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PRIVATIZING NEW YORK CITY'S PUBLIC HOSPITALS:
The Politics of Policy Making

By

Maria K. Mitchell

A dissertation submitted to the Graduate Faculty in Political Science in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

1998

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4/27/98
Date

John Mollenhuth
Chair of Examining Committee

4/27/98
Date

W.B. [Signature]
Executive Officer

Dr. Christa Altenstetter

Dr. Bernard Brown

Dr. Thomas Halper

Dr. Peter Salins

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

Abstract

PRIVATIZING NEW YORK CITY'S PUBLIC HOSPITALS:
THE POLITICS OF POLICYMAKING

by

Maria K. Mitchell

Advisor: Professor John Mollenkopf

This is a case study of New York City Mayor Rudolph W. Giuliani's initiative to privatize municipal hospitals. The study analyzes how Giuliani's belief in reinventing government brought him to the conclusion that privatization was a solution to the long standing problems of the New York City Health and Hospitals Corporation (HHC), the largest municipal hospital system in the country. The research analyzes in depth the factors that influenced the Giuliani administration's decision to seek privatization of the municipal hospitals in New York City. It also examines the course of events that effected this initiative. The study also challenges the thesis of Sayre and Kaufman (1960), and others, that change in New York City is impossible. Finally, this case study examines the relationship of the public and private sector during the three-year effort to privatize the public hospitals. John Kingdon's model of policymaking is used as a framework for presentation of the research (1995).

This research supports the literature that finds that competition induced by privatization is a fundamental and positive element of privatization. This study also confirms the

findings in the literature that public accountability is paramount to the success of privatization and that the Kingdon and Birkland theories that crises and focusing events help bring and maintain policy items on the agenda is accurate. There is a need to articulate clear goals and expected outcomes at the outset of privatization. Because privatization is often driven by ideology, it disrupts other privatization initiatives in that it is easy to misperceive intentions or purposefully distort the goals of the advocates of a particular privatization initiative. There is a need to discuss and evaluate privatization on more than a cost-benefit basis. This study adds to the privatization literature, and provides a guide to policy makers in outlining the need for assessment of the political environment, strategy development and strategy implementation during privatization. It is demonstrated here that through innovative leadership, it is possible to make positive changes in New York City's bureaucracies.

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Thank-you to Lincoln, my friend through it all. I'm sorry you didn't see the finale.

PREFACE AND OVERVIEW OF RESEARCH QUESTIONS

This dissertation examines a leadership decision by an elected official to place an issue high on his policy agenda and how that decision wound its way through the political maze of policy making. It is a case study of the decision of Rudolph W. Giuliani to privatize several of New York City's public hospitals. The study analyzes how Giuliani's belief in reinventing government brought him to the conclusion that privatization was a solution to the long standing problems of the New York City Health and Hospitals Corporation (HHC), the largest municipal hospital system in America. The case study details how advancing the idea of privatizing public hospitals culminated in a three-and-a-half-year policy making whirlwind to which there is little analogy in the privatization literature.

The research that follows analyzes in depth the factors that influenced the Giuliani administration's decision to seek the privatization of municipal hospitals in New York City. It also examines the forces that determined the course of events that affected this initiative. Finally, it challenges the thesis that change in New York City is impossible (Sayre and Kaufman 1960). John Kingdon's model of policymaking as described in Agendas, Alternatives, and Public Policies guided this research (1984, 1995). The model presented here is consistent with that of Kingdon's which stresses an appreciation of "the confluence of separate streams of problems, policies, and politics at critical junctures facilitated by entrepreneurs alert to the prospects of coupling divergent forces" [as an aid in understanding these events] (1995 216). This author also concurs with Birkland whose view is that theories of the "policy process must avoid the tendency to

arrange policy making into neat, orderly steps" (Birkland 1997, 5). The New York City hospital privatization policymaking process was, as Kingdon would say, highly fluid.

Throughout this study it will be clear that privatization was an "idea whose time had come" as Kingdon theorizes. The process was not at all a tidy package that can easily be understood simply by looking at the HHC privatization process in isolation. Rather, it was an idea that took many years of "softening up," as is made clear in the review of the privatization literature in Chapter One. This historical perspective on privatization and its evolution in U. S. governance guided the thinking articulated primarily in Chapter Three. It becomes clear that despite the value of his charismatic leadership in sustaining a privatization effort for over three years, Rudy Giuliani was elected Mayor at a time in our nation's history when there was great emphasis placed on making government run more like business. Such thinking, and the trends that followed, had roots much deeper than the "reinventing government" notion of Osborne and Gaebler (1993) that Giuliani modeled much of his thinking on. There was indeed a growing trend away from big "government" towards "governance" where the state is more of a facilitator. The Giuliani administration's effort to privatize the public hospitals benefited from the increasingly popular notion of governance where the government "steers" and orchestrates, and relies on market mechanisms in order to attain collective goals (see *International Social Science Journal*, March 1998).

Given then, both the long history of softening up, the national trend toward a new acceptance of governance, as well as the convergence of so many political, national, local, and "focusing" events that made privatization in New York City a possibility, this case study conforms to Kingdon's model. He describes the success of policymaking as many simultaneously occurring "streams" that come together to place a particular issue

high on an elected official's policy agenda. According to Kingdon, the "development in the policy stream might well resemble the long process of natural selection, in which ideas are tried, revised, tried again, and gradually emerge to prominence or die away" (1995, 226). This statement rings particularly true in the case of privatizing HHC. Not only is there a long and historical development of privatization in the United States, but HHC has an equally long history of problems as well as solutions that were raised, some implemented with varying success, and many that died away, as will be clearly demonstrated in Chapter Two. The historical perspective cannot be underestimated. As Rockman concludes: "We need history and comparison to understand why policy problems tend to get defined as they do, why they bump into similar obstacles and occasional opportunities. We need both history and comparison to evaluate the impact of institutional architecture on politics and to see how politics can differently configure the same basic architecture" (1994, 158).

It was the combination of these two historical perspectives (that of HHC and that of privatization), along with the convergence of a dramatic shift in the national and local health care delivery systems and politics in general, described in Chapter Three, that come together to take advantage of the long but separate histories of privatization and HHC. Detailed in the coming chapters are the events that describe the combination of the policy stream (privatization evolution) with the problem stream (HHC's longstanding problems), coupled together at the right time with the political stream (national and local mood, fiscal crisis, and health care changes), to "open the window" for privatizing HHC hospitals.

Included in the various streams were "focusing events", as described by both Kingdon and Birkland, which helped highlight HHC's problems for the public in a way that the

massive hospital system's day to day problems were incapable of doing. The assistance of focusing events in bringing media attention, and therefore broad population focus, on an otherwise easy to ignore problem such as the lack of quality care received by the poor, is crucial in keeping an agenda item on track. Birkland advances Kingdon's notion of "focusing events" a step further, and posits that "disasters" are often events that focus the attention of the public and policymakers alike on a problem in a unique way (1997). While Birkland refers primarily to large-scale disasters such as hurricanes and the Exxon Valdez oil spill, HHC's privatization history has, albeit more limited, its own set of "focusing" disasters that helped bring privatization to the fore.

The Giuliani administration entered office ready to propose this bold new initiative of privatizing HHC hospitals, and the confluence of the policy, political, and problem streams made it possible to do so. While understanding that privatization is controversial, the words of Savas--both during the process itself, and in the review of the process--while simple, seem particularly poignant. "It is an understatement to say that privatizing a current government function is not a simple matter. Attitudes have to be changed, and new skills have to be acquired. Coalitions of supporters have to be pieced together, and converts won over. The legitimate concerns of beneficiaries and providers have to be addressed, and their unfounded fears have to be dispelled" (Savas 1987, 289). Chapters Four and Five provide a detailed accounting of these complexities that were encountered as the privatization process unfolded.

Whether or not privatization was the correct solution to the problem was the subject of much heated debate. While the administration's goal in privatizing HHC hospitals was to improve the quality of health care services while maintaining full access to indigent care, the privatization option would be vigorously contested. But, as Kingdon would say, the

“policy entrepreneurs” cleverly took advantage of the open window and the power of a new administration to strike while the iron was hot and push forward a contentious, but in their view sorely-needed solution to a long standing problem (1995).

The privatization of New York’s public hospitals also demonstrates that in order to fully understand this particular privatization initiative, or to contemplate others, it is imperative to understand that such policymaking processes involve an understanding of government bureaucracies and the way that services are delivered to citizens. As Salamon describes, there exists “a complex set of relationships between public and private organizations tied together in a variety of financial and legal arrangements to carry out the public’s business” (Salamon 1989, 264). Salamon also maintains that these intricate relationships have had little attention in the literature. This case study will describe and analyze in detail the relationship of the public and private sector as an effort was made to transfer the management of hospital services from the government to the private sector. The study also provides a detailed discussion of the strategy, and the short and long-term consequences of a chosen strategy or at times, lack of strategy, underscoring the importance of strategic thinking in any privatization effort. Thus, this case study adds to the privatization literature in that there is a distinct lack of discussion regarding political assessment, strategy development and strategy implementation in the policymaking process and privatization. Through the use of both Kingdon and Birkland, this case study offers policy makers an approach to assessment and political readiness for privatization as well as an assessment of the political and practical methods for choosing a particular type of privatization. Chapter Six will evaluate the HHC privatization effort and include a discussion of the lessons learned during this policymaking process.

By reviewing the New York City public hospital privatization effort through both the Kingdon and Salamon lenses, one observes a fascinating process. In doing so this study aims to make a serious contribution to the privatization literature as well as the literature on policymaking. Both Kingdon and Birkland call for more empirical research to substantiate their theories. This case study should please them both.

In addition to the policy making process of privatization, a second theme is underscored in this case study. The ability to make change in a highly political environment, in particular, one like New York City where well-entrenched beliefs, systems and bureaucracies have long held sway under a vastly different philosophy than that of a new Mayor, Rudolph Giuliani, is examined. The literature is replete with theories of the difficulty of change in bureaucracies in general (Weber, Crozier, Rockman, Zucker). Sayre and Kaufman, the classic experts on New York City government maintain that most proposals for change in New York City, in particular, prove fatal. They maintain that the "system is more favorable to the defenders of the status quo than to the innovators" (1960, 716), in other words the system is "stalemated". The New York City hospital privatization effort while clearly depicting the difficulties these authors and others describe, is enough to take exception with Sayre and Kaufman's assertion. The HHC privatization effort succeeded through a three and a half-year political and legal process through to a final court challenge that awaits a decision at this writing. Such a high degree of success in the bold effort of privatization, as well as the successfully implemented changes in one of New York City's largest bureaucracies, which occurred largely as a result of the *threat* of privatization, provide a formidable challenge to Sayre and Kaufman's thesis. Those changes in the bureaucracy are also outlined in Chapter Six.

Finally, it is important to acknowledge that the author was a key participant in the privatization process as Mayor Giuliani's Health Policy Advisor and later the Chairperson of the Health and Hospitals Corporation. In conducting the research and evaluating the process, the author made every effort to be objective (see the appendix on methodology). However, as the author was a policy actor so closely aligned with the Giuliani administration, the analyses may reflect unintended biases.

INTRODUCTION AND RESEARCH QUESTIONS

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CHAPTER ONE

PRIVATIZATION LITERATURE REVIEW

Privatization is a concept that conjures up varying thoughts in policy and political circles in the United States. Many today believe it was a concept invented by Ronald Reagan. Others will tell you that it came alive during the “reinventing government” period brought so sharply into focus during the early Clinton years, particularly by the authors of the well-known book, Reinventing Government (Osborne and Gaebler 1993). While there is truth in both notions, the fact is that the basic premise of privatization had long and deep roots in the United States. In reviewing the politics and policy making of a recent and vast privatization effort in New York City, that of its public hospital system, it is instructive to review the history of privatization in this country. First, it is a significant political phenomenon when any political figure is identified so closely with a particular policy as Mayor Rudolph Giuliani has been with privatization. It is tempting for critics and supporters alike to treat the particular policy, identified with a political figure, whether positively or negatively, as if that “policy entrepreneur” invented or at least first attempted to institute that policy.

In understanding the roots of privatization in America's history it helps to distance the personality of the policy maker from the policy. In the case of the New York City hospital privatization effort, it was a policy fraught with extreme views. It is useful to understand the history of privatization in making sense of those opposing views. While in this case, local politics bear much of the responsibility for those highly-variable perspectives, the misconceptions of privatization itself are also significant in analyzing the politics and the policy making.

John Kingdon's theory of policy making and agenda setting provides a useful framework for reviewing the history of privatization and understanding the effects of the events surrounding privatization over time and how they were integral to the New York City hospital privatization effort. Kingdon's theory describes a long period of "softening up" prior to a particular policy's becoming an active agenda item, which is certainly relevant to this case study (Kingdon 1995). While it is Kingdon's theory of agenda setting that is pertinent to this case study, he in fact uses privatization during the Reagan administration as an example in the second edition of his book, Agendas, Alternatives, and Public Policies (1995). He states, "This conservative policy. . . was bubbling along, evolving proposals that could be enacted at the right time, and softening up the system. This process eventuated in concrete proposals that were ready to go" (1995, 211).

The reality is, asserts Kettl, that the American government has steadily been increasing its reliance on private contractors, "a practice which developed far in advance of the rhetoric" (1993, 199). The fact remains that "privatization is as old as government, by definition, but apparently the concept was first proposed as a deliberate public policy to improve government as recently as 1969" (Savas 1987, 291). Savas also maintains that the distinction between the public and the private is elusive (1987, 3), thus making the history of privatization policies that much more significant in analyzing and understanding modern-day efforts to privatize. This notion of softening up is an appropriate place to begin the review of privatization in the United States.

The History of Privatization in America

Kettl affirms that "for more than a century before the privatization movement of the 1980s, state and local governments had contracted with companies to provide a range of services" (1993, 156). Concern, however, over the efficiency and integrity of

government incited progressive reformers to develop formal procedures for government contracts with the aim of decreasing private competition and increasing government power (1993, 156). Salamon posits that the entire debate over the proper role of government in postwar America has completely overlooked the extent to which the key features of "privatization" and decentralization advocated by conservative critics of government are already well-entrenched in American government at all levels (1989, 3). It was the United States' participation in World War II that is in large measure responsible for such practices.

In the period since World War II, governance in the United States has undergone a transformation. Beyond viewing government as a safety net for the disenfranchised and a tool for procuring the most basic services necessary for survival, postwar American society envisioned an expanded new realm for government. The weaponry, materials, resources, and innovations of the war effort, from the marine vessels that landed in Normandy to the atomic bomb, memorably reinforced the notion that collective determination and national mobilization could produce dramatic results. If collective sacrifice and hard work yielded the fruits of victory, so could it disperse the bounties of peacetime.

With new expectations came new demands. No longer was government a setting for ensuring the bare necessities but suddenly it embodied the collective potential of a nation newly awakened to the awesome triumph of collective action. There were new demands for government to help people own homes, go to college, and give their children new opportunities. The GI Bill was most notable among congressional responses to new public expectations.

