Care, I,” Papers of John Vilet Lindsay, Manuscripts and Archives, Sterling Memorial Library, Yale University, New Haven, Conn.

supposed to have provided. At Kings County Hospital, he encountered a resident using an electrocardiogram who said, “I hope another more serious patient doesn’t come in since there is no other electro-cardiogram available, and we would have to take this one away from this patient.”<sup>50</sup> At two hospitals, he heard house staff complain about unreliable blood samples from laboratories. Suspecting problems, the physicians had sent the same blood in separate vials and received two different sets of results. Besides problems with reliable equipment and laboratory technology, the physical plants remained in lackluster, even outright abysmal, shape. At Fordham Hospital—site of so much foment over affiliation—Thaler watched surgeries in three operating rooms with open windows and no other ventilation. Broken locks allowed anybody to enter the swinging doors. Nearby, surgeons “scrubbed up across the hallway 20 feet from the operating rooms and then walked through a main corridor, occupied by visitors and hospital.”<sup>51</sup> Elsewhere, Thaler and his fellow inspectors found “an enormous accumulation of filth and debris in the basements of two buildings used for patient care,” alongside walls with flammable paint and nonworking water pumps.<sup>52</sup>

Thaler adopted the tone of the muckraker, and he wavered between two modes of analysis. On one level, he blamed hospital administrators and personnel. On another, he pointed to the wider system in which they were embedded. But the latter systemic strand of thinking ultimately emerged as the more prominent one, and it highlighted deep defects in affiliation overlooked by the Trussells and Cherkaskys who had pushed for it. Consider this illustrative episode: One evening, Thaler observed an eighty-two-year-old woman who had been admitted to Greenpoint Hospital after falling down some stairs and cracking multiple ribs. Greenpoint transferred her to Kings County Hospital without X-rays, which resulted in a prolonged wait for a repeat of the process. What seemed like a gratuitous transfer from one hospital to another was, Thaler learned, in fact standard practice. One resident with whom he spoke told him that “approximately 20% of the patients received in the Kings County Hospital emergency room were transferees from other municipal and voluntary hospitals” with many arriving in “in severe states of shock or even dead.”<sup>53</sup> The transfers occurred not by accident or disorganization. They

50. “The New York City Municipal Hospitals: Interim Report to the Honorable Nelson A. Rockefeller Governor, State of New York,” box 506, Folder “New York City Dept. Hospitals Mar. 1966–Feb. 1967,” CUMC Papers.

51. *Ibid.*

52. *Ibid.*

53. *Ibid.*

were a regular result of hospitals ridding themselves of patients without insurance or other means of payments, namely by transferring them to the most taxed of public hospitals.

To Thaler—and subsequent investigators—this phenomenon of shuffling nonremunerative patients, later dubbed “patient dumping,” occurred most often at the hands of private institutions participating in Trussell’s affiliation program.<sup>54</sup> Moreover, it was just one indicator that the affiliations were more often parasitic than benign private-public resource sharing. In the longest section of his report, Thaler argued that the affiliation money, more than two hundred million dollars since the start of the program, lacked oversight to ensure proper spending. This “failure to provide yardsticks for the performance of affiliation contracts,” in Thaler’s words, had led to a poorly supervised arrangement, at best, and at worst, outright abuses.<sup>55</sup> They included physicians who drew double salaries from both the private hospital and the affiliated city institution; use of affiliation funds to provide “exorbitant” salary boosts to administrators; inconsistent work appearances by permanent staff hired for city hospitals; and movement of equipment, originally purchased for city hospitals, to private affiliates instead.<sup>56</sup> In short, affiliation had become a money funnel, a means of diverting resources away from city hospitals and to private institutions.

Subsequent reports substantiated the basic thrust of the early Thaler findings. The final report of the Rockefeller commission, under whose auspices Thaler worked, appeared later in 1967. It noted “inadequate upkeep of physician facilities, insufficient supplies, obsolete and insufficient equipment, shortages and balance among the many essential categories of personnel, insufficient funds and rigidity in legal and administrative procedures which impede prompt decisions and prompt implementation of decisions.”<sup>57</sup> In 1968 another state-level report appeared, confirming not only these conditions but numerous “fiscal abuses” that contributed to them.<sup>58</sup>

54. In this same time period, emergency rooms across the country, especially in large cities, found themselves becoming receptacles for unwanted patients. See, for example, Beatrix Hoffman, “Emergency Rooms: The Reluctant Safety Net,” in *History and Health Policy in the United States: Putting the Past Back In*, ed. Rosemary A. Stevens, Charles E. Rosenberg, and Lawton R. Burns (New Brunswick, N.J.: Rutgers University Press, 2006), 250–72.

55. “New York City Municipal Hospitals: Interim Report” (n. 50).

56. *Ibid.*

57. *Report of the Blue Ribbon Panel to Governor Nelson A. Rockefeller on Municipal Hospitals of New York City* (Albany: New York State Department of Health, 1967), 2.

58. State of New York Commission of Investigation, *Recommendations of the New York State Commission of Investigation Concerning New York City’s Municipal Hospitals and the Affiliation Program* (New York: Community Council of Greater New York, 1968), 47–52.