Given abrupt new expectations, how did government agencies expand to quickly accommodate new demands? Just as the war effort had depended on the private sector to produce materials and weaponry of war, so in the postwar era agencies began to contract with the private sector to produce the services demanded of peacetime. Indeed, the postwar generation had new hopes for the confluence of private industry and public resolve—a hallmark of the success of the war effort. So began a major transformation in federal governance, into what Salamon (1995) calls the “third party government” (p. 6), characterized by

the pervasive sharing of responsibility for the delivery of publicly financed services and the exercise of governmental authority with a host of ‘third parties’—states, cities, counties, commercial banks, industrial corporations, savings and loan associations, and many others (1995, 5).

If government agencies were not equipped to provide the new bounties of peacetime, the private sector could share the work. Under “third party governance”, the United States expanded the tools of governance. Public agencies no longer necessarily delivered tax-subsidized goods and services but worked in partnership with the private sector to ensure that these services were delivered and used. The new tools included loans, loan guarantees, tax subsidies, grants-in-aid, social regulation, purchase-of-service contracts, government corporations, and more. (Salamon 1995, 5). The new tools changed governance in the United States, and the private sector became inextricably entwined with the daily affairs of public business. So dramatic and long-lasting was this transformation that, as Kettl points out, “every major policy initiative since World War II has been a public-private partnership,” including Medicare and Medicaid, environmental cleanup and restoration, antipoverty programs, job training, interstate highways and many more (Kettl 1993, 4).

With the marriage of public and private sector enterprise, the public sector inevitably grew dependent on the private sector--and elements of the private sector have developed a similar dependence on the public sector. This has resulted in dramatic economic and sociological shifts. For instance, Smith and Lipsky estimate that today nonprofit organizations in the United States depend on government for half of their revenues (1993, 4), while at the same time more than half of all government spending on goods and services is publicly financed but privately produced (Handler 1996, 7). Similarly, those same nonprofits have evolved and grown driven by the demands of government contracts. For example, in a statistical analysis of clientele patterns in nonprofit human service agencies "the greater the government support, the more likely an agency is to focus primarily on the poor" (Salamon 1995, 8). Other public policy priorities have been influential and sometimes transformative of the private sector as well, such as the demands of affirmative action on universities and other institutions benefiting from federal subsidies and loans, which had a dramatic influence on access to higher education for minorities and literally changed the composition of some of America's oldest and most influential institutions of research and education. Clearly the interdependence of the private and public sectors pervaded postwar America with deep implications for the nature of government work and the economic and strategic direction of significant segments of the market and nonprofit sectors. The term "privatization" would not be coined for several decades, but the realities of it had begun. The politics of "privatization" would not emerge until the Johnson era.

Despite the interdependence of public and private sectors, or perhaps as a result of it, with the postwar period came an unprecedented expansion in the apparatus of American government--the agencies that ensured delivery of the new services and goods demanded in the new times. Why would government administration explode amid the new reliance on the private sector to conduct the public's business? As Smith and Lipsky

(1993) point out, government contracts with private enterprise have the ironic effect of masking growth in government activities and spending. Contracting with private agencies enables government agencies to increase spending and services without hiring large numbers of new workers and expanding their own facilities (199-204). The involvement of the private sector might well have masked the enormity of the expansion of the realm and role of government activities. The expansion of the public sector may thus have been aided and abetted by the expansion of the role of the private sector in conducting public business.

The notion of involving non-public organizations in the administration of public business accelerated with the "War on Poverty", the name chosen by the administration of Lyndon Johnson to describe a series of federal social services, housing, and welfare initiatives in the late 1960s. The objectives of the War on Poverty were belied by the chosen name of the effort. As Zarefsky (1986) points out,

The metaphor of war profoundly influenced the objectives of the poverty program. It made them vast; nothing less than the complete conquest of the foe would do. It made them national in scope and called for a centralized command (6).

Indeed, in postwar America the metaphor of war would have a powerful resonance for Americans, harkening back to World War II when the country--not only the public sector--mobilized for action under one national central command. Indeed, the notion of involving the citizenry at all levels in the national war effort was a central component of these new policies. "Local community action" was identified as a key not only to the effectiveness of the "war" effort in general but also as a form of therapy for the poor. Their participation in the efforts of instituting the Johnson policies could help lift them out of the doldrums of poverty (Zarefsky 1986; Morris 1980).

With the War on Poverty and the policies that went along with it, millions of dollars flowed from the federal agencies to state and local governments as well as to myriad nonprofit community groups that arose to enlist in the battle. Community groups and citizen participants that worked with the nonprofit anti-poverty groups grew into a Welfare Rights Movement, parallel to the Civil Rights Movement. Thus, by transferring functions from the public to the private sector, the War on Poverty succeeded in generating public involvement and attention to the problem of poverty at all levels of society. But, in fact, Dahl and Lindblom had acknowledged a decade before that the acceleration of the new tools of public action effectively replaced ideological competition as the leverage of the political debate and, therefore, represents "perhaps the greatest political revolution of our times" (1953, 8).

Indeed, the War on Poverty not only transferred and decentralized many of the administrative aspects of government to the private sector, but also succeeded in transferring or, at minimum, sharing--the political agenda-setting function of government. With the Welfare Rights Movement and the burgeoning political presence of nonprofit social service advocacy groups came new notions about what the War on Poverty should accomplish. Far from the Johnson Administration's original goal of moving poor Americans into the middle class, "the goal of community action groups was to confront the existing power structure and force a redistribution of power" (Zaresfsky 1986, 142). The movement that arose from the policies of Johnson's Great Society aimed to create class equality, redistributing wealth from the upper and middle classes and changing society in the process (Riessman 1973, 53-55).

The difference in goals between the community groups and the Johnson Administration was also fueled by the Administration's own growing ambiguity about the purpose of the War on Poverty (Zarefsky, 138). Originally intent on lifting the poor into the middle class,

as the program evolved the results did not reflect this hoped-for shift out of poverty. On the contrary, the numbers in poverty appeared to grow--especially in localities that were particular targets of poverty funds. For example, in New York City, a major target of the War on Poverty and the seat of the Welfare Rights Movement, between 1967 and 1970, the welfare caseload doubled, with spending skyrocketing from \$400 million to \$1 billion (Morris, 70)--plunging the City into a budget crisis.

Administration officials reported satisfaction with the results of the War on Poverty, however, pointing out the number of local programs and the extent of public awareness of the problems of the poor. The means became the ends--poverty programs and public involvement in the problem were measured as achievements. By pointing to the activities of community groups and others as success factors in its social policies, Johnson administration officials inadvertently surrendered to those groups the authority to set the goals for their actions. If the activities of a community group were by definition an achievement, then the goals of that group--different as they might be from the original goals of the War on Poverty--were tacitly approved as well. Eventually President Johnson became frustrated with the political movement he opposed that seemed paradoxically energized and fueled by the vast resources expended on his administrations social policies. Combined with accelerating battles between local and federal officials and community groups and increasingly obvious failures in reducing poverty, the "war" came to a quiet closure in the late 1960s, when the administration withdrew much of its resources from the "campaign".

The Nixon Administration came to office intent on reversing the out-of-control decentralization of the approach of Johnson's Great Society.

Nixon's essential criticism of the New Frontier and Great Society was that there was too much dispersal of responsibility and authority; the public

could not determine who was to be held accountable for different governmental functions (Nathan 1975).

During the Johnson Administration, community groups seemed to set the goals. But Nixon now insisted that federal administrators should evolve and become "politician-managers," professional civil servants who would also have roles in making policy. Nixon's team would now set the goals, administer programs, and be held accountable for results. His administration aimed for a top-down, rigid rule of order and efficiency beginning at the White House (Nathan 1975).

Under the Nixon administration, contracts with private sector agencies and groups would be monitored for compliance with the stated goals. He also called for a "re-privatization" of many human service functions--attempting to energize the private and voluntary sectors to take over, and fund, more social services and care of the needy. For his "re-privatization" efforts, he encouraged charitable and civic groups to assume certain human services functions that were then in the purview of the public sector. Within these programs there would no longer be public involvement; de facto privatization.

While at times the War on Poverty seemed to lose sight of its mission amid mounting opposition from community organizations and local governments, the Nixon Administration encountered opposition from within the public sector--in the civil service. White House officials felt "surrounded" by civil service and unions opposing them (Nathan, 82). With the Watergate scandal, the Nixon Administration's efforts to operate a command-and-control operation to oversee the federal bureaucracy was even less feasible than it might otherwise have been (Schwarz 1983, 117). But the concept of holding service providers accountable for public functions and transferring responsibilities wholesale to the private sector would resurface. Despite the fact that as

a result of the failures of implementation of the Great Society policies and the ensuing debates with local groups and the ensuing decline in federal financial support for such programs, since the late 1970s the management strategy has remained consistent. Thus governmental action is increasingly complex as the public and private sectors have become, subtly, inextricably intertwined (Kettl 1993, 10).

If the postwar period represented Americans' optimism about the many possibilities of government, the 1960s and 1970s brought about widespread disapproval for the possibilities and operations of government. Antigovernment sentiment grew more rapidly than anti-business sentiment during that period (Savas 1987, 8). This antigovernment sentiment was spurred on by the tax revolts of the late 1970s and would spark new demands for privatization (Kettl 1993). Proposition 13 capping property taxes in California in 1978 which cut the tax base of the city of Visalia by 25% is most frequently cited as the catalyst of the privatization wave of the 1980s (Osborne and Gaebler 1992, Kettl 1993 Savas 1987). "Popular distaste for government, though never wholly absent from American politics, reached a level in the 1970's and 1980's that had not been seen for half a century" (Donahue 1989, 3).

Thus, in the 1980s, a new kind of optimism emerged in the belief that the public sector bureaucracy could be vastly reduced and people in their own communities could be counted on to improve the social fabric (Handler 1996, 3). President Ronald W. Reagan, elected in 1980 on a platform that included a pledge to reduce the size of government, suggested that the social scale be tipped away from the public sector. Let society voluntarily take care of itself, without the imposition of government restraints and ambitions (Kettl 1993, 3).

While the new political tenor harkened back to the populism of the War on Poverty--letting people participate in the rebuilding of their communities--in fact the Reagan Administration borrowed from the tactics of the Nixon Administration to pursue its goals. The Reagan Administration's movement was for "privatization"--an ambiguous term with a wide spectrum of definitions. "However varied the meaning of privatization," argues Starr (1988),

It is unambiguously a serious political counter movement against the growth of big government. It should be viewed as a conservative attempt to reconstitute the major institutional domains of society, to roll back state activities in the name of efficiency, effectiveness, and freedom of choice (54).

Like the Nixon Administration, the Reagan Administration aimed to accomplish one significant goal when approaching key government functions: transfer all operations and funding responsibility for certain functions to the private sector completely. Two examples of this asset sale approach to privatization during the Reagan administration were the successful privatization of Conrail and the ultimately unsuccessful attempt to sell the Amtrak train service to a private company. It was this more aggressive approach to privatization that provided the non-conservatives with disdain and distrust of the term and ultimately the policies of privatization. Other efforts of privatization during this period included more of a control over the policy agenda by contracting out the service delivery (i.e., privatize prisons, setting the goals for incarceration but letting the private sector administer the prisons (Salamon 1995, 194)).

Reagan did not endorse Nixon's "top-down", centralized approach to the bureaucracy, however, perhaps attempting to avoid the opposition of the civil service that so plagued the Nixon presidency. Instead, one major strategy pursued by the Reagan and Bush administrations was to reduce the scope of government agencies by decentralizing their authority. One means of decentralization were "block grants"--federal funds allocated to

states to implement identified programs at local discretion. Block grants for health and social services required local decision making about expenditures for services previously in the domain of the federal government. State and local governments as well as private agencies and enterprises abruptly found themselves with increasing responsibilities and opportunities for setting new rules and developing new programs to respond to the needs of their communities. Those local governments once again turned to the private sector for assistance in delivering the goods and services that were needed, contracting with private agencies and enterprises to deliver mandated goods and services (Hirsch 1991).

Another means proponents advocated for reducing government was "privatizing" major segments of government. Though widely touted as a hallmark of the new conservative approach to governance, there was little agreement about the meaning of privatization. Also, proponents often failed to differentiate among the myriad possible definitions.

Theorists studying privatization referred to it variously as a "social movement" (Tarrow 1989), a form of "new populism" (Boggs 1986), and a form of "postmodernism" that is "antibureaucratization" (Handler 1992). Most agree its roots emerged from the Reagan Revolution ideal of modest government, diffused government authority, minimized public reliance on the functions of government, and enhanced individual reliance on the private sector. Handler argues that privatization has two separate and mutually exclusive meanings: "privatization can mean reducing the collective domain, or providing the same level of public services but more efficiently by using the private sector" (1996, 6). Donahue (1989) calls Handler's two alternate meanings "strategic privatization"—the constriction of the public realm, and "tactical privatization"—the maintenance of the public purpose with fewer costs. (p. 136). Savas defines privatization in the more conservative way as "the act of reducing the role of government, or increasing the role of the private

sector, in an activity or in the ownership of assets (1987, 3). He counters the opponents of privatization who view it simplistically and harshly as a means to cut back government with little regard for how the less fortunate can obtain services. Savas further asserts that privatization "can be at least as compassionate as the welfare state; moreover, when applied properly it offers even more for the less fortunate among us" (1987, 3). Yet for the Reagan/Bush administrations, the political impetus for privatization was in large measure built on reversing the postwar expansion of the mission and scope of responsibilities of government. However, the practical reality was that privatization was far more often occurring as a continuation of the postwar phenomenon of entwined contractual relationships between the public and private sectors.

While the Reagan movement for privatization was undoubtedly a conservative campaign, its components were in many respects aligned with the tactics espoused by Democrats who had spearheaded the policies of the Great Society and the War on Poverty. The components were to decentralize control and encourage citizen participation in the functions routinely assigned to government bureaucracies. Instead of defending government agencies, opponents of the conservative privatization movement tended to defend the appropriateness of the mission of government agencies, not so much their success in carrying out that mission. This would clearly be the case in the Giuliani administration's attempt to privatize its public hospitals which is discussed at length in Chapters Four and Five. Opponents concentrated their arguments against privatization on what Handler defined as the "strategic" form of privatization, the constriction of the public realm. In doing so, the opponents failed to address the "tactical" privatization that had arguably been a much more substantial and pervasive part of the fabric of governance since World War II (Gormley, 217).

The Modernization of Privatization

Opponents of privatization generated a new movement commonly called "reinventing government" (Osborne and Gaebler 1993). The reinventing government movement arose at the state and local government levels, where the strategies developed in Osborne and Gaebler's book were widely used among mayors and state agencies. Arkansas' Governor Bill Clinton wrote the introduction to the first edition of the book; subsequently President Clinton's administration brought the principles of "reinventing government" to Washington with an initiative, led by Vice President Al Gore, to transform the federal bureaucracy.