In response, Montefiore's Martin Cherkasky published an article for the *New York Times* where he acknowledged the criticisms of affiliation that were appearing. But the reasons for the problems were due, in his view, to the affiliation program's not having gone far enough. He proposed shutting down the municipal hospital system in its current form entirely and instead "turning over the complete operation of appropriate municipal hospitals to selected voluntary institutions which have demonstrated their robustness," though what exactly "appropriate" and "robustness" meant was anybody's guess. If such an arrangement became reality, it would greatly increase the local power of the selected private institutions, which would now control most public hospital care. "The medical schools and a handful of voluntary hospitals have the conjunction of brains and ability on all levels required to create a first-class medical system serving the entire community," Cherkasky asserted.<sup>59</sup>

Cherkasky's proposal for an accelerated Affiliation Plus failed to gain any traction. But it did appear around the same time as two major assessments of affiliations. Both tackled the same question posed by Cherkasky: where next? The first, sponsored by the Institute for Policy Studies (IPS), a left-leaning think tank, accentuated the exploitative and undemocratic qualities of affiliation. Written by Robb Burlage, a founding member of Students for a Democratic Society, the so-called Burlage Report recommended an end to "omnibus" affiliations, which had been marked by "too much uncontrolled domination by the scattered 'private' and 'academic' sectors of health service." In its place would be a centralized agency to oversee the municipal hospitals, and at the same time, local neighborhood health councils composed of residents who would provide bottom-up policy input. Burlage's proposal brimmed with the intellectual influence of the American New Left and its push for "participatory democracy"—that is, more decision-making influences by everyday people on the institutions that affected their lives. For Burlage, private medical institutions were a perfect testing ground for the notion.<sup>60</sup>

Burlage's interest in the New York medical world was not coincidental. IPS received much of its funding from Samuel Rubin, who just happened to be a member of the Fordham Hospital Lay Advisory Committee that had campaigned to save the facility from closure. The experience had left Rubin deeply invested in how power flowed in the New York City health care sector. After Burlage's report appeared and received

59. Martin Cherkasky, "A Hospital Administrator Says That the City Should Get Out of the Hospital Business," *New York Times*, October 8, 1967.

60. Robb K. Burlage, *New York City's Municipal Hospitals: A Policy Review* (Washington, D.C.: Institute for Policy Studies, 1967), 262, 515–29.

coverage in the *New York Times*, Rubin gave him additional seed money to start a small New York City–based think tank called the Health Policy Advisory Center (Health/PAC). In the winter of 1968, the *Health/PAC Bulletin*, the organization’s newsletter, explicitly compared the affiliation relationship between the private medical centers and the public hospitals to imperial powers and their colonies, a direct influence of the “Third Worldist” discourse from revolutionary movements abroad. Advocating a “De-colonization Program for Health” in the form of bottom-up neighborhood health boards, its front-page headline asked, “MEDICAL EMPIRES: WHO CONTROLS?”<sup>61</sup>

A less rhetorically scorching, but still critical, report grew out of an investigation ordered by Mayor Lindsay. Chaired by *Scientific American* editor Gerald Piel, the so-called Piel Report appeared about six months after Burlage’s. Like the latter, it also found lingering problems under affiliation and spared no words in saying so. As presently constituted, the city was “perpetuating a dual system of medical care with a built-in invidious double standard of private and welfare medicine. The system is demeaning to all concerned and wastes the resources of the local medical economy.”<sup>62</sup>

Unlike Burlage and Health/PAC, the Piel Report aimed not at unequal power relations between private and public institutions but at the labyrinthine city bureaucracy impeding effective hospital administration. Almost all prior critics had zeroed in on private affiliates. The Piel Report turned the tables on the city itself, arguing that ossified city procedures, irrespective of private affiliates’ conduct, were blocking effective health care provision as well. Many of the problems identified, such as plant deterioration and equipment hoarding, resulted from remedial directives having to flow through multiple agencies, to say nothing of the ones dealing directly with health. Going from a plan to an approval to execution within this “fractionation of authority” occurred glacially, with a “cumulative impact [that] has so hamstrung administration and delivery that, were it not for the activities of many extremely dedicated personnel—heroes of quiet determination—the ‘system’ would come to a complete breakdown.”<sup>63</sup> Affiliation contracts themselves, nevertheless, were not off the hook.

61. “Medical Empires: Who Controls?,” *Health/PAC Bulletin*, November–December 1968, 1–4.

62. “The Final Report of the Commission,” in Parks, *Community Health Services for New York City* (n. 34), 15, 17. The Parks volume contains Piel’s report, along with a series of supplemental commentaries and studies.

63. “Problems, Causes, Solutions,” 506–10, in Parks, *Community Health Services for New York City* (n. 34), 506–10.