Reinventing government was the neoliberal approach to the neoconservative movement meant to remove government from certain functions (Kettl, 2). If conservative theory characterized privatization as a prized goal--the desired outcome of efforts to reduce the scope of government responsibilities, the "reinventing government" movement saw privatization as one possible means (among others) of better meeting those responsibilities through improved public management. The movement aimed to promote the "entrepreneurial spirit" within government works and give "customers" choice among competing service deliverers (Osborne and Gaebler 1989). Ultimately the "reinventing government" movement was a combination of the Great Society's emphasis on community involvement and the Reagan/Nixon Administration's emphasis on defining objectives and assigning accountability. The major difference between the theoretical underpinnings of the "reinventing government" approach and the Reagan "privatization" approach was the transfer of authority for carrying out functions. In the ideal Reagan privatization, all funding and administration would be transferred to the private sector--which would then have the authority to perform those functions. In the ideal "reinventing government" model, at least some of the funding would come from the public sector and

the private contractor would be accountable for meeting the stated public goals--thus the public sector would retain the ultimate authority.

One year after the publication of Reinventing Government and the inauguration of President Clinton, New York City Mayor Rudolph W. Giuliani assumed office. Like other mayors and state officials at that time, Mayor Giuliani inherited a city in fiscal peril, with some of the nation's highest residential and commercial taxes and a staggering debt load. Despite the taxes and borrowing, city services were widely perceived as inadequate. Schools were deteriorating, with abysmally low test scores and a crumbling infrastructure. The city job base was constricting rapidly, crime was breaking records, and the public hospitals were plagued with scandal with many fighting simply to maintain national accreditation. Despite significant public investment in the health, welfare, and infrastructure of the city, conditions by all objective measures were worsening (see Chapter Three for a full discussion of these issues). Giuliani, like other local officials such as Democratic Mayor Edward Rendell of Philadelphia, was clearly able to take advantage of the long "softening up" period that Kingdon espouses as so essential to bringing policy items to the fore. Ironically, it was the aftermath of much of the Reagan fiscal policies which quadrupled the national debt over a twelve year period (Kingdon 1995) that brought financial crisis to many state and local governments, allowing privatization options to become not only viable, but under the reinventing government guise--popular. Indeed, Osborne and Gaebler, the fathers of "reinventing government", confirm Kingdon's notion not only of "softening up", but that the "national mood" is an imperative in moving a policy item ahead on an agenda. They acknowledge that for some ten years confidence in American government had been dropping. This was the period that allowed privatization to enter the national dialogue. But then, they state "in 1990, the bottom fell out. It was as if all our governments had hit the wall at the same

time. Our states struggled with multibillion-dollar deficits. Our cities laid off thousands of employees. Our federal deficit ballooned toward \$350 billion" (1992, 1)

As the first Republican Mayor of New York City in a generation, Mayor Rudolph W. Giuliani pledged to return the city to fiscal solvency, promising to reduce the tax burden and at the same time improve the efficiency of city government. The new Mayor also promised to privatize some city services, including public hospitals, and improve the management of other agencies to make managers accountable for performance and results. This was a Mayor influenced by the "reinventing government" philosophy of changing the way government does business--promising to restructure bureaucracies to emphasize performance and accountability in the "reinventing government" model espoused by Osborne and Gaebler (1989). Yet this Mayor was also a former Reagan appointee who saw value in privatization as a tool to reduce the size of government by transferring authority for functions to private entities. The Giuliani administration advocated both strategic and tactical privatization.

The Shapes and Forms of Privatization

Privatization, asserts Donahue, "is not only an inelegant term; it is also lamentably imprecise" (1989, 5). Within the categories of strategic and tactical privatization are a variety of definitions and approaches equally complex in their administration and interpretation. Gormley (1994) divides privatization into four types: "contracting out," "vouchers," "asset sales," and "load shedding" (p. 217). The most common in the United States is "contracting out," whereby government contracts with a private enterprise to deliver a particular service or good. Ninety-nine percent of all local governments have contracted out services in the previous five years. Arguably less common is Gormley's second type of privatization, "vouchers". Gormley defines vouchers narrowly, however, to include programs that explicitly refer to themselves as "voucher" programs, such as

school choice vouchers--still controversial and rare--and vouchers for public housing, also an experimental program few jurisdictions have implemented. Considered more broadly, vouchers may be viewed as means for eligible residents to choose the vendor that provides them with government-identified services. For example, Medicaid and Medicare together constitute the largest purchasing agent of health services in the country, with many hospitals relying on government programs for half or more of their revenues. Individuals eligible for either insurance program are usually free to choose their own health providers, frequently selecting among voluntary or for-profit providers--analogous to a voucher program allowing recipients to select among qualified private sector providers of specified services. Food stamps is another program analogous to vouchers, in which recipients are free to spend their benefits on any certified vendor.

Gormley argues that the other two types of privatization he identifies are more notable in Eastern Europe, the former Soviet Union and other burgeoning free markets. They include "asset sales", in which property or holdings of the government are sold, and "load shedding" in which functions of government are sold to the private sector (1994, 4). This is the equivalent of the Reagan/Bush ideal of strategic privatization, the wholesale transfer of responsibilities of government out of the public sector.

American movements toward load shedding or asset transfer have tended to be highly politicized and controversial. A good example of the highly explosive nature of such policies was the movement to defund the National Endowment for the Arts. Conservative proponents argued that government should not be in the business of funding the arts at all--and should transfer the mission of promoting the arts out of government. Slightly more common but still rare in the United States are asset sales, in which property but not necessarily functions are sold to the private sector; Gormley estimates 24% of local government have sold assets in the past (1994, 216).

In many cases, the kind of privatization undertaken by the Reagan Administration, as well as initiatives modeled after the "Reinventing Government" theories, were usually hybrids of one or more of the four Gormley functions. Load-shedding or asset sales were accompanied by requirements analogous to contracting-out, requiring that the property continue to be used or services continue to be provided according to certain criteria. The ultimately unsuccessful attempt to sell Amtrak was an example of such a hybrid: the federal government aimed to sell the railway as an asset sale, while at the same time imposing requirements that rail service continue to be offered to the public on certain terms (Gormley 1994, 215).

Donahue offers a guide for mapping hybrid privatization in his typology for defining an initiative as privatization or not privatization. Donahue weighs two factors: financing and delivery of services. An initiative is defined by whether financing for the initiative is collective or individual, and whether performance is delivered by public or private entities. An initiative financed by individuals and delivered privately is a market transaction, without a public dimension--the unfettered privatized service, the Nixon/Reagan ideal. Alternately, if an initiative is financed collectively, it may be an example of government privatization, perhaps a contracted-out service (Donahue 1989, 40).

To Donahue's typology weighting financing and delivery of services, Gormley added a critical dimension: decision making (1994, 217). By noting the identity of the decision-makers, it is possible to distinguish between types of privatization that are significantly different but would fit in the same categories of the Donahue typology. For example, within the confines of Donahue's typology there is no discernible difference between contracting out a service and distributing vouchers: both theoretically use collective

financing for services performed in the private sector. Yet the differences between them may decide the rationale for initiating privatization in the first place. For example, Patricia Gabow from the Denver Department of Health and Human Services explained the decision to privatize Denver's public hospital:

If people in your community don't like the police force, they don't go use the police in a neighboring community. If we're not operating our hospital well, our patients will go elsewhere (Lemov, 1996, 44).

The public hospital earns most of its public funding from vouchers (Medicaid and other public health reimbursements) while the police force earns public funding from direct tax subsidy--relying on a very different set of decision makers.

The significant distinction between the two types of privatization is accounted for in Gormley's model by examining the decision makers. With contracting out, the decision-maker is the authorized government agency issuing the contract. By contrast, with vouchers the decision maker is the individual recipient of services deemed eligible by the government agency.

The Gormley model is particularly instructive when added to the Donahue typology in understanding the problem of privatizing a New York City public hospital. In the Donahue typology, public hospitals are financed mostly through collective funding (mostly public programs funding health care for the poor) with services delivered in the public sector. Thus public hospitals in the Donahue model would seem to fit the classic paradigm of a public agency: publicly financed services provided on public property by public servants.

In fact, however, examination of the decision-makers reveals a significant difference in the operations of public hospitals. While most of the revenues from New York City's

public hospitals come from public sources, those sources are analogous to “vouchers”, as discussed above: Medicaid and state pool funding for the uninsured. Qualified individual patients select public hospitals, which in turn are reimbursed for services through these public sources. Thus in order to receive their public funding, public hospitals must compete with voluntary hospitals for the same patient base. Examined this way, it is clear that the public hospitals, since the inception of third party reimbursement and Medicaid and Medicare in particular, have not been fully “public”—they have, for more than three decades been subject to the demands of the marketplace as long as the voucher system created by federal reimbursement generated the need for competition among providers.

With changes in the marketplace and Medicaid, the competition for Medicaid patients accelerated in the early 1990's, in many cases leaving public hospitals with a severely declining patient base and fewer revenues (see Chapter Three). The public hospitals were faced with several ideas when viewed in the context of the Donahue/Gormley model: change the financing, change the decision-making, or change the delivery. To change the financing, the hospitals would need to persuade the city or state to grant additional public funds to hospitals to make up for the declining Medicaid revenues. This had been successfully argued in the past, but in an era of fiscal austerity it was politically unpalatable. In addition, why should the city in essence offer more money--and by extension, rewards--for hospitals failing to attract patients or run an efficient business the way most hospitals were now doing? To change the decision making, government authorities could remove it from the patients: instead of “vouchers” through Medicaid, government could simply remove the choice of provider from Medicaid recipients and assign them to the public hospitals. While ensuring a sufficient public funding stream to maintain the hospitals, the approach was politically unpalatable and unattractive to patients, advocates, and voters on both sides of the aisle.

The final option in the Donahue/Gormley model would be to change the delivery of services: thus "privatize" public hospitals. Given that the hospitals already competed in an open, competitive marketplace, the option of delivering those services in the most competitive way possible should have made the most sense.

The element of competition is universally cited in the literature as fundamental to any successful "privatization." So important is competition that the competitiveness of the environment matters more to the success of privatization than whether the deliverer of services is a private or public-sector entity (Kettl 1993, 162). Theorists point out that accountability is enforced economy-wide--in the private as well as public sectors--through competition (Donahue 1989, 45). Without effective competition, contracting-out and other forms of privatization are ineffective (Salamon 1989, 258).

According to the literature, competition is a key component of successful contracting out, one of three main factors most often cited in the literature that determine the success of a tactical privatization initiative. Researchers point out that without competition among vendors delivering a service, it is difficult and sometimes impossible to ensure the quality and cost-effectiveness of the goods and services delivered. Indeed, "the benefits from contracting out occur only with competition" (Handler, 217). Kettl argues that competition is so important to the success of a privatization initiative that the level of competition is more important than whether or not a service is ultimately delivered in the public or private sector (1993, 162).

In the private marketplace, competition has clearly-defined parameters for what constitutes successful performance: companies seek market share, customers, and sales. The parameters for successful performance are much more complex in the public

sector--and identifying those performance parameters is the second key component of successful privatization cited by researchers. When contracting out, for instance, public agencies must define the purpose of the contract and what is expected of the contractor (Hirsch 1991). According to Donahue, ideally the contract is an "output-based transaction," by which the contractor is rewarded for delivering the agreed-upon products or services. However, output-based transactions are rare and difficult, Donahue explains, because frequently government agencies must contract services that depend on variables outside the control of the contractor or the government agency.

Under such circumstance, the prudent [vendor] may decline to enter into a purely output-based contract, or may demand a steep premium for accepting the risk. The principal [i.e. government agency], then, may do better to bear the risk himself, and to offer a contract paying the agent according to the input rather than outputs (Donahue 1989, 41).

Nonetheless, even when a contract cannot specify output-only standards for successful performance, identifying and measuring the output is essential to a successful contract. This, of course, was the key problem with the War on Poverty programs, where the Johnson Administration ultimately abdicated responsibility for defining the goals of poverty fund grants. As the Johnson Administration found, identifying goals for output can be a major challenge for public organizations. For example, it is notoriously difficult to identify an acceptable output for a human services agency (Smith & Lipsky 1993, 194-203). What constitutes an acceptable output for a nonprofit agency that works with troubled youths? It is too simplistic and may be counterproductive to measure output by the number of youths who become "untroubled." Government does not want to discourage agencies from taking on the toughest cases by measuring progress that way. Moreover, few will agree on the definition of an "untroubled youth" to measure performance. Thus human services contracts are often input-based, with measurements of performance of specific tasks related to caring for clientele.

Once performance expectations are established in a contract, successful tactical privatization depends on a third component: a mechanism for holding vendors accountable for meeting those expectations. "Accountability is essential if contracting is utilized. Yet accountability continues to be the Achilles Heel of many contracts" (Gormley 1994, 224). Accountability is not only defining when a service fails to meet performance standards, but also ensuring that there is appropriate consequence to inadequate performance--and incentives for superior performance. Gormley cites two conditions that help promote accountability: freedom of the contracting government agency to intervene when problems arise, and competition among vendors. Researchers point out that these factors are frequently not available. Often government contracts are lengthy projects not readily or efficiently interrupted. And frequently few vendors are available to deliver a service, particularly a service requiring a large delivery infrastructure (Kettl 1993, 180-189).

Ironically, the three components of successful (tactical) privatization most frequently cited in the literature--competition, defined performance standards, and accountability--do not require private sector involvement. In theory, at least, public agencies could compete for contracts and meet established accountability standards without involving the private sector--thus completing a successful privatization entirely within the public sector. Gormley refers to this as "contracting in"--a process by which public agencies bid for government contracts on a level playing field with outside private sector enterprises (1994, 223). Osborne and Gaebler cite myriad examples of "contracting in" involving public sector employees competing for defined contracts, accountable for outcomes (1989). This is in essence similar to the goals of the Nixon Administration--to hold the Civil Service accountable and eliminate departments that were not (Nathan 1975).

As Nixon discovered, this model can be problematic because of the nature of bureaucracy. While there are some examples of government agencies performing public works within the same framework as a private sector contract, the inherent nature of a public sector agency may prevent widespread adoption of the "contracting in" model. For instance, whereas contractors must account for results, researchers studying government bureaucracies have argued that public sector organizations value the means over the ends. Merton identifies this as part of the "bureaucratic personality," in which, "operators tend to value means over ends: that is, they worry more about following the right rule than about achieving the ultimate goal" (Merton 1940, 566).

Management expert Drucker (1995) decries the bureaucratic personality, arguing that the means-versus-ends orientation of government bureaucracy is exactly the problem that needs reforming. He argues that federal agencies should define results, performance, quality, and costs. Agencies should be reinvented through a process of "rethinking," involving three steps: define their mission, decide if that mission is worth doing, and for every task, ask "if we were not already doing this, would we now go into it" (Drucker 1995, 54)? Drucker concludes that a process of rethinking would identify many functions in federal government appropriately eliminated or turned over to the private sector, such as the administration of Veteran's Hospitals.