There existed “no provision for accountability other than a post-audit of the voluntary hospital’s books.” No clear measures for gauging affiliation success existed, and worst of all, the contracts created disorganized and “divided management”—additional “fractionation”—between two sets of administrators, some from the city and some from the private affiliate itself.<sup>64</sup>

All these reports carried one implication: politically, affiliation was on the rocks. Whether rooted in craven power grabs, mismanagement, or bloated bureaucracy, affiliation as it existed in the late 1960s not only had failed to improve the fortunes of the public hospital system substantially but also may have even made things worse by opening the door to all sorts of abuse. In 1970, then, it was not clear at all whether affiliation would even survive or what the future of the public hospital system might be, given all the scandal-laden publicity surrounding the program and the neighborhood protest against it.

### Historical Contingency and Health Care: The New York City Financial Crisis of 1975

An unanswered question lurked beneath all the volleys and counter-volleys around affiliation: if there had not been an affiliation program, could the system of unaffiliated hospitals in existence have continued and somehow eliminated the pathologies that had clearly afflicted it by the late 1950s? Those who *avored* affiliation argued that the redundancies and waste of the system required nothing less than administrative overhaul. Those *against* affiliation asserted that the problems were just a matter of more secure city funds and money, which would allow for upkeep of physical infrastructure, reverse the stigma of public hospitals that drove away residents and interns, and preserve community-to-institution bonds. There was not a clear answer to the question of affiliation’s necessity in the early 1960s—when it was being rolled out—or in the mid-1960s, when it confronted the firestorm of criticism over the quality of its implementation.

But the parameters of the discussion changed markedly and suddenly in the mid-1970s. In 1975, the city experienced a fiscal crisis and was pushed infamously to the brink of default by more than nine billion dollars of accumulated municipal debt. The resolution of the crisis took the form of an austerity regime, with severe budget cuts to all city functions,

64. “Final Report of the Commission” (n. 62), 15, 17. This is discussed further in “The Municipal and Other Health Care and Hospital Systems,” in Parks, *Community Health Services for New York City* (n. 34), 318–21.

health and otherwise. It would have huge implications for how the policy impasse over affiliation and its future would be resolved.

Before the crisis, the city had been leaning toward staying the course with affiliation. In 1970, New York State chartered a quasi-private public benefit corporation, first proposed by the Piel Report, to oversee the program and named it the Health and Hospitals Corporation (HHC). The headline-grabbing investigations of the affiliations had shown that they were overly reliant upon private institutions' integrity and resources with few enforcement mechanisms assuring proper implementation. A more centralized home for public hospitals could allow it to exert more authority over the affiliation contracts themselves, preventing some of the documented abuses of the late 1960s. As important, the HHC entity allowed for it to independently raise funds without the political and bureaucratic impediments that a formal city agency had to face.

In practice, the early years of the HHC were anything but stable, and the organization fumbled along. For one, it inherited a dated collections and bookkeeping system from the city's Department of Hospitals that left it with a whopping \$45.2 million deficit in its first year. On top of that, the city had allowed individual hospitals (and, by extension, their affiliates) to make personnel decisions autonomously—but with little oversight from the new agency, contributing to a \$40 million overrun. As its first president put it later, the transition to HHC had occurred “prematurely,” before an exact agreement had been made with the city on its contribution in tax revenue to the corporation. The resulting debt stalled the agency's operations in its early years, with the HHC forced to implement a one-year hiring freeze that lasted until September 1972.<sup>65</sup>

Affiliations themselves, meanwhile, remained a persistent headache. A 1972 audit by the state comptroller's office found that private institutions filed mandated monthly expense reports irregularly and that most ended up spending less than the monthly advance made to them for

65. Office of the State Comptroller, “Report on Review of Budget and Financial Operations, New York City Health and Hospitals Corporation, July 1, 1970—December 31, 1971,” box 43, folder 568, Subject Files “Health Servs. Admin-State Audit Report—Overpayment for Psychiatric 1972–1973”; Office of the State Comptroller, “Audit Report on a Review of Budget and Financial Operations of the New York City Health and Hospitals Corporation for the Period July 1, 1970 to December 31, 1971,” John Lindsay Papers, LaGuardia and Wagner Archives, LaGuardia Community College, City University of New York, Queens, N.Y. (hereafter Lindsay Papers); Joseph T. English, “Annex A to Fiscal Year 1972 Letter from Director of the Budget (Mr. David A. Grossman) to President of the Corporation (Joseph T. English, M.D.) Concerning Expense Budgets Fiscal Years 1971, 1972 and 1973 for the Health and Hospitals Corporation,” ca. mid-1972 (from context); Joseph T. English to John Lindsay, August 23, 1972, box 32, folder 438, Subject Files “H.H.C. (1),” Lindsay Papers.

their services. At best, the latter was a sign of affiliates spending money more efficiently than projected. At worst, it was evidence of institutions' continual use of affiliations to create, in the words of the comptroller's investigation, "a major reserve of unneeded cash" then used for nondesignated purposes. Either way, HHC oversight of the affiliations remained lax, with the amount advanced to private affiliates unadjusted to what they were actually spending. It was hardly the sort of thing that inspired confidence from critics of affiliation. In response, the HHC planned to enforce a thicker firewall between funds specifically earmarked for affiliation and those used for an institution's general operating expenses. It required, too, that excess unused funds be placed in interest-bearing accounts specifically for affiliation.<sup>66</sup>

Even greater difficulties stemmed from emerging economic pressures beyond the hospital system itself. Signs surfaced years before the 1975 fiscal crisis. One involved the unreliability of Medicaid funds. In 1968, only a few years after the program began, New York State's Medicaid program announced an alteration to eligibility requirements that eliminated 600,000 people from rolls, prompting the city to ponder cutting hospitalization stays and increases in home care as temporary solutions.<sup>67</sup> One estimate by the Health and Hospital Planning Council of Southern New York, an area-wide planning agency, estimated that Medicaid revenue could fall by as much as 20 to 30 percent because of the changes.<sup>68</sup> Federal budget cuts in the era of Richard Nixon and Gerald Ford added still more pressure to city health care operations. One year, two of the city's neighborhood health centers learned that they would be facing a sudden 13 percent budget reduction, requiring "existing programs and/or program elements . . . to be eliminated."<sup>69</sup> After taking steps to correct some of the problems identified by the comptroller, HHC president

66. Paul J. Kerz to Arthur Gordon, memorandum on interest-bearing accounts, June 15, 1972; Office of the State Comptroller, "Audit Report on Review of Affiliation Management of Cash Advances under Contract with the New York City Health and Hospitals Corporation for the Period July 1, 1970–December 31, 1971," box 32, folder 446, Subject Files "H.H.C.-Audit-Central Processing Unit," Lindsay Papers.

67. Commissioner of Health (New York City), staff meeting, February 8, 1968, March 14, 1968, box 41, folder 458, Subject Files "Health Servs. Admin-Health, Department of (NYC)," Lindsay Papers.

68. Health and Hospital Planning Council of Southern New York, Inc., memorandum on "Notes on Progress and Problems in Neighborhood Health Center Planning and Development," June 4, 1968, box 39, folder 514 "Health Servs. Admin.—Comm.-Ambulatory Care Facilities," Lindsay Papers.

69. Joseph T. English, memorandum on HHC activities, January 25, 1973, box 43, folder 566, Subject Files "Health Servs. Admin—Reports, HHC," Lindsay Papers.

Joseph T. English stated bluntly that “the survival” of the corporation’s operations, “let alone their improvement, is dependent upon money.”<sup>70</sup> Writing in 1972, English had foreshadowed the end of his reign as the HHC’s first president and that of John Lindsay, the mayor who had appointed him.

Lindsay fell due to perceptions of inefficacy that arose in the run-up to the city fiscal crisis of 1975, when the city found it had been cut off from credit markets. A confluence of forces had resulted in the city’s crunch. One was loose administration and monitoring of cash flow, prevalent across dozens of agencies and exemplified by the HHC’s early years. For years, in response to an insufficient tax base, the city had taken to generous financing of operations with bond sales, selling a staggering \$8.3 billion and \$900 million in short- and long-term bond notes, respectively, in fiscal year 1975. This was an increasingly untenable strategy that papered over larger budgetary problems and catalyzed the crisis after a lender strike by banks that refused to service city debts further in the next cycle.<sup>71</sup>

But a larger, and overlooked, contributor to the crisis was rollbacks in state and federal commitments to large urban municipalities, as Kim Phillips-Fein has argued, which necessitated such lending in the first place. This tendency persisted through the crisis itself, with the Ford administration and Congress initially refusing to support federal aid packages to New York City. Such aid might have prevented the years of stringent financial discipline imposed by New York State on the city via two ad hoc agencies, the Municipal Assistance Corporation (MAC) and the Emergency Financial Control Board (EFCB). These makeshift agencies’ chief solution was to swap short-term bonds with long-term bonds while assuming control of city finances and imposing harsh austerity budgets in the hopes of restoring access to credit markets. When additional federal intervention did arrive, it came not in the form of aid but as short-term loans with rates pegged at 1 percent higher than Treasury bill interest rates. The cumulative result, Jonathan Soffer has noted, “creat[ed] a city in which almost nothing was maintained or repaired for a decade,” after a 27 percent workforce reduction and a 75 percent decline in capital spending.<sup>72</sup>

70. Joseph T. English, appendix, memorandum on miscellaneous HHC issues, February 10, 1972, box 43, folder 568, Subject Files “Health Servs. Admin-State Audit Report- Overpayment for Psychiatric 1972–1973,” Lindsay Papers.

71. Ester Fuchs, *Mayors and Money: Fiscal Policy in New York and Chicago* (Chicago: University of Chicago Press, 2010), 87; Kim Phillips-Fein, *Fear City: New York’s Fiscal Crisis and the Rise of Austerity Politics* (New York: Metropolitan Books, 2017), 41–44.

72. Phillips-Fein, *Fear City* (n. 71), 24–25; Jonathan Soffer, *Ed Koch and the Rebuilding of New York City* (New York: Columbia University Press, 2010), 119. On the crisis more

The effects on the HHC, already struggling to gain fiscal and administrative footing in its infancy, were immense. Between 1975 to 1980, a net payroll reduction reduced the total HHC workforce by almost 18% of what it had been at the start. Service cuts complemented workforce shrinkage. Between 1972 and 1982, average lengths of stay fell from 11 to 8.3 days, with the total number of “days of care” falling 23 percent. Even with reduced capacity, admissions in 1978 began exceeding those from 1975, indicating an overtaxed and underresourced system.<sup>73</sup> Five years after the crisis, bed capacity dropped 18 percent. The cuts were directly propelled by fiscal stringency and the inability to sustain pre-1975 spending practices under the new MAC and EFCB oversight.