Wilson (1989) argues that the nature of government bureaucracy and the American political system makes solutions like Drucker's—which hold so much logic when applied to a profitable market enterprise—impossible or counterproductive in the public sector. First, Wilson contends that agencies can rarely identify or define their mission. Moreover the exercise of doing so is rarely fruitful or productive to the products produced by that same agency. Citing public organizations that achieved dramatic results,

including the German army *Blitzkrieg* during World War II, Wilson points out that the key to success in each case was the agency's ability to manage its "critical tasks:"

Notice I have referred to tasks, not goals. It is often the case that many analysts and executives who wish to improve an organization begin by trying to clarify its goals. Sometimes, this is useful. But government agencies, much more than business firms, are likely to have general, vague, or inconsistent goals about which clarity and agreement can only occasionally be obtained (Wilson 1989, 25).

For example, citing the successful reform of a high school, Wilson notes that the effort began with a series of agreed-upon actions--not a process of clarifying the mission and agreeing on what the goal of educating children must mean. Wilson argues the process of achieving consensus on the mission would result in arguments, disagreements, reports, studies, and little effective action. Moreover, Wilson points out, the definition of mission is normally not at the discretion of the agency, but instead elected officials who authorize the agency and assign its political mandates. Nor do agencies have unlimited authority to define the priorities of their work, which are also determined by political mandates. "The tasks of a government agency are more likely than those of a firm to be defined by factors other than the preferences of the executive" (p. 32).

Perhaps the most significant constraint of government agencies is the necessity of negotiating with political stakeholders. Wilson points out that whereas a private corporate CEO might meet with the Board of Directors six times a year, the head of the FBI meets with committees of Congress eighteen times a year, often with acrimonious sessions. The FBI cannot borrow money, and must rely on annual appropriations from Congress. Agency performance is measured and rewarded based on numerous, often contradictory factors more than likely related to the interests of the electorate than the precise level of quality and efficiency the agency brings to its tasks (p. 32).

Nor can agencies wield the carrots and sticks that private sector managers use to reward good work and punish poor performance. Agencies cannot retain their earnings for the private benefit of their members or employees; they cannot allocate goods and services to the preference of their managers; and, they must serve goals developed externally. Not surprisingly, agencies tend to be driven by the demands of external entities and focused on avoiding constraints imposed by those same entities. Wilson argues, then, that to improve the efficiency of a government agency, "one must decide which constraints one is willing to sacrifice" (p. 331). That is a decision made at the discretion of the electorate, rarely by the public manager.

Thus the operations of a government agency as portrayed by Wilson are at odds with the model for management of a successful tactical privatization. Whereas successful privatization depends on defining a mission, agencies cannot typically define their mission. Whereas privatization appears most promising when performance standards are clearly defined, agencies function in response to performance standards that are often contradictory and subject to the whims of the political process. Inasmuch as privatization depends on accountability through enforcement of performance standards, government agencies and the people who work for them are not directly impacted by the nature of their actions, whether their performance is exemplary or not. Indeed, in a Brookings Institute study on improving government agencies, Dilulio and colleagues recommend precisely the steps necessary for a successful privatization: strengthen performance measures through budgeting and management reforms, strengthen systems to improve accountability, and deregulate the civil service to encourage a focus on achieving agency mission (1993).

If public agencies by their very structure are ill adapted to the model for successful privatization, so would they appear ill adapted to carrying out missions accountable to

the public for their efficiency and quality. This in turn argues for the continued advocacy of further tactical privatization as a means of improving the performance of public agencies. Indeed, one leading proponent of privatization argues that nearly every public agency's function should be privatized, with the sphere of public sector activity reduced to "... making decisions and raising money" (Savas 1987, 58). In theory, the discipline of contracting out could help government achieve Drucker's vision to more rationally order government priorities and define core missions. In fact Savas asserts that "privatization can produce large and long-lasting improvements because it involves institutional change rather than spasmodic exhortation. Indeed, privatization is a strategic approach that causes government agencies to adopt the well-known, good management techniques because it poses a competitive threat" (1987, 289).

Presumably, in order to develop contracts for outsourcing nearly every service provided by government, politicians would be forced to define their goals, set performance standards, and enforce accountability for results. Alternatively, politicians would fail to agree on goals, and thus either generate failed privatization agreements or create constrained, politically motivated bureaucracies in the private sector rivaling public sector counterparts. Indeed, Handler notes that many nonprofits contracting with government agencies "become bureaucratized and increasingly resemble public agencies" (1996, 12). Alternatively, contracting agencies could become like many of the community organizations in the War on Poverty: working at cross-purposes or in opposition to the goals of politicians who provided the funding for them. Thus bureaucracies and their problems with performance are not the exclusive domain of the public sector but the result of the constraints imposed by government on any agent--public or private--acting in the public interest. The framework of successful privatization, competition, accountability, and performance standards--is essential regardless of

whether the privatization involves public or private entities, although the nature of public bureaucracy makes it more difficult for public sector agencies to participate effectively.

Moreover, whether a private or public organization is charged with performing a given function, and even if that function is well-defined--as discussed not easy to achieve--the problem of evaluating that performance remains. Yet effective evaluation and its consequences--rewards or punishments--is essential to ensuring accountability for standards. Without accountability, the model is no different from the traditional mode of carrying out government functions. Yet as Browne and Wildavsky (1983) point out, the process of evaluation is often riddled with challenges and inconsistencies, with evaluators coping with shifting program goals. There can be a blurring of the distinction between carrying out a policy and evaluating it--which tends to blur the distinction between "means" and "ends", the key problem with bureaucracies (Browne and Wildavsky 1983, 187). The process of defining and evaluating outcomes has become an increasingly important challenge in the "reinventing government" era.

Most researchers concur that stakeholder influence in the political process imposes serious constraints on the efficient conduct of public business and can make the performance and accountability goals of privatization more difficult, if not impossible, to achieve. Stakeholders can include interest groups, unions, as well as elected officials charged with overseeing the conduct of agencies (Handler 1996, Starr 1988, Donahue 1989, Gormley 1994). Stakeholders can impose rules on agencies that impede efficiency and distort clarity of the agency's mission. At the same time, stakeholders can invoke "overcome the imprecision and unfairness of majority rule (Donahue 1989, 29) and provide crucial information and expertise to agencies. The influence of stakeholders can confound agency operations, creating contradictory missions and

aims. For instance, in regulatory agencies lobbyists for the regulated industries may work with politicians to influence and shape agency policies (Handler 1996, 199-116).

Privatization through contracting-out or vouchers does not eliminate stakeholder influence; on the contrary, contractors frequently lobby legislators and have influence over the policies that govern their contractual relationship with agencies. This influence is particularly notable in areas where there are few private sector entities competing for government contracts:

Nonprofit organizations, it turns out, bring their own resources to the bargaining table with the state, not the least of which is the fact that they are often the only mechanism available to deliver the services that government agencies have been authorized to provide but for which they lack the experience and staff (Salamon 1995, 8).

Those same organizations can have considerable political clout as well. Stakeholders vary among agencies, depending on the issues taken up by the agency and the extent to which their functions are politically sensitive. But one stakeholder is always at the center of any privatization arrangement, no matter what public agency pursues it: unions and other organizations representing public employees. Public employees bear the brunt of changes invoked by privatization of any kind, whether their job descriptions are altered or their jobs eliminated altogether. Not surprisingly, unions have tended to resist privatization in all its forms.

The problem of union resistance can be severe enough to derail any privatization initiative, no matter how logical or politically attractive it may appear. Indeed, union opposition is probably the most important reason why so few “asset transfer” privatizations have occurred in the United States—in spite of the advocacy of popular

presidents and support of public opinion. In Argentina, because of union opposition to the privatization of the telephone system, government officials took steps to curb civil unrest (Campo-Flores 1994, 236). While public opinion appeared to support the privatization of the notoriously inefficient and mismanaged telephone system, the union representing telephone employees lobbied aggressively to stop the process and nearly succeeded.

Ultimately, the final agreement with the unions that enabled the privatization transfer involved major concessions to the unions, including raises for nearly all employees, stock offerings, an improved retirement plan, productivity bonuses, and expanded fringe benefits, including vacation leave, day care centers, and sports facilities (Campo-Flores 1994, 242). In the United States, successfully completing privatization often requires unusual concessions to public employees. For example, in order to complete the highly touted model privatization of a public hospital in Navarro County, Texas, all employees were maintained on the payroll with full pay and benefits (Fitzgerald 1988, 134).

However, increasing or even maintaining expenditures on employees is rare in privatization initiatives. Indeed, savings in public expenditures that result from private contracts are frequently achieved through reductions in labor expense. "Delegating certain functions to private firms usually saves tax dollars, and much of those savings comes at the expense of public employees," explains Donahue, "The losses to labor present a real problem that is too often ignored or submerged in rhetoric" (1989, 145-146).

In addition to salary and benefits reductions, unions often resist changes to work rules and job descriptions. Given the nature of bureaucracies described by Wilson, in which tasks may be well-defined but missions and performance standards are not necessarily

so identifiable, public employees have special concerns about the scope and range of tasks they are assigned to do. Since it is rarely clear what employees in an agency must ultimately accomplish--since missions are not always clear--tasks take on an added importance.

In addition, the emphasis on fairness and non-discrimination expected of publicly funded agencies translates to the hiring process as well. Agencies must have the ability to demonstrate that hiring is based on standard, fair criteria, and that wages are determined by objectively defined skill, education and experience levels. These requirements create civil service job classifications in which job descriptions, required skill levels, and hiring criteria are banded together for a set of employees allowing for minimal flexibility for managers to restructure their departments when and if missions or administrative requirements change. Numerous attempts have been made to reform the civil service, introducing more role flexibility and performance standards, but changes have been incremental at best (Volcker 1989; Kettl et al. 1996).

In all cases of privatization, it is clear that the impact on public employees is significant. Indeed, the fact that privatization requires an emphasis on outcomes and performance not normally present in civil service suggests that personnel changes--of work rules, salaries, and/or individuals themselves--are central to the effectiveness of privatization. By the same token, unions and other representatives of public employees have been central to the political resistance to attempts to privatize among other governmental reforms (Boggs 1986; Tarrow 1989).

Given the constraints of public agencies and the inflexibility and intransigence of civil service rules, the advantages of privatization emerge as particularly attractive. Privatization can escape the constraints imposed by civil service and in some cases

remove a function from the constraints of the political oversight. Conducted appropriately, in a competitive environment with clear performance and accountability standards, privatization can afford the opportunity to deliver services more efficiently with even greater accountability to the public for quality and cost-effectiveness. Reviews of studies of privatized services have suggested that privatization can greatly enhance efficiency (i.e., Dor 1994) and reduce public expenditures by as much as 50% while improving quality (Donahue 1989, 140).

On the other hand, privatization presents perils. Conducted inappropriately, privatization can actually reduce efficiency, create private-sector bureaucracies every bit as problematic as public-sector bureaucracies, obscure large increases in public spending and breed inappropriate influence by private sector stakeholders—especially if one private firm has no competitors for key contracts. In addition, the impact on public employees cannot be underestimated as a sideline issue in privatization.

Privatization of Health Care

“Among the most important applications of private means to public ends (and very likely the most complex) is health care, where public financing and private delivery has become the norm. Recent trends in American health care policy can be seen as efforts to refine the terms of the contract between the government and the physicians and the hospitals (most of which are private, and many of which are profit-seeking) that actually deliver care” (Donahue 1989, 220). Donahue is referring to the changes in the American health care system, which have been occurring for more than a decade, and are still advancing today under the aegis of managed care. The discussion of the changing health care environment and its effect on New York City's hospital privatization effort will be discussed at length in Chapter Three. There is little doubt that the rapidly changing

competitive health care environment had a significant impact on the "idea" of privatization rising to the top of the agenda. The increasingly competitive nature of the field created interested and eager participants out of New York City's medical school deans and hospital presidents, whereas at any other time in history, privatization would have been seen as a threat.

Donahue points to an overall conundrum as it relates to the privatization of health care services in the United States in general, and specifically the privatization of government run hospitals. The fact that so much of health care is already "privatized" is not often acknowledged in the privatization of public hospitals. This would surely be the case in the New York City effort.

The United States has always supported an infrastructure of "safety net" providers that rely on public funds to care for the indigent (for example, Musser 1996). Often a government entity owns the facility or provides primary support. Hospitals and other health facilities with a primary mission of serving the poor are typically run through one of five administrative structures. Facilities may be direct government-administrated agencies, such as a hospital run by a local health department. Other safety net providers may be run through a public commission set up to administer the facility, a hospital authority or hospital district that is usually somewhat autonomous from the local government and able to issue its own bonds—yet still subject to open meetings and other requirements of publicly-financed institutions (Marmor, et al.1987). The New York City Health and Hospitals Corporation (HHC) is one of two public benefit corporations in the nation set up to administer public facilities. Like hospital authorities and districts, the corporation structure allows the issuance of separate bonds and permits some limited

level of autonomy from local government (National Association of Public Hospitals 1996).

A number of safety net facilities have changed governance in recent years, either through conversion to nonprofit status, sale, lease, or contract of the facility, or in a very few cases such as Philadelphia General Hospital, outright closure (National Association of Public Hospitals 1996). In most cases the transfer of key administrative or management functions to the private sector has been necessitated by financial considerations. According to a study by the Agency for Health Care Policy and Research, hospitals nationally choose to contract part or all of their management to external private sector entities only when faced with financial difficulties (Dor 1994). The study found that in 1994, 12.4% of all hospitals were managed by contract with a private group, an increase from 10.4% of all hospitals two years earlier. This included 312 public hospitals. According to the researchers, "the prime motivation appears to be to improve financial performance" (Dor 1994, 5).

Studies have found that contract-managed hospitals had an improved financial performance, higher revenues, higher occupancy rates, and lower labor costs (Shortell, et al. 1986). One study found a 17% lower average adjusted cost per discharge(a key hospital financial performance indicator) among not-for profits compared with publicly managed hospitals (Renn, et al. 1985). The cost effectiveness of the not-for-profit or contract management has been attributed to a variety of factors, including access to capital, as well as exemption from public laws such as open meeting laws that constrain management's flexibility to implement competitive programs. In addition, public managers rarely can finance debt or major capital purchases without public approvals, and their budgets are often subject to approval by external publics (Shortell et al. 1986).

Two privatizations have been reported as most successful, in terms of reducing expenses and improving quality of care. One was the Detroit Receiving Hospital, Detroit's only public hospital, which was leased in 1980 to the nonprofit Detroit Medical Center. The Detroit Medical Center pays the city \$1 million per year toward debt service on the facility, and the city in turn funds indigent care at a varying rate each year. The Mayor maintains some control with three Board appointees on a 10-member board. When the lease started, the hospital was deeply in the red with threatened bankruptcy or increased tax levy required to continue its operations. Since the lease transfer, the hospital has turned a profit every year, mostly by reducing labor costs and vastly improving efficiencies (Dor 1994).

The other key successful transfer was Louisville University Hospital, leased to the for-profit chain of Humana Hospitals in 1982. The hospital had been regarded as a place of last resort, with rampant complaints about quality of clinical care. At the same time, costs were rising steeply. After the transfer to Humana, the hospital finished every year in the black and complaints about quality were almost eliminated. The hospital pays 20% of pre-tax profits to the local authority, and receives reimbursements for indigent care from the City, County, and State (National Association of Public Hospitals 1996).

Other nonprofit conversions have been equally successful, such as Truman Medical Center in Kansas City, MO and Jackson County, MO, the Memphis Regional Medical Center, TN, and Bernadillo County Medical Center in Albuquerque, NM. In those cases, local governments retained a presence on the Board of Directors and imposed some minimal requirements typical of public sector entities, including open meetings requirements in Memphis and annual budget appropriations for indigent care in Missouri

and New Mexico. However, the transfer greatly enhanced management's flexibility to design programs and authorize expenditures within facilities--accounting for some new efficiencies (Dor, A. 1994; Marmor et al. 1987; Renn et al. 1985).

Management flexibility has been key to the success of Wishard Memorial Hospital. Indianapolis retains ownership of Wishard, but contracts all administration and medical services to Indiana University, which has substantial flexibility to run the hospital without public intervention. Property tax subsidizes indigent care. This has resulted in some administrative savings as well as a reputation for innovation. For example, Wishard has been noted nationally for innovative approaches to indigent care, including a provider-sponsored managed care program for uninsured patients (O'Brien & Mechanic 1998).

Other key privatizations included Rome Hospital, in Rome, New York; Bridgeport Hospital in California, Ashland Regional Medical Center in Pennsylvania, Miners Memorial Medical Center in Coaldale, Pennsylvania, Roseville Hospital, in California, and Mainland Country Hospital in Texas. One of the most widely publicized hospital privatizations occurred in Boston, when Boston City Hospital merged with Boston University Medical Center in 1996. According to a Mayoral Blue Ribbon Panel in 1994, the Boston City Hospital was extremely inefficient and in danger of collapse. Privatization was resisted by the politically powerful union representing most of the workers and nursing staff, American Federation of State County and Municipal Employees (AFSCME). Considerable concessions were made to the unions, preserving pensions and other benefits, and ultimately a merger took place, though it was a politically difficult process and has just gone into effect and long term success is difficult to ascertain (Boston City Hospital 1995).

Hospital privatizations differ in size, shape, and scope, but all share four qualities common to privatizations in general. First, they are prompted by financial difficulties at the hospital. This research has not encountered a privatization that occurred when a hospital was doing well. Second, the public sector retained some governance authority, usually justified by the continuation of government subsidies for indigent care. Third, all of the facilities were expected to continue to provide indigent care and serve as a community safety net. In other words, privatization was a tool to better achieve the main objective of government--to improve the provision of safety net health care services. In no cases were privatizations used to eliminate or even reduce services. Finally, most privatization efforts encountered opposition from unions within the hospital. In almost all cases, unions were the primary or driving force opposing privatization.

There is surprisingly little detail available in the privatization literature about the processes of privatizing or converting the structure of these institutions. Much of the information comes from health care news journals and individual interviews over the past several years. What becomes glaringly apparent in observing these hospital privatizations is that none come close to the scope or magnitude of the New York City hospital privatization effort. During that privatization effort key policy entrepreneurs involved in the process traced the other privatization efforts and found that many were moving public hospitals toward the model of a public benefit corporation as HHC had done some thirty years earlier. The second biggest difference is that most cities had only one, if any, public hospital without the large and unwieldy bureaucracy that is HHC. Finally, local politics, while present in most privatizations are minimal when compared to the politics of New York City's health care delivery system, particularly the public system.

From the perspective of the politics of policy making, the literature on privatization is disappointing. The privatization literature, in summary, focuses primarily on four main areas.

1. The history and evolution of privatization. As indicated above, there is a long history of the private sector assuming an increasing role in areas that had been considered the purview of the government. This was the case long before the classification of the term "privatization".
2. The typology of privatization. That is the defining and debating of the actual meaning of the term itself. Because the role of the private sector has, ironically, become such an inherent part of the government's ability to do business, there is great variation in the meaning and the interpretation of the term privatization.
3. The mechanics of each type of privatization. This area includes the various methods of privatization such as contracting out, asset sales, vouchers and load shedding to use Gormley's (1994) typology for one, but the various experts then describe the different ways that these privatization efforts can be carried out and the mechanics for doing so.
4. Evaluating the outcome of completed privatization efforts. Various researchers such as Savas and Stephens, in particular, evaluate primarily the cost-effectiveness of various privatization initiatives. While there is attention paid in the literature to the importance of accountability, cost-benefit analyses are the primary focus of most researchers. Included in this area are case studies of two types: 1.) longer detailed case studies that involve "full asset sales" primarily of Eastern Europe, Britain and the former Soviet Union. These were not addressed in this literature review, as they were not relevant to this study. 2.) U.S. "local level" privatizations, which are limited primarily to less complicated privatization efforts of simpler services than hospital privatization discussed here such as sanitation, park maintenance, employment and

training. The literature is lacking any in-depth discussion of hospital privatizations. The focus of hospital privatization, to the extent it exists in the literature, is primarily related to the contracting out of a particular service within a hospital. This gap in the literature is significant in looking at a privatization of this nature because of the uniquely complex and changing nature of health care delivery as well as the complicated role that government plays in the delivery of health services and the federal, state and local financing roles in hospitals in particular.

There is a distinct lack of discussion in the literature about three key areas involving the policymaking process and privatization. Those three areas are:

1. Political Assessment: First and foremost there is little attention paid to the importance of, or how to assess the political environment and the readiness for privatization, which is a key determinant for a successful privatization. Using the Kingdon model of policymaking, there is no discussion of appraising whether or not the right degree of "softening up" has taken place.
2. Strategy Development: There is no discussion of developing a strategy for choosing the appropriate type of privatization, particularly as it relates to the political environment (i.e. the environment might be more ready for a more aggressive type of privatization, or a more modest approach might be better depending on the political environment).
3. Strategy Implementation: Implementing a chosen strategy for carrying out privatization and the need for ongoing assessment of that strategy is critical, particularly in a complex privatization initiative such as that of the New York City hospital privatization discussed here and in any case is likely to be a highly political environment.

This case study will provide the most detailed analyses of any health care privatization, and likely any privatization in this country of such a complex nature. It will focus on the areas of strategy assessment, implementation and development and thus will greatly enhance future policymakers in their efforts to privatize. Finally, it offers a unique and unparalleled view of the Giuliani administration's intent to, and process of, privatization. Understanding the relationship of the history and politics of privatization as detailed above is essential to this study and considering it in the context of the Kingdon theory of policymaking. Equally, if not more fundamental is understanding the history and the politics of the public hospital system in New York City.

CHAPTER ONE

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CHAPTER TWO

A HISTORY OF THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

"The further backward we look, the further forward we can see"
Winston Churchill

This chapter examines the history of public hospitals in New York City and how those hospitals, founded as almshouses for the poor over a century ago, developed into the multibillion-dollar Health and Hospitals Corporation (HHC) that we know today. The focus of this historical account is on the problems that repeatedly plagued the public hospital system over its long history and how successive mayors tried, mostly in vain, to solve those problems. A detailed chronicle of the myriad commissions that studied the problems of the public hospitals is provided. Despite repeated recommendations of virtually the same nature that were made to solve the many and consistent problems the large hospital system faced, the public hospitals were impervious to permanent change. Perhaps Daniel Fox is correct in his surmise that "few of the instances when public health politics intersected with general politics have resulted in lasting changes in policy or institutional arrangements. Even public health crises have not precipitated institutional change as they did in the nineteenth century" (Fox, in Rosner 1995, 203). This notion was supportive of the earlier finding of Eli Ginzberg who, in summarizing the results of his study of health care in New York City in the early 1970s, found that "while changes have occurred in response to emergencies, opportunities, and alternatives in the marketplace, the outstanding finding is the inertia of the system as a whole" (in Alford 1975, xi).

The well documented historical problems, culminating in the severe problems that HHC faced during the Mayoral administration of David Dinkins, and the truly “focusing events” that took place during the end of the Dinkins administration, allowed Mayor Rudolph Giuliani to call for sweeping new changes in the system—most notably privatization. It was the quintessential “problem stream” that Kingdon refers to.

The History of Public Health in New York City

The City of New York has a long and rich history of providing health care services for its poorest and neediest citizens, and fighting the diseases that affect them. Dating back to the establishment of the nation's first Board of Health in 1866, New York's fight against disease set an example for the rest of the nation. The City's public health system was, according to some, at its pinnacle in the period between the 1880s and World War I when times were dominated by the “innovative policies of Herman M. Biggs and his colleagues” (Fox 1995, 197). The City's public health mandate has always gone beyond that which is typically seen as the mandate of the Department of Health and has included “therapeutic” services for the poor and medically indigent (ibid., 198). The most pressing health care problems of the Nineteenth Century were of a public health nature, primarily unsanitary living conditions and disease spread through unclean drinking water. It was the poor that suffered these diseases in greatest numbers because of their living conditions. Finding cures to their ills in those times superseded the issue of health care service. Hospitals as we know them today were non-existent.

Later in the century, New York City's Board of Health was at the forefront of caring for the poor as well as fighting disease. It drew national attention by focusing on the regulation of the water supply, resulting in a decrease in many diseases but most notably a decline in infant mortality and morbidity. The Board also established sanitation

and quarantine laws earlier than any other city, even before the germ theory was broadly accepted. Moreover, New York became the first municipality to provide health care services to the poor. Infirmaries were set up in the tenements of New York, serving as the City's first hospitals. At that time, it was primarily the poor that were cared for in hospitals. The more affluent were cared for at home (Duffy 1991).

By the beginning of the Twentieth century, the predominance of fatal diseases shifted from infectious to chronic diseases. Therefore, health care services became a significant component of the health care agenda. Once again, New York City was among the first American cities to take control over the quality of care through the creation of its public hospitals. Moreover, as Fox points out, "the politics of accretion has led to an impressive record of innovations in the enterprise of public health in New York City. Most of these innovations have taken the form of new service or outreach to new populations" (1995, 204-205). Further, he cites a number of key examples including neighborhood clinics and integrated service centers (late 1920s on), public health nurses assigned to domestic relations courts (1929) and maternity and infant care.

In 1929, the City charter gave jurisdiction for its twenty-six public hospitals to the newly formed Department of Hospitals (Duffy 1991). Thus, health care was no longer viewed as a provision of welfare, but a distinct service. Moreover, the provision of the service alone was no longer sufficient. The quality of those services became consequential. Despite the very strong commitment of the City government to take care of its poor, from its earliest days, the Department of Hospitals drew frequent and strong criticism for the poor quality of care and often "deplorable" conditions of its public hospitals (Piel Commission Report 1969, Barrondess Commission Report 1993).

The NYC Department of Hospitals

From the time of Fiorello La Guardia in the 1940s, reform became a common theme of the public hospital system. As Mayor, La Guardia brought civil service into the hospitals to reduce political patronage, and with the creation of the Bureau of the Budget, instituted close monitoring of the hospitals' budgets (Brecher and Horton, 1993). During that time, there were already accusations of corruption and the view that there was a need to professionalize the staff. Again, a decade later, under the Administration of Mayor Robert Wagner there were calls for major reform. The Department of Hospitals had come to be seen as overly bureaucratic and inefficient, and the hospitals were staffed primarily with foreign-trained physicians. The controls that La Guardia put into place to prevent corruption left a system that was inflexible and difficult to manage. In 1959, Mayor Wagner appointed a blue-ribbon Commission at the same time as an independent effort under the sponsorship of the Hospital Council of Greater New York undertook a similar, critical review of the municipal hospital system (Brecher 1993, 331). Both groups found problems with hospital staff and recommended closer relationships with medical schools and voluntary hospitals to bring higher quality medical staff to the system.

Consequently, Mayor Wagner appointed a new Commissioner of the Department of Hospitals and mandated him to develop affiliation relationships with the academic health care institutions in the City in order to improve the poor quality of medical care in the public hospitals. The new Commissioner successfully carried out his mandate, and the quality of care appeared to improve at the municipal hospitals.

However, only six years after the Wagner Commission made its findings on the public hospital system, John V. Lindsay, a reform candidate, was elected Mayor in 1965. Lindsay had promised to address the myriad problems plaguing the municipal system. Despite the reforms of the Wagner Administration, the Department was still seen as providing inferior care in less than adequate conditions and these problems often displayed themselves in the press and other public venues, proving to be an embarrassment and political time bomb for any sitting Mayor. At the time Lindsay took office, there were eighteen municipal hospitals totaling sixteen thousand hospital beds. The average daily census was only about 13,000 for a yearly total of about 5,000 days. There were 2,846,000 visits to outpatient departments and another 1,381,000 emergency room visits totaling four and a half million outpatient visits. There were also over one million home care visits made (Manning 1969, 1-2). While the Department of Hospitals' budget was about \$400 million, the City's expenditure for health care services amounted to about one-sixth of the total City budget (exceeded only by education and welfare). Included in this equation was about \$100,000,000 in services bought from the City's voluntary hospitals through its affiliation contracts (Leiman 1969, 3).

By 1966, because of the high degree of press attention, six different investigations into the operations of the Department of Hospitals were conducted by various levels of state and city government. These investigations were conducted by:

- The Governor's Blue Ribbon Panel
- The Joint Legislative Committee on the Public Health
- The Department of Investigation of the City of New York
- The New York State Investigation Commission
- The New York City Comptroller's office

- The Mayor's Commission on the Delivery of Personal Health Services (Piel Commission) (Manning 1969, 5)

Mayor Lindsay announced the appointment of the Commission on the Delivery of Personal Health Services on December 22, 1966. The Mayor's charge to the commission, dubbed the Piel Commission after its chairman, Gerard Piel, was:

. . . to make a thorough inquiry into the institutional, administrative and fiscal aspects of the system through which public funds now deliver personal health services to one-third of the people of New York City. The inquiry shall consider the services rendered directly by public agencies, the services delivered through voluntary and private institutions, and it shall review the existing modes of delivery in the light of opportunities presented by new sources of public funds and by innovations in medical and management technology. The Commission should set as its objective the optimum employment of the magnificent resources available in the medical economy of the City for the delivery of personal health services to all the people of the City. It shall recommend to the Mayor specific institutional, administrative and fiscal measures for implementation by the Health Services Administration (Piel 1967, 9-10).

The Piel Commission undertook its work at a significant time in the history of health care in America. It was during the days of Lyndon Johnson's Great Society. The Congress had just passed the Medicare and Medicaid laws. For the first time in the nation's history, there would be government health insurance for a significant portion of its citizens. Heretofore it was only through employer coverage or unemployment insurance that Americans received health care insurance (Marmor, 1973). Now, Medicare would pay for health care services for the elderly, and Medicaid, along with a commitment from the states to pay a percentage of the bill, would pay for some health care services for the poor. This was a significant step forward, particularly for the elderly. Medicare, a totally federally funded program with uniform national standards, did not suffer the stigma of Medicaid. While the purpose of Medicaid was to move care for the poor into the

mainstream of the American health care system, neither the states nor the federal government were willing to commit the resources to make that happen (Starr 1982).