### The Consolidation of a Vision: Affiliation in the Age of Austerity

The tenor of controversies over affiliation had now transformed. In the early 1960s, debates had centered over local control and preserving decentralized authority. By the late 1970s, control of institutions took secondary priority as the public hospital system stood again at a critical juncture but of a different sort created by the fiscal crisis: simple survival. Fiscal turbulence allowed a young Ed Koch, then making a name for himself as a federal House representative, to ponder secretly the radical possibility of getting rid of the public hospital system altogether, with exceptions for a facility here or there. “The city of New York could reduce its enormous budgetary deficit by removing itself from the hospital business, without diminishing services to the population now cared for in those hospitals, who would be served by the voluntary and proprietary hospitals, even though there might be greater inconvenience in getting to some of those hospitals,” Koch wrote to the city’s new commissioner of health, Lowell Bellin, in 1975.<sup>74</sup> In his view, the \$200 million of unreimbursed care provided by the municipal hospitals was a budgetary albatross. Bellin, in turn, speculated that Medicare, Medicaid, and other federal reimbursement

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generally, see Phillips-Fein, *Fear City* (n. 71); William K. Tabb, *The Long Default: New York City and the Urban Fiscal Crisis* (New York: Monthly Review Press, 1982); Roger Alcaly and David Mermelstein, eds., *The Fiscal Crisis of American Cities: Essays on the Political Economy of Urban America with Special Reference to New York* (New York: Vintage, 1977).

73. Charles Brecher, “Historical Evolution of HHC,” in *Public Hospital Systems in New York and Paris*, ed. Victor Rodwin et al. (New York: New York University Press, 1992), 71–72.

74. Edward Koch to Lowell Bellin, June 9, 1975, box 9, folder 137, Subject Files “Health Department,” Beame Papers, LaGuardia and Wagner Archives, LaGuardia Community College, City University of New York, Queens, N.Y. (hereafter Beame Papers).

of health providers would eventually give way to more and more patients who “vote with their feet,” opting for private care over the municipal system.<sup>75</sup> Later in the year, Bellin suggested that a large segment of the system—“hospitals with low occupancy and high per diem cost”—should be closed and that the HHC, so long as it refused to consider closure, was helping “bleed all the hospitals including the viable ones.”<sup>76</sup> Bellin’s views fused health services technocracy with a general growing suspicion, exacerbated by the crisis, over whether a robust public sector was maintainable or even desirable.<sup>77</sup>

Action soon followed closed-door deliberation. In 1976, at multiple municipal facilities—most notably Morrisania (Bronx), Gouverneur (Lower East Side), and Sydenham (Harlem)—the city eliminated inpatient and emergency services. Fordham Hospital, the center of the stand-off over city plans to shut it down a decade and a half prior, was closed entirely this time. The moves had come, first and foremost, as responses to EFCB demands on HHC. But they also reflected longer standing power relations within the municipal health care sector. Fordham had a weak (and unwanted) affiliation with Misericordia, a small voluntary facility. Sydenham was an outlier that had never affiliated and, back in the days of the Heyman Commission on affiliation, had been eyed by Trussell for closure. Gouverneur’s affiliation with Beth Israel was a strong one but marked by discord and was coming to a close. It, too, had been eyed by Trussell but not yet closed.

The EFCB and the new fiscal climate converged with a longer standing desire to close or scale back these three facilities and others that had been in the crosshairs since the early days of affiliation. In 1978, the city implemented a “hospital closure incentive program” that compensated private affiliates for public facilities’ closure, allowing them to receive higher Medicaid reimbursements and move resources they would otherwise spend on an affiliation to other operations.<sup>78</sup> A year later, an emboldened Ed Koch, now mayor, moved forward with plans to close Sydenham Hospital in Harlem, something prior officeholders had avoided for fear

75. Lowell Bellin to Edward Koch, June 13, 1975, box 9, folder 137, Subject Files “Health Department,” Beame Papers.

76. Lowell Bellin to Abraham Beame, September 24, 1975, box 9, folder 137, Subject Files “Health Department,” Beame Papers.

77. On Bellin more generally, see James Colgrove, *Epidemic City: The Politics of Public Health in New York* (New York: Russell Sage Foundation, 2011), 82–100.