The Piel Commission had to consider the context of the times in which it was working. For the first time there would be a major influx of government resources into all hospitals in New York City, not just the public hospitals. This meant that the entire health care system in New York City warranted review. Fragmentation and discrimination as well as inefficiencies for all government levels were in order. A critical question needed thorough investigation: Was there a need to segregate the poor into a second class hospital system if the federal and state governments were providing health insurance for a large percentage of patients that relied on the public system?

Prior to the enactment of Medicaid and Medicare, the City of New York had funded the public hospitals to care for the poor. A laudable effort by New Yorkers, however, left a health care system chronically under funded and hospital buildings in a constant state of disrepair. Moreover, because of the system's inability to vie successfully with other government agencies for limited resources, any economic downturn would leave the hospitals in even worse shape. The emerging reports over the years and the innumerable press accounts left little doubt that the public hospitals were inferior to the voluntary hospitals. It seemed imperative to view the new resources as a way to join the two components of the system--public and private.

The Piel Commission released its report, citing an array of managerial, political, financial and quality problems. In addition to finding hospital conditions "deplorable," the Piel Commission concluded that under the existing arrangement, "the City's hospitals [are] irreparable" (Piel 1967, 10). The Commission also found the following:

- ❑ Ambulatory care services, available principally in outpatient departments and emergency rooms of hospitals, are grossly inadequate.
- ❑ Facilities and services available for ambulatory care of the mentally ill have not met the newly recognized need and opportunity to provide therapy for such illnesses in the supportive setting of the community.
- ❑ The affiliation contracts, that have brought some measure of qualified professional service into the City Hospitals, place them under divided management.
- ❑ The procedures set up to secure the desirable and necessary end of public accountability thus function to stifle initiative and paralyze decision.
- ❑ Waste of resources is evident in the declining occupancy of the City hospitals, in the deterioration of the City hospitals, and in the chronic under spending of the City's capital budget (Piel 1967, 6-7).

Many of the findings were not new. Further, they were problems that had a significant impact on the health and well being of New York's poorest citizens. The twin problems of access and quality, combined with the new health care environment prompted the Piel Commission to call for fundamental reform of the entire health care delivery system in New York City.

In providing inadequate and substandard health services and in serving only the indigent population through its own clinics and hospitals, the City is perpetuating a dual system of medical care with a built-in invidious double standard of private and welfare medicine (Piel 1967, 6).

The Creation of HHC

The Commission concluded that the City needed to turn over management of its public hospitals to the City's private sector. The recommendation was for the creation of an independent "Health Services Corporation" to coordinate all public funds for health care, and use that control as leverage to create decentralized regional networks of municipal

and private hospitals. Ultimately, the Commission recommended that: the systems should be merged into one, high quality community health service, eliminating a second class of hospitals for the poor (Piel 1967, 7-8). The Health Services Corporation was to dissolve over time, and the City was to pay for management and monitor the performance of all hospitals --a classic privatization as defined in today's terms.

Much of the Piel report focused on the City's larger health care system and the lack of a local government role in monitoring the massive delivery system. Piel viewed it as vital to combine the public and private sectors and view them in totality to determine how to ensure the best health care services to all New Yorkers. The full recommendations of the commission were never implemented. Politics intervened and rather than a single class hospital system, the public system was memorialized in the form of a public benefit corporation.

The politics of the time almost immediately discounted the Piel Commission's recommendation that the public hospitals be turned over to the voluntary sector. In an address to the American Public Health Association in November of 1969, Deputy Commissioner Manning of the Department of Hospitals stated that

this approach was quickly vetoed as an abrogation of the City's tradition of operating institutions for the care of its sick poor, and might represent a denial of the rights of citizens to receive health services on the basis of need alone (Manning 1969, 6).

Even the original legislation that was ultimately sent to Albany to create HHC was significantly altered. Aggressive lobbying by the municipal unions left the civil service system virtually in place. While the Corporation would not be subjected to specific civil service per se, the Corporation's policies mimicked them but allowed flexible hiring practices. It also left the City's Labor Commissioner responsible for collective bargaining

for the Corporation with the same municipal labor union continuing as the collective bargaining agent. That meant that HHC would be forever tied to the politics of the City system and its relationship to labor. This very issue would pose many operational problems and burdens for the municipal hospital system for years to come.

Because that tie to the City's bargaining system remained, HHC facilities remain particularly and somewhat uniquely beset by problems brought on by the union environment in which they operate. Because HHC's status continued as a public benefit corporation, rather than a not-for-profit as originally envisioned, the labor structure is unduly onerous. HHC throughout its history, has had to deal with over 44 unions (at its staffing peak in 1990) representing nearly 50,000 employees. Atypically, 97 percent of HHC's employees are members of labor organizations, leaving only a 3 percent management cadre to deal with all of the union personnel and issues. The following categories are some extreme examples of professionals that are unionized within the HHC system, unlike the voluntary hospital system where generally only clerks, technicians and entry level staff are unionized:

- All salaried physicians
- Postgraduate medical residents (while categorized as *students* in virtually all private institutions)
- Nursing personnel through four levels of supervision are all represented by the *same* union, NYSNA (in the private sector all supervisors are management)
- Chaplains on the HHC payroll are all members of a union

The structure and hierarchy of the municipal labor unions, and their chartered relationship with the City and HHC ultimately dictated an unavoidable conflict between and among the three entities. The conflict stems from the fact that District Council 37

(DC37) is the umbrella union and chief negotiator for *all* civilian unions (excludes uniform unions such as police, fire and sanitation) on general terms and conditions of employment, including HHC employees. By virtue of that role, it is easy for the union to play the City's arguably larger interests against HHC's issues in negotiating citywide deals, and vice versa. For example, during the Koch administration, in 1985, the City negotiated a two week reduction in vacation time to fund the establishment of Martin Luther King Day as an additional paid holiday, a critically important initiative for the union in its member relationship. This action crippled HHC's recruitment effort for "hard to recruit" health care professionals, as HHC had to compete with the voluntary sector for these employees, and the significant vacation reduction was highly unattractive to potential employees choosing between the two sectors. This action was taken by the City's Office of Labor Relations without even conferring with HHC (Interviews with former HHC Senior Vice President, November, 1997 through February, 1998 and interviews with former and current staff of the New York City's Corporation Counsel's Office). Ultimately, HHC's interests were subsumed by larger issues of both the union and the City, a scenario that would play out many times over the years.

In addition to the more confounding problems created for HHC by the "big picture" issues of the City and labor, the very structure of the unions was an ongoing source of frustration for managers in the HHC system, making it very difficult for them to run their hospitals effectively. From the perspective of hospital managers, these unions operate through a maze of time consuming committees, labor management structures, grievance procedures and adhoc groups. Political pressure is continually placed on the hospital executive directors, personally, to attend and participate in regularly scheduled labor management committee meetings dealing in productivity, workforce and grievance issues that no hospital president in the private sector is expected to attend. While the

hospital executive must put aside operational responsibilities to spend time in these meetings, hospital employees are also released from their hospital work assignments to engage in these activities for the union while their salaries are paid by the hospital. The hospital managers have the further burden of determining how the work of these employees is to be completed without the necessary staff.

More confounding to hospital executives is that they are expected to manage their local labor relations' affairs in an orderly, fair and acceptable way, and at the same time, they have a very limited role in the overall corporate labor relations program. Moreover, since the City's labor relations commissioner negotiates all collective bargaining agreements for HHC, the hospital executives have little or no opportunity to address problems they face in that forum. In sum, they have the worst of all possible worlds.

Civil service requirements create operational conundrums for hospital executives. They must contend with:

- Civil service lists that dictate whom they can hire and when
 - "bumping rules" which requires the dismissal or demotion of employees if a more senior person is sought for their job
 - job descriptions which are inflexible or unresponsive to organizational need
 - layoff procedures that are lengthy, time consuming and bureaucratic and allow no flexibility or discretion
 - Disciplinary procedures which sometimes take years to complete through a 5-step process often resulting in employee reinstatements costing thousands of dollars.
- These procedures impact managerial morale and discourage them from pursuing

actions against disruptive and unproductive employees (Interviews with former and current managers at HHC, 1997-98).

Finally, the labor unions at HHC have traditionally been a powerful political force protecting their interests by aligning themselves with elected officials, community groups and other political forces whose interests are also served by maintaining this arrangement. This makes the management of HHC even more difficult

The final deleterious effect of changing the Piel Commission's original goals was that, according to the HHC Act of 1972, its enabling legislation, the City's Budget Office would retain control over HHC's budget and the process of negotiating that budget. The consequence was that HHC would be subjected to the fiscal uncertainties of the local economy. As long as the City retained control over HHC's budget, it could withhold needed resources if in fact, those resources were deemed more appropriate or more urgently needed for other municipal services.

In addition, under the enabling legislation the City needed only to provide a *minimum* allocation to HHC. In sum, and notwithstanding the state of the hospitals, the City was under no obligation to appropriate additional resources other than that mandated minimum amount. The municipal hospitals had to compete along with fire, police, sanitation, parks, and other City agencies for its budget. That would become an ongoing dilemma over the years because hospital service, particularly in a world of third-party reimbursement, was not considered a core municipal service. The dependence on the City for closing gaps (in the end, most Mayors did not want to be seen as letting the public hospitals go without necessary funding) would also inhibit fostering good management. Future HHC presidents would become confident that the City would

rescue their budgets from the result of overspending. As former Mayor Ed Koch would say:

In a voluntary hospital, when you don't pay your bills the hospital goes broke. In a municipal hospital, the City comes in with a subsidy over and above the funds that were originally planned, and then it is the City that goes broke (Koch 1984, 149).

The new HHC system brought some important positive changes. For one, it provided greater hiring flexibility, which was crucial in the health care arena where various disciplines are from time to time competitive and difficult to recruit. Many health care professionals also have salary needs that cannot be compared with other City workers. Nurses are one example of this hiring flexibility. In a health care environment, a hospital needs to be able to respond to changes in demand by increasing or decreasing its number of nurses. A provision for hiring flexibility made it easier to upgrade the level of staffing at HHC hospitals above and beyond what existed under the Department of Hospitals.

Another advantage related to improved purchasing agreements and the elimination of ongoing complaints about the frequent shortage of hospital supplies. While the hospitals had been held under the purchasing rules of the City, it was a time-consuming, cumbersome process that did not allow the system needed flexibility to buy and retain critical hospital supplies. This problem had contributed to the accusations of the "deplorable" conditions often cited in the negative public reports on the hospital system.

In total, the legislation creating the Health and Hospitals Corporation truly reflected the politics of the day. City officials were quoted as saying that the notion of the public benefit corporation would be a solution "acceptable to the public and also highly effective" (Manning 1969, 8). Thus, political realities caused compromises that simply

would not allow the vision of the Piel Commission to be realized. The overriding goal of eliminating a two-tiered system of care was not to be. A broader City oversight role in the health care system overall had also not come to fruition. Another fundamental change that would critically effect both the way HHC operated, as well as future options of dealing with the institution from a strategic perspective, was the make-up of the Board of Directors. The Piel Commission had recommended a nine-member board of private citizens all appointed by the Mayor. Instead, the Board was expanded to sixteen members. Five members were to be appointed by the City Council, and included one representative from each borough, five were *ex officio* (including the Commissioners of the Departments of Health, Mental Health, The Human resources Administration, the Deputy Mayor for Operations and the Health Services Administrator who would also be the chairperson) and five citizen members were to be appointed by the Mayor, with the President chosen by the Board. The terms were to be six years and would overlap any single mayoral term, assuring that there would be times when the Mayor would not control the Board.

The New York City Health and Hospitals Corporation finally began operations in 1970. At the time HHC assumed control from the Department of Hospitals, it also assumed responsibility for its uncollectable accounts receivable, which totaled \$144 million. One year later, HHC was already behind in its collections and failed to pay the first \$13 million installment to the City on its enormous debt. Poor record keeping and billing systems had not improved. HHC closed its first fiscal year \$48.2 million in the red. Halfway through its second fiscal year, HHC was \$98.2 million in debt. On June 15, 1972, the New York State Study Commission charged that HHC was a "financial disaster" and that it failed to achieve the goals for which it was formed. It was not only the finances that were problematic in the new system. Quality problems continued to

plague the new Corporation. On December 17, 1971, State and City legislators and HHC Board members made a surprise visit to Kings County Hospital. An article appeared in the New York Times with the headline "A Grim Midnight Tour at a City Hospital". The conditions were again described as "deplorable" and included evidence of narcotics trafficking, unsanitary kitchens and toilet facilities, nursing shortages and inadequate patient monitoring systems. Further, several HHC presidents had been forced to resign, continuing to add to the problem of unstable management. It was no surprise, given the lack of improvement in the system (after all the hyperbole about the new structure saving the system) and the "focusing event" of the Kings County visit that, in 1973 the State Study Commission concluded "the people of New York City are not being materially better served by the Health and Hospitals Corporation than by its predecessor agencies" (State Study Commission 1973).

Then, in 1975, the fiscal crisis hit New York City. As predicted, there were budget and staff reductions at HHC's now seventeen acute care hospitals. Five of the hospitals had been turned into outpatient facilities due to declining utilization. There was an actual decline in acute care beds at HHC facilities of eighteen percent between 1975 and 1980 (Brecher 1993, 333). The fiscal crisis brought the same kind of tightening of HHC's budget process and spending oversight as it did to the City of New York in general. The City would now have more direct control over HHC's budget than previously. While that was good for the City, it eliminated more of the supposed benefits of the creation of an independent public benefit corporation.

Edward I. Koch was elected Mayor in 1977 at the peak of the fiscal crisis. Charged with turning around the fiscal chaos in New York City, Koch seized control of HHC and began treating it much more like a City agency than it had been since its formation. But it was

not easy. As Koch later described in his memoirs, politics was very much a part of the culture. One could not simply deal with HHC as a hospital system. It had its own political agenda and a very strong constituency in the minority communities it served. As noted by Koch:

. . . there was [one other] issue that became a major irritant in my relations with the City's Blacks: my plan to save the money being wasted in the municipal hospitals and use it for *good* medical treatment....The City of New York in 1978 was operating seventeen municipal hospitals. Of these, only two served primarily white patients. The Health and Hospitals Corporation, like the poverty programs, had long been viewed as the turf of minority politicians. These were unspoken rules. And if it meant more tax-levy money was needed to keep the hospitals functioning, than more money was appropriated under the general political heading of "keeping things cool" (Koch 1984, 144).

Koch no longer allowed the HHC Board to pick its presidents. He put his own appointees in as presidents and they were subsequently approved by the Board he controlled. During the effort to gain control of HHC, the political volatility that was present in New York caused the downfall of several, short-term successive presidents and chairmen of HHC. Finally, by 1981 the City had balanced its budget and HHC was on much sounder footing, both fiscally and managerially. Koch appointed as president one of his most accomplished and trusted Commissioners, Stanley Brezenoff and more than ten years after the creation of HHC, stability set into the municipal hospital system.

A draft campaign document from Koch's campaign for re-election for a third term read:

Prior to my administration, the NYC HHC, the nations largest municipal hospital system, was known to many. In fact, the Corporation made newspaper headlines almost daily. Unfortunately it was instability, poor patient care and gross mismanagement that brought public attention to the City Hospitals. Frankly, I am sure there are few who would argue with an assertion in the book "The Cost of Good Intentions", that from the end of World War II, this City's municipal hospital system found itself in a state of permanent crisis...The fiscal and programmatic turnaround of the Health and Hospitals Corporation is one of the proudest accomplishments of my administration (Koch 1985, 1).

The Koch administration had made improved patient care quality, both in the hospital system as well as the emergency medical services that were under the auspice of HHC, a priority. At the beginning of the Koch days, stories of poor quality and unacceptable response times at the City's Emergency Medical Services (EMS) abounded. At that time EMS was a part of HHC (nearly a decade later, Giuliani would subsequently remove EMS from HHC and put it in the Fire Department to again improve response times). Response times were at 22.9 minutes. Today, average response time for Priority Calls is eight minutes and 14 seconds (Mayors Management Report, Preliminary Fiscal 1998, Ring Mayor p.11). Further, the EMS was fraught with stories of employee misconduct and ambulances that were barely functional as well as obsolete. There was no system to EMS. Ambulance drivers took patients where they wanted without any organization throughout the system (Koch 1985, 10).

During the Koch years HHC made fiscal and overall quality improvements. Under Koch, the central office, long viewed as bureaucratic and unresponsive to the individual hospitals, attempted to tighten controls to improve fiscal performance and again, as in the Wagner days, reduced patronage. Despite the many improvements that resulted from centralization, there remained a recognition that the central office micromanaged the hospitals. For example, the Executive Directors of HHC hospitals long complained that they had little control over hiring, particularly around budget constraints that may have been caused by another hospital's poor performance. They, as discussed earlier, were not delegated the appropriate authority to manage labor/union issues often rendering them powerless. On a day to day basis they bemoaned the top-heavy management staff of the central office that would duplicate policy initiatives at their more local level, and then try to control them. One example during the Koch administration was a push to develop more ambulatory care sites. There was a large central office staff

overseeing the initiative, but that left the local directors often confused and sometimes undermined in their own efforts to meet the local community needs. Despite the best intentions of the Piel Commission and City officials at that time, who declared that "we are most emphatically working for strong, decentralized hospitals . . . Replacing a Departmental bureaucracy with a Corporate bureaucracy would be folly" (Manning 1969, 10), decentralization would not be operationalized.

Other improvements during Koch's tenure included the implementation of a strong management information system to improve billing and collections. Also, by this time, affiliation contracts amounted to over \$200 million with little accountability. In 1983, for the first time there were signed affiliation contracts that gave HHC control over areas such as admitting, discharge planning, medical records and ambulatory care. In 1985, two-year contracts were negotiated with selected affiliates based on overall performance. For the first time Chiefs of Service in each HHC facility were required to produce formal annual reports describing the activities and performance of their clinical departments (Graham 1985).

By May 1985, the financial success of the New York City Health and Hospitals Corporation was the cover story of Modern Healthcare, the business magazine for health care managers. The article stated that

HHC is reshaping the way its public hospitals do business...its winning the respect of City officials, health care providers and the financial community after years of struggling with severe financial difficulties and management problems (Graham 1985, 50).

The impetus for the story was HHC's \$68 million tax-exempt bond issue, the first in its history. There had also been an 85% increase in collections from Medicaid and

Medicare and Blue Cross/Blue Shield. Between 1974 and 1985 HHC's third party collections rose over 300% (Graham 1985).

The financial success had come at a political price for Koch. Much of the financial difficulties at HHC were due to keeping hospitals open when their beds were unoccupied. Early in his administration he attempted to close two hospitals, Metropolitan Hospital in East Harlem and Sydenham in Harlem. As Koch describes his efforts at the time, he felt very much alone in making those difficult choices. He said,

The State and federal authorities basically wished to see the status quo preserved....the local officials all agreed there were too many empty beds, but no one wanted a single bed closed in *his* or *her* community ...It was only a matter of time before the Harlem leaders began invoking the old standby "racism" charges in their denunciations of the City administration's plan (Koch 1984, 146-7).

Despite the fact that as far back as the Wagner administration recommendations had been made to close Sydenham Hospital and move the remaining patients to the much newer Harlem Hospital, there was no shortage of political controversy over the plan to close Sydenham. All reports of the condition of the hospital and the quality of care were abysmal. Yet, those in the Harlem community perceived the planned closing as an affront and an insensitivity to Blacks. Koch had lost favor with the Black community because he had, at one time, called them anti-Semitic (Koch 1984, 147). Sydenham Hospital held great significance for the Black community because it had been at the forefront of training the nation's first Black physicians. Closing the hospital was seen as a disregard for that history. Koch viewed preserving the hospital as a virtual and inappropriate landmark and waste of valuable health care resources (Koch 1984, 207).

The days of the Sydenham closing were among the most tumultuous of the Koch administration. There were demonstrations at the hospital. Koch was burned in effigy at

the site. Few, if any, politicians defended Koch's position despite support from both the State and federal agencies that oversaw the hospital.

Despite all of the political shenanigans, Koch's tenure seemed to bring about the highest point in HHC's history. Among the major achievements were the following:

- ❑ In 1984, for the first time in its history, HHC signed formal, revised contracts with all of its affiliates and set up policies and procedures for monitoring those contracts.
- ❑ The difference between expense and revenue which is funded by the City tax levy fell from about 31% of operating expenditures in 1980 to about 22.6% in 1988.
- ❑ Third-party revenues increased from \$814 million in FY1980 to \$1.82 billion in FY 1988.
- ❑ Until 1983, HHC had no 10-year capital plan; its 10-year capital commitment from the City is \$2.582 billion.
- ❑ From 1985 to 1990, HHC installed automated lab and risk management systems in seven of its acute care hospitals and procured MIS systems for many of the key service areas (New York City Health and Hospitals Corporation 1989).

All of this was accomplished in an environment where the scope of HHC services had grown enormously. At the end of the Koch administration, HHC's budget was \$2.2 billion (City of New York Enterprise Funds, combining statements of revenues, expenses and changes in Equity fund, June 3, 1988 OMB p. 154). The HHC network was providing over 4.3 million ambulatory care visits annually. There were twelve freestanding satellite primary care clinics organized into ambulatory care networks as a result of an ambulatory care initiative begun in 1984. HHC was also providing 46 percent of all psychiatric emergency room visits and 13 percent of all ambulatory mental health visits

in New York City. More than 30 percent of births in New York City occurred at HHC hospitals (New York City Health and Hospitals Corporation 1989, 7-8).

At the end of the Koch administration the HHC Board adopted a new strategic direction for the Corporation, a "Community Oriented Health Care System". The goal was to redirect the primary focus of HHC from acute hospital based care to becoming an integrated health care delivery system. By that time it was clear that "capitated" arrangements were becoming the way of the world, and HHC would not survive unless it prepared appropriately.

The closing of Sydenham occurred in Koch's third year as Mayor. Despite his many achievements at HHC during three terms as Mayor, Sydenham would overshadow Koch's accomplishments in many of the minority communities around the City for the duration of his tenure. However, the hospital ultimately did close, and was replaced by an outpatient facility, then the hub of a series of clinics that was to become the Sydenham network. One fact did become quite clear in the closing of Sydenham. Significant and fundamental change at HHC had a political price tag. The communities in the City viewed (and view) these hospitals as their own. No interim Mayor has the right to make those kind of changes, unless there is full community support. That is the community view.

Edward I. Koch lost his bid for a fourth term as Mayor of New York. Racial tension and unrest marred the end of Koch's tenure. His chief Democratic opponent had been the Manhattan Borough President, and a longtime political figure in New York City, David Dinkins. Dinkins was elected the City's first Black Mayor in 1989 after defeating his Republican challenger, Rudolph Giuliani, by a very slim margin.

From the start of the Dinkins administration HHC was problematic. Dinkins had campaigned using a theme of "the gorgeous mosaic" that was New York's people. He was elected during a period of racial tension and he made it clear that he was going to be the Mayor that put an end to the uneasiness that plagued New Yorkers. His own philosophy, as well as the politics of the day, indicated that he needed to appoint more and varied minority Commissioners and other high level City officials. HHC was clearly no exception. Given HHC's role in serving minority communities, it was a key place to appoint a minority head.

Dinkins made most of his key appointments before he decided on a President for HHC. Many of his early appointments had been African-Americans, and he was receiving a great deal of pressure from the Hispanic community to appoint more high level Hispanics (New York Times Oct 21, 1991 B2). A number of Hispanic and other advisors to the Administration searched and recruited a young, private practice physician from Boston, Emillio Carillo. Whatever the politics were in hiring Carillo, it was not long before his lack of experience, both in managing a large agency, and in operating in a political environment became clear. The tenure of Carillo was reminiscent of earlier years when it seemed as though HHC presidents went through a revolving door. There were thirteen presidents in twenty-two years. The average tenure of HHC presidents was under two years.

How Dr. Carillo won his job as president of the City's Health and Hospitals Corporation, lost the confidence of the professionals who worked there and then ended up with a governmental golden parachute is both a lesson in the business of hospitals in New York and a case study in the powerful and often debilitated interplay of governmental politics at City Hall (New York Times Oct 23, 1991 A1).

Carillo, after numerous *and* public problems managing the large HHC system and increasing evidence of quality control problems, was also found borrowing large sums of

money from subordinates and paid affiliates, as well as using his HHC credit card for his own personal use. He was ultimately forced to resign. Carillo's tenure was only 19 months but that was time enough to do substantial damage to both staff morale, and to reverse some important accomplishments. The financial situation eroded during that period as well. It was a matter of grave concern to the staff that Carillo had hired many of his friends from Boston, despite the fact that HHC staff deemed those individuals as unqualified for their positions. Moreover, many of them were paid salaries well beyond what they were making in Boston. All of this had a chilling effect on the staff.

The tenure of Mayor Dinkins would again see HHC under repeated fire, primarily because of severe quality problems. During the four years of the Dinkins' Administration, HHC would lose all or part of the nationally recognized Joint Commission on Accreditation of Healthcare Organizations (JCAHO) at five of its eleven acute care hospitals. Hospital accreditation was a very important national symbol of quality of patient care services; loss of accreditation was a strong and unusual step. It was virtually unheard of to have multiple hospitals in any one system run into so much trouble with the JCAHO. These quality problems made it clear that there were systemic problems in the HHC system as well. For five hospitals in an eleven hospital system, run by a corporate office well known for its micromanagement, including an office that oversaw JCAHO preparedness, to fail accreditation was a condemnation of the entire management structure. There is also a linkage between managing finances and providing good patient care. Obviously, the finances necessary to run the system were not being well managed.

Carillo's lack of experience in working in a political environment, as well as his weakness as a manager, was also becoming a problem for City Hall in that the resulting troubles

were becoming very public. Early in 1991 the City was experiencing tough fiscal times and the City was calling for across the board budget reductions, including a reduction in the workforce. Carillo, along with other City Commissioners was given both budget and headcount reduction targets. City Hall was clear in its desire to make cuts in personnel as well as programs given the strategy to deal with the unions that the City had established. A long-standing criticism of HHC had been the bloated central bureaucracy, and Carillo determined that he would make personnel cuts there. He and the senior management team members spent several months developing a plan to downsize the central office, including the elimination of a number of Senior Vice Presidents (there were 19 Corporate Officers), given that management was extremely top heavy. Despite the months of planning and the paying of outside consultants to establish the downsizing, when it came time to implement the reductions, he backed down (Former HHC management staff 1997).

Moreover, as part of the same reduction plan, program and administrative reductions throughout the system had been carefully planned. HHC even sent the required thirty-day notice to the City's office of labor relations to advise them of about 2,500 reductions in personnel. Only weeks before the beginning of the new fiscal year when the reductions were to be implemented, Carillo publicly went before the HHC Board of Directors and decried the cuts, an effort which led to a clear and public break with City Hall. The entire episode created chaos within HHC as well as the City overall. It complicated union negotiations, budget projections and created a major rift between HHC and City Hall. Lawsuits were brought against the City to stop the cuts at Kings County and Harlem Hospitals in particular. City Hall did not walk away from the needed reductions, and some were ultimately implemented. It was becoming all too clear that Carillo was both an inexperienced and weak manager (*ibid.*).

There were some bright spots during that time. HHC conducted its own independent bond deal for a half a billion dollars. Also, HHC completed a negotiation with the City begun under the Koch Administration. The deal would address some of the long-standing criticisms that HHC, structurally, could not manage its own budget. Because of its enabling legislation any surplus that HHC might acquire would have to be turned over to the City, thereby decreasing any incentive to improve performance. Further, the City's ability to extract reductions from the Corporation at any given time in the year did not allow HHC to manage itself appropriately. By the end of the Koch administration, as HHC began to manage more responsibly, the City recognized that changes had to be made. The Dinkins administration followed through. In 1990 the City and HHC reached the first of three revenue sharing agreements which allowed HHC to retain a portion of the revenue collected over a specified level. They also fundamentally restructured their financial agreement. Under the new arrangement, HHC was to develop a consolidated budget including revenue and expenses as well as the projected City tax-levy payment. The City and HHC would then negotiate the level of the City's general support payment to HHC rather than their whole revenue and expense budget. Once it had been negotiated the City payment would be established for that year. Except for new regulatory or program initiatives, HHC was to be exempt from budget cuts for the year (Barondess 1992). This arrangement was supposed to bring the management and financial stability to HHC that was called for by the Piel Commission. This positive step, however, was not enough to quell outcries of poor quality and mismanagement within the system.

In August of 1991, a murder in Brooklyn that resulted from the now notorious Crown Heights riots would change the course of both the Dinkins administration and HHC. This

was truly the kind of “disastrous” focusing even that Birkland refers to (1995). For clarification and illumination on just how important this event was in the “softening up” process, Birkland’s definition of such an event is as follows. “. . .an event that is sudden, relatively rare, can be reasonably defined as harmful or revealing the possibility of potentially future harms, inflicts harms or suggests potential harms that are or could be concentrated on a definable geographical area of community of interest, and that is known to policy makers and the public virtually simultaneously” (Birkland 1997,22).

The riots began when a car driven by a Jewish man had hit and fatally injured a young Black boy. The incident set off riots in the Crown Heights neighborhood. In the midst of the riots, Yankel Rosenbaum, a young Jewish man was knifed and critically injured. The events surrounding the riots in general would fundamentally change the perception of the Dinkins Administration. It was widely perceived that the police did not do enough to control the incident. It was also alleged that the Mayor and his staff demonstrated clear disregard for the Jewish community during the incident. The attack on Yankel Rosenbaum would particularly effect HHC, and would be the final undoing of Carillo. The incident also pointed to how HHC was a health care system that was negatively impacted and, for that matter, inextricably tied to the City’s overall politics.

The knifing of Yankel Rosebaum in Crown Heights sent the critically injured man to Kings County hospital emergency room for treatment. Amidst the racially charged situation were accusations that hospital personnel let the Jewish man die either through incompetence or neglect (Kings County served a primarily black population). In fact, Rosenbaum was taken to the Kings County Emergency Room and the physician on duty treated him for a single puncture wound to the lung. It was only after 45 minutes that they realized there was a second puncture to the lung, which had not been treated.