78. Allen G. Schwartz to Edward Koch, May 11, 1979, box 32, folder 1, Departmental Files, Ed Koch Papers, LaGuardia and Wagner Archives, LaGuardia Community College, City University of New York, Queens, N.Y. (hereafter Koch Papers).

of potential racial connotations. One influential guiding hand in Koch's administration was none other than Martin Cherkasky, whom Koch had appointed as a "special advisor" on health. At one point, Koch and Cherkasky mused over the possibility of shrinking the municipal system by half, through either closures or sales of facilities to private institutions like Cherkasky's own.<sup>79</sup> Although nothing of that scale occurred, many public hospitals, like Cumberland and Greenpoint hospitals in Brooklyn, were eventually shuttered.<sup>80</sup> What was left in the wake of the fiscal crisis was a municipal health care landscape transformed: scaled down and consolidated in the hands of New York City's unique cluster of private medical centers. By the end of the 1970s, it was clear that there existed a health analogue to what journalists Jack Newfield and Paul Du Brul memorably called "the permanent government," an unelected group of New York institutional stakeholders working behind the scenes who often exerted far more power than elected officials.<sup>81</sup>

Through all these developments, Ray Trussell, architect of the affiliations, had faded from the center stage of New York City health politics. For a while, during the heat of backlash against affiliations in the late 1960s and before the fiscal crisis, affiliations looked like they might be in serious need of revision or, worse, a half-realized policy in jeopardy. But when the city announced the second wave of closures in 1979, they looked almost intractable. By then, Trussell had been out of city office for more than a decade. But the attempted planning revolution in New York City municipal health care that he had started was now complete. It was the synthesis of two developments: ideas of rationalization and consolidation spottily translated in practice until contingent developments of 1970s political economy greatly diminished the feasibility of alternative options. It made Trussell the most important health official whom most people in the health care sector had never even heard of.

## Conclusion: Affiliation and Its Ramifications

During the 1960s and into the 1970s, two visions of hospital provision competed in New York City. But austerity politics threw into relief the limits

79. Victor Botnick to Edward Koch, memorandum on "Montefiore Hospital Expansion," January 2, 1979 in Box 45, Folder 17, Departmental Files, Koch Papers; Robert J. O'Connor to Edward Koch, January 22, 1979 in Box 45, Folder 18, Departmental Files, Koch Papers.

80. New York City Health and Hospitals Corporation, "Closing of Cumberland Hospital Testimony," March 7, 1983 in Box 33, Folder 6, Departmental Files, Koch Papers; Edward Koch to Stanley Brezenoff, memorandum on Greenpoint and Cumberland hospitals, August 12, 1983 in Box 67, Folder 29, Departmental Files, Koch Papers.

81. Jack Newfield and Paul A. Du Brul, *The Abuse of Power: The Permanent Government and the Fall of New York* (New York: Penguin, 1978).



of the community-oriented, anti-affiliation vision. That vision prized local control of public facilities and rejected the need for outside private forces' meddling in community affairs. Problems with hospitals could be fixed without affiliations. With the fiscal crisis and a city functioning under an austerity budget for the next decade, however, it was hard for obstinate public hospitals that resisted affiliation to claim they could get along in a self-sufficient manner. The original protests over affiliation, in its early days, were fundamentally over governance. Although there were signs of budgetary duress in the 1960s, they had not reached the magnitude they would a decade later when, in an austerity climate, there was a new battle and crisis: one over outright sustainability.<sup>82</sup> Contests over governance retreated into the background, as unaffiliated hospitals struggled to go it alone without the material resources an affiliation provided.

The fiscal climate of the 1970s, then, is the central explanation for the entrenchment of affiliation today. Whereas affiliation was uncertain in 1968 or 1969, by 1975 it was hard to see any other means of saving public hospitals without the resource sharing that affiliation afforded. In fact, in such a budgetary context, affiliation looked much more benign than some of the harsher alternatives floated in the wake of the crisis, such as outright privatization. After its rough start, HHC achieved remarkable stability as an agency by the early 1980s, with regulatory powers to clean up the abuses that had wracked affiliation in its early days, though enforcement could still be an uneven process. As importantly, its new bonding powers helped it raise independent revenue for the hospital system, free from future budgetary turbulence.

A second trend at the time also complicated the anti-affiliation argument: a decline in demand for inpatient services in public hospitals. This was not unique to New York, and public hospitals in major cities faced the same problem. Much of it was due to the influx of Medicaid and Medicare, which allowed patients to take their dollars to private facilities, which saw, in turn, new streams of revenue, as Rosemary Stevens has argued.<sup>83</sup> The resulting fall of inpatient demand carried huge implications. From a public administration standpoint, it raised questions of what to do with expensive but unused inpatient hospital capacity that the city had built in the early twentieth century. This reality was elided in protests over affiliation and related rationalization proposals, such as downsizing or closure. The best example of this could be found at Sydenham Hospital in Harlem, which the city slated for closure in the late 1970s. Predictably,

82. Phillips-Fein, *Fear City* (n. 71), 30–33.

83. Stevens, *In Sickness and in Wealth* (n. 3), 291.

it catalyzed angry, if short-lived, neighborhood opposition that interpreted the closure as malevolent withdrawal of services from a community with heavy medical needs. Yet Sydenham, however powerful a neighborhood symbol, was decreasingly important as an actual provider of services compared to Columbia-affiliated Harlem Hospital. Warm collective memories of it were inaccurate indicators of how many people actually depended on Sydenham. The 1975 Harlem Community Health Survey, conducted by Harlem Hospital, found that for those who used hospital care when they “were sick or needed medical attention,” Sydenham accounted for only 4.7 percent of visits, compared to 25.1 percent for Harlem Hospital.<sup>84</sup> And the city’s own data showed a low utilization rate, hovering between the mid- to high-60 percent ranges. Between 1973 to 1978, its daily census fell from 122 to 90.<sup>85</sup> Uproar around Sydenham in fact had as much to do with the symbolic and cultural connotations surrounding the hospital than with an actual real blow to services itself from a closure.