Mayor Dinkins visited Rosenbaum in the hospital that night, and was assured by hospital personnel that he was stable. Within hours, Rosenbaum's lungs filled with fluid, and he died. Despite the fact that x-rays had been taken, no one had looked at them and identified the second puncture wound (New York Times, 24 September 1991). The misdiagnosis and the subsequent death were immediately reported to the State Department of Health as appropriate. However, HHC President Carillo failed to inform the Mayor that Rosenbaum had died.

Rosenbaum's death went unnoticed by the public for about three weeks. Andrew Stein, a political foe of Mayor Dinkins and a sure challenger for Mayor, was apparently given the State Health Department report of the death that revealed the facts about the hospital's neglect. The New York Times later revealed the results of the report stating that "doctors did not conduct a full examination of Mr. Rosenbaum, did not document his vital signs, and did not order a chest X-ray for more than an hour" (ibid.). The State Health Department report then went on to say "the patient was not provided care that meets generally acceptable standards of professional practice" (ibid.). Stein then publicly condemned HHC for its mishandling of the situation and called for an investigation into the death of Yankel Rosenbaum. This was how Mayor Dinkins learned of the events surrounding the death. Soon thereafter, and to make matters worse, the Mayor learned that the physician who treated Rosenbaum was not properly credentialed to work in the Emergency Room. That revelation indicated problems in management as well as quality. Emilio Carillo resigned within a month of the events at Kings County.

Rosenbaum's death, and subsequent condemnations of his care, prompted outcries of inferior care at not only Kings County Hospital Center but in HHC as a whole—a public hospital system in which five of its eleven acute care facilities had recently failed to

obtain hospital accreditation. This event meets all of the criteria of Birkland's focusing event. It was sudden, unexpected and with respect to the circumstances surrounding Rosenbaum's death as it related to inferior care at Kings county Hospital, both the public and policy makers found out virtually simultaneously, even the Mayor himself. Moreover it affected a specific geographic area in Brooklyn that was already politically charged, and turned this murder into a public showcase for the ills that long plagued HHC. The subsequent commissions that would be appointed to review the HHC system would bring influential policy actors much closer to the realities of HHC's problems thereby helping to soften them up to Giuliani's idea of privatization when the time came.

Mayor Dinkins solicited the legal expertise of attorney Stanley Lowell and launched an investigation of the quality of care and management of the hospitals. This investigation evolved into a commission to study HHC under the leadership of Dr. Jeremiah Barondess, President of the New York Academy of Medicine (Brecher and Spiezio 1995, 32).

It took the Dinkins administration a long time to appoint a successor to Carillo. The HHC Chairman at the time, Dr. James Dumpson, became the acting president for six months. Finally, Dinkins appointed his Commissioner of Mental Health, Mental Retardation, and Alcoholism Services, Dr. Billy Jones to head HHC. From the outset that appointment was also criticized. Dr. Jones had been the head of Psychiatry at Lincoln hospital (an HHC hospital in the Bronx) when that hospital lost its JCAHO accreditation. During the tenure of Dr. Jones, the Barondess report was conducted and released. The results of their findings kept a critical eye on HHC for the duration of the Administration, and would give the main challenger to Dinkins, Rudy Giuliani, ample reason to call for the

privatization of HHC. The Barondess commission findings were strikingly similar to the Piel Commission of more than twenty-five years earlier.

HHC had been created as a public benefit corporation to shed the structural problems that the 1966 Piel Commission pointed out had long plagued the system from operating efficiently. Yet, a key finding of 1992 the Barondess Commission was that "long-standing organizational constraints have inhibited the ability of HHC to function effectively as a competitive and uniformly high quality health care provider" (Barondess 1992, xi). Much of this assessment was based on the fact that the City still remained very much involved in the operations of HHC. There was also frequent turnover of key leadership, lack of managerial control at the local facility level and lack of collaboration between HHC and its affiliates. The Commission, composed of a group of highly respected health care and business leadership, stated specifically that "there is a direct link between these obstacles and quality of care" (ibid.). These very same issues had been outlined by the Piel Commission. They concluded generally that the problems of the HHC system are for the most part long-standing and therefore difficult to resolve. In addition: HHC's ability to shape its environment is limited: federal, state, and city budget constraints place significant fiscal pressure on HHC; it operates in a heavily regulated field; and it faces the requirements and scrutiny imposed on public entities. HHC and its affiliates have not adequately monitored or assessed the quality of care provided throughout the organization. They further concluded that HHC had not always ensured an appropriate environment for high quality patient care and effective quality assurance. And like the Piel Commission before them, as well as the ongoing criticism, they found that significant access issues remain unresolved.

More specifically, the Barondess Commission concluded that:

- ❑ The Board of Directors does not make key decisions affecting HHC, and is not able to provide leadership on quality of care, access, fiscal, and policy issues.
- ❑ The historical level of City control of the financial operations of HHC has limited the ability of the Board, the President, and the Executive Directors to set policy and to manage HHC facilities.
- ❑ Excessive central control of its facilities by HHC Central Office compounds the problem of the City's extensive involvement in HHC operations.
- ❑ Excessive turnover in leadership at the level of both the HHC president and the Executive Directors has had a deleterious effect on HHC policy and management.
- ❑ Independent action by the affiliates can limit the ability of the Executive Directors to direct the operations of their institutions and to assure that the appropriate levels of clinical resources are available to meet patient needs.
- ❑ Many existing affiliation contract-monitoring mechanisms are not completely implemented or utilized by HHC or the facilities.
- ❑ If HHC is unable to respond to the challenge of managed care; its financial base could be significantly eroded.
- ❑ A comparison of JCAHO survey results for HHC with those of the acute care voluntary hospitals in New York City found that the voluntary hospitals are more successful in meeting accreditation standards.
- ❑ The wide variations in the rates of incidents reported by HHC hospitals to the state suggest that HHC may not consistently apply guidelines for incident reporting.
- ❑ Although no single source of data can be used to assess the quality of an institution, the results of surveys by JCAHO and the state, incident rates reported to the state, and the Health Care Financing Administration mortality rate reveal significant problems that require further review and investigation by HHC.

- ❑ Medical staff appointed by affiliates in HHC facilities have not consistently completed medical staff quality assurance activities mandated by JCAHO and the NYSDOH.
- ❑ There is a discrepancy between the intent of the Corporation to monitor, evaluate, and improve the quality of care and the realization of these intentions.
- ❑ Affiliated institutions have not in all cases taken adequate responsibility for the quality of care provided by their staffs in the HHC facilities with which they are affiliated.
- ❑ Declining match rates and changes in national and state regulations and voluntary accrediting agency requirements are likely to limit to some degree the Corporation's reliance on resident-delivered care.
- ❑ The capital needs of HHC are extensive.
- ❑ HHC has significant problems attracting and retaining staff.
- ❑ 911 receiving hospitals and trauma centers are not surveyed for re-designation by EMS at the intervals required by the EMS standards.
- ❑ HHC ambulatory care services are significantly overburdened.
- ❑ Formal transfer agreements with other facilities for specialty medical services are not in place for all services at any HHC facility.
- ❑ Linkages among HHC hospitals and the six Diagnostic and Treatment Centers are inadequate.
- ❑ HHC has not adequately involved its affiliates in its major planning efforts.
- ❑ HHC has not facilitated continuity of care for those of its patients who have personal community-based physicians, and has not forged mutually beneficial relationships with community physicians.
- ❑ Because of the importance of health care and the City's significant investment in health, it is appropriate for the Mayor to play a greater role in policy direction, coordination, and advocacy for health care services (Barondess 1992).

Despite myriad serious problems found by the Barondess Commission, it specifically rejected the option of privatizing the HHC system. At that time, privatization in general was receiving more national attention than ever before, and Rudy Giuliani who had lost the prior Mayoral election to David Dinkins and was clearly going to be running against him again, was talking very openly about the issue. However, the Commission was of the mind that privatizing hospitals might serve to threaten the City's goals of improving care and better serving communities without equivalent benefits. Sadly, Dr. Barondess would later, in testimony before the New York City Council in 1995, conclude, "privatization should be considered as an option." He indicated that he had become frustrated and disillusioned by the fact that his commission had spent so much time and effort examining HHC and making sound and thoughtful recommendations while almost none of them were implemented.

In almost all of the commission reports, and all those who looked at the problems that plagued HHC over the years, it was nearly always mentioned that there were many, many hard working and dedicated people employed in the HHC system. That would serve to perplex those who couldn't understand why things were rarely done efficiently. It also strengthened the argument that the structural problems plaguing HHC were so severe that the best and most well intentioned people would have trouble making permanent change in the system. Quality was not the only area that was mismanaged.

Capital construction was a long-standing cause for grave concern in the HHC system. All reports of the status of HHC over the years cited problems with the physical plants of the hospitals. Later, as the system advanced and efforts were made to deal with the dilapidated infrastructure, the criticisms turned to the grossly inefficient capital

construction plans and projects. As referred to in the Barondess report, the actual process of capital construction would become as problematic as the deteriorating physical plants had been. During the Koch years there were constant discussions at Board meetings about project cost overruns and multiple delays in any given project. However, it was probably the plan to rebuild Kings County Hospital that both epitomized the problems in the system of capital reconstruction and also pointed again so glaringly to the interlocking issues of politics and the operation of a public hospital system. It was also a public display of HHC's dysfunction that would give both candidate and later Mayor Giuliani ammunition in his fight to privatize the public hospitals. It was an event that both Kingdon and Birkland would describe as a "focusing event".

In May 1985, based on an HHC consultant study on the health services in Brooklyn, HHC incorporated a \$500 million project to rebuild Kings County Hospital in its ten-year capital plan. In September 1987, HHC executed a contract for architectural services for a total of \$42.6 million and a month later entered into a contract with Turner/Santa Fe Venture for over \$19 million for construction management services. The Corporation initially assumed that twenty to forty prime contractors would be used for the project. The original contract outlined a plan for total project duration of ninety-six months. The actual construction phase would take eighty-four months. Design work began in August 1987, and a master plan was completed in July 1988. By May of 1989, the Certificate of Need (CON), (a document prepared by the owner of the construction project and reviewed by a state committee to determine actual need in the health care delivery system for such additional construction and delivery of services and is required by the New York State Health Department) was generally approved for the "make ready" phase of the project and a new CON filed for the main hospital construction was filed in December of 1990. The CON was finally approved in February of 1992 with twelve

contingencies (Internal Task Force on the Kings County Major Reconstruction Project 1994).

The Master Schedule, completed in 1988, had set the excavation date for July 1991. There were significant delays in the excavation due to several factors. Those included redesign, revised relocation of, and revision in the scope of work involved in the "Make Ready" phase and most significantly, the decision to implement a multiple contract packaging strategy. Although four other contracts were awarded for excavation of the Main Hospital in May 1992, all contracts were suspended on February 1994. Excavation of the Main Hospital had not even begun (*ibid.*).

By the time the contracts had been suspended, the approved Capital Budget plan totaled \$924 million, nearly double that of the original plan. The largest construction project HHC had ever undertaken prior to the Kings County reconstruction plan was a \$19 million renovation of one of its other facilities. Thus, all internal procedures for capital projects were geared to much smaller projects. Throughout this time, the construction manager was paid a monthly fee of \$55,000 regardless of adherence to the planned schedule. By the time the contract was suspended, only 11 percent of the necessary construction had been completed. HHC, however, had paid almost 94 percent of the total contract management price. Total monies expended for construction had already piled up to \$53 million. (*ibid.*)

Despite the many delays in all areas of the project, much of them obviously due to all around lack of experience, there was one particular flaw in the process that likely contributed most to the delays. That same problem was also most political and most avoidable, by all accounts. That was the process of choosing multiple prime contractors.

In August 1991 HHC adopted a strategy of providing for the largest possible number of prime contractors. The key objective in this strategy was to lower the dollar value of each contract to enhance opportunities for minority and women owned business as well as giving local groups the opportunity to benefit from the business. There was also, apparently, a thought that increasing competition would keep costs down. It took the next twenty-three months to decide that the number of prime contractors would be set at 110. Only five of the 110 were awarded to prime contractors. None of them were women or minority contractors. (ibid.).

The Kings County debacle would be used in the Mayoral election against the incumbent David Dinkins. Ultimately, Mayor Giuliani would put a moratorium on the project, and not until the last year of his first term as Mayor, would plans be announced to move ahead on a much-scaled back version of the plan. While it remains unclear that there was ever any actual public corruption, nonetheless, the criminal indictment of one of HHC's consultants in 1997 was directly attributed to work performed on the Kings County reconstruction project. At minimum, the project had been riddled with local politics. This reinforced one of the longstanding criticisms that local politicians often used the public hospital system for political gain. There were also several senior managers at the time that discussed very privately, and actually sought out the Giuliani campaign staff during the election to discuss how uncomfortable they felt about the political decisions that were being made around the project. Disgruntled staff, in any sector, private or public can behave in the same way to distort facts to their own advantage, but the facts around Kings County were reviewed by many independent sources, including the press. There was no denying that it was a grossly mismanaged project that wasted millions of taxpayer dollars. Worse, it denied the people of Brooklyn a desperately needed new hospital. It is hard to not conclude that time and time again in a government-run health

care system, politics too often prevails over the health care needs of the public, despite what may often be the best of intentions.

As the end of the Dinkins administration drew to a close, the face of health care delivery in New York City was changing rapidly. Increasing demands were facing the Corporation as managed care moved into the New York marketplace for the first time. It was clear that in order to keep the very solid base that was HHC's paying customer, Medicaid, HHC would have to know how to play in the Medicaid managed care game. New York City's voluntary hospitals were already marketing to attract Medicaid patients. With a pre-paid capitated arrangement, it was now possible to make money on Medicaid patients. HHC had every advantage to keep those patients, and every incentive. HHC also had an HMO license from a project called Citycaid which had been created in the Koch years to save Metropolitan Hospital from demise once it was clear that Koch couldn't afford, politically, to close another hospital (Koch 1984, 148).

Citycaid had been a laudable effort, but it was an idea before its time. It was a managed care program for both Medicaid patients and the uninsured. The idea behind Citycaid had been to offer the patients in that catchment area "family doctor" at Metropolitan Hospital, rather than waiting in long clinic lines and seeing a different doctor every time. It would also improve the quality of care for those patients by encouraging use of an ongoing physician, rather than a fragmented approach of using the emergency room, as Medicaid patients were known to do at that time. The project was never really successful because the health care advocacy groups at the time felt that the Medicaid population was being denied choice of access due to a "lock in" provision. "Lock in" would have assured that patients would go only to Metropolitan Hospital for their care, as the hospital had been given the pre-payment for the care of those patients. However,

despite the lack of success of the program overall, a few patients remained in the program, and HHC still held the license that had been required to run such a program. That license was now a valuable asset in that many health care organizations in the City, both hospitals and entities that sprouted up for the primary purpose of being in this particular business, were attempting to obtain such a license (Koch 1985).

HHC