It was a point that Samuel Wolfe, a Columbia University public health professor and otherwise prominent critic of the austerity regime, wrote about eloquently. Wolfe analyzed two years of municipal hospital data, and he found that utilization rates of in-patient beds were in the 70 percent range, with a substantial number of beds used for nonmedical purposes. The data suggested that an excess capacity of inpatient beds thus might exist. Therefore, cuts targeted at non-outpatient services might have the dual effect of eliminating both redundant (and costly) infrastructure while responding to budgetary imperatives posed by the fiscal crisis.<sup>86</sup>

In Wolfe’s larger analysis, decisions about hospitals, whether new cuts or new construction, had to be judged by the logic—or illogic—used to carry them out. Unfortunately, for Wolfe, too many decisions made by New York City health care players of all kinds, past and present, had been driven by institutional self-interest, not dispassionate needs assessment. “It seems very evident,” Wolfe wrote, “that local interests and pressures—often with powerful financial backing—have determined whether or not beds would be created. Whether they would be needed and how

84. “Harlem Community Health Survey: Utilization of Harlem Hospital,” August 13, 1975, box 323, Folder “Harlem Hospital 1975,” CUMC Papers.

85. “Sydenham Fact Sheet,” March 6, 1979,” box 32, folder 1, Departmental Files, Koch Papers. Discussions on the closure are in Bernard Challenor to Donald F. Tapley, memorandum on Sydenham Hospital closure, May 19, 1976, box 323, Folder “Harlem Hospital,” CUMC Papers.

86. Samuel Wolfe, “The Hospitals of the City of New York: A Policy Overview of the Municipal Hospitals in Relation to the City’s Other Hospitals,” January 1976, box 504, Folder “Health and Hospitals Corp. Nov. 1976–Dec. 1976,” CUMC Papers.

they would be used seems to have been another matter.” Wolfe’s most perceptive insights concerned how hospitals fit into larger neighborhood contexts and the multiple ripple effects that could follow cuts or closures. Such decisions, he stated, carried “profound political implications.” As the neighborhood fights around hospitals demonstrated, residents infused the facilities with enormous cultural meaning that was as important as the immediate surface function of medical needs. Wolfe elaborated,

Health care does matter to people. In addition, a health facility creates jobs, job opportunities, secondary services in the surrounding community, and so on. It is therefore understandable that people will react with fury and anxiety combined when both their jobs and their health care security are under assault at the same time. Thus, while some have seen the delay in paring down the municipal hospital system as evidence of recalcitrance, others may see it as a strategy to assure that caring and compassion be shown to the part of the community that will be affected.<sup>87</sup>

It was not surprising, then, that the affiliation wars were infused, from the very start, with political emotion from all quarters. Health care was about more than just health care.

Looking back a half century after the affiliation battles, what are we to make of the policy and others like it? One way is to avoid thinking of it as only good or bad in a context-free abstract and to focus instead on its *execution*. And when it comes to execution, there is little doubt it was implemented, at least in its early stages, in a frequently undemocratic and unaccountable manner. In the case of Fordham Hospital, the fiscal crisis allowed for the completion of the Bronx political power play that many had long suspected. While other public hospitals closed, the construction of a new public hospital, North Central Bronx, continued, the product of long-term lobbying by Montefiore and Martin Cherkasky. North Central Bronx not only would become Montefiore’s new affiliate—something that would continue for twenty years—but would be located right next to Montefiore Hospital.<sup>88</sup> With the opening of North Central Bronx, the city deemed both Fordham and Morrisania, another public hospital in the Bronx, redundant and obsolete. Behind closed doors, New York State had explored the possibility that Montefiore purchase North Central Bronx outright, though the proposal never came to fruition.<sup>89</sup> The

87. *Ibid.*

88. *Ibid.*

89. Victor Botnick to Edward Koch, memorandum on Montefiore Hospital expansion, January 2, 1979, box 45, folder 17, Departmental Files; Robert J. O’Connor to Edward Koch, January 22, 1979, box 45, folder 18, Departmental Files, Koch Papers.

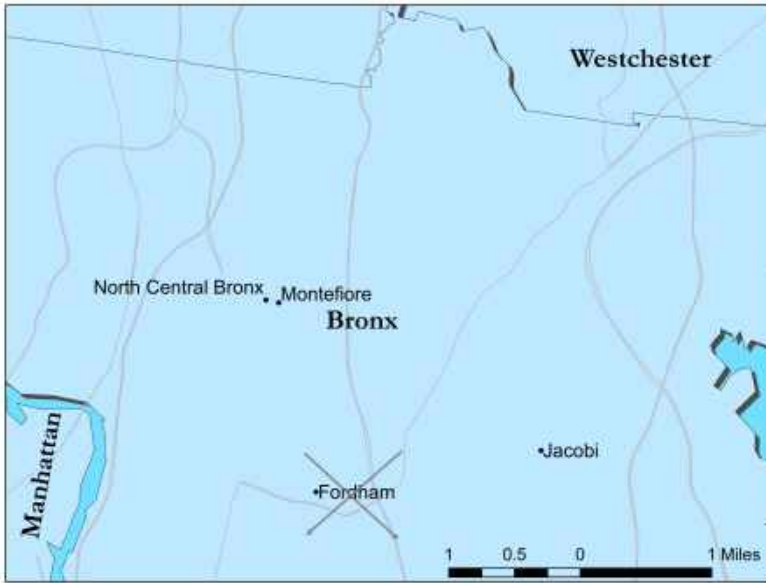


Figure 3. North-Central Bronx and Montefiore together, alongside the closed Fordham and Jacobi, a more distant Bronx public hospital to the east, also affiliated with Montefiore. For many, this spatial arrangement demonstrated Montefiore's consolidation of regional power. Source: Author's cartography.

North Central Bronx–Montefiore affiliation prompted Samuel Wolfe to declare that “decisions about the creation of municipal hospital beds and the perpetuation of the municipal system of care have been made by spokesmen for the non-public sector over the years.”<sup>90</sup> For Wolfe and other critics, Montefiore's role in planning North Central Bronx's location amounted to “irrationality,” driven by Montefiore and other private affiliates. (See Figure 3.)

But if we separate out the bungled execution of affiliation, if we think about the reasons for and the historical moment when affiliation arose, and if we accept the material need for some hospital affiliation, especially after the fiscal crisis of 1975, is it really affiliation in principle that is upsetting, or is it the way it was rolled out? And if it is the way it was rolled out,

90. Samuel Wolfe, “The Hospitals of the City of New York: A Policy Overview of the Municipal Hospitals in Relation to the City's Other Hospitals,” January 1976, box 504, Folder “Health and Hospitals Corp. Nov. 1976–Dec. 1976,” CUMC Papers.

were there ways to do affiliation better, with proper accountability that would serve as a check against academic medical centers controlling the process in nakedly self-interested ways? Were there ways to think more centrally about preserving jobs that came under threat with major institutional shake-ups and closures?

In the coming decades, these are the questions we must be asking. Rapid health care sector transformation will require assessing new institutional arrangements and the proper balance between private and public or whatever else. Take, for example, the wave of consolidations in health care that researchers predict will come during the next decade.<sup>91</sup> Observers have pointed out both potential benefits—cost cutting, resource pooling—and huge drawbacks, the most severe being the creation of medical monopoly power. But just as I have argued with hospital affiliation, consolidation is neither good nor bad on its own, nor is it effectively assessed, in a contextual vacuum, by automatically casting normative aspersions upon it. Rather, one must debate what yardsticks are most important in assessing its execution and start the analysis from there. That means avoiding the temptation to slap on, a priori, ready-made labels, like “neoliberalism,” or to depict developments, as analysts did then and do now for affiliation, as nothing more than public institutions serving as handmaidens for “private interests” on the march.<sup>92</sup> There is no doubt that the fortunes of public institutions and governmental support for social welfare have become ever more uncertain in the past five decades. But as Kim Phillips-Fein and Suleiman Osman have recently argued, these post-1970s shifts originate from multitudes of sources: some premeditated and ideological, launched from the most rarefied global and national levels, others variations in local practices that over time resulted in new modes of governance. It is a combination, in the political scientist Tim Weaver’s words, of social transformation both “by design” and “by default.”<sup>93</sup>

91. David M. Cutler and Fiona Scott Morton, “Hospitals, Market Share, and Consolidation,” *J. Amer. Med. Assoc.* 310, no. 1 (November 13, 2013): 1964–70.

92. For an example of such an analysis, see Adele Oltman, “Liberalism and the Crisis of Health Care in Harlem in the 1960s,” *Soc. Hist. Med.* 29, no. 1 (February 2015): 44–65, quotation on 65. And for an analysis along these lines from the time, see Barbara Ehrenreich and John Ehrenreich, eds., *American Health Empire: Power, Profits, and Politics* (New York: Random House, 1970).

93. On the multiplicity of late twentieth-century conservatism or “neoliberalism’s” sources, see Kim Phillips-Fein, “The Roots of American Conservatism,” *Nation*, May 4, 2016; Suleiman Osman, “‘We’re Doing It Ourselves’: The Unexpected Origins of New York City’s Public–Private Parks during the 1970s Fiscal Crisis,” *J. Planning Hist.* 16, no. 2 (May 2017): 162–74; Timothy P. R. Weaver, *Blazing the Neoliberal Trail Urban Political Development in the United States and the United Kingdom* (Philadelphia: University of Pennsylvania Press, 2016).

Affiliation marked a new organizational form for the American hospital that resulted from larger historical tides and the constrictions they posed to policy makers. It was another chapter in an ongoing institutional transformation. It is unlikely to be its last.



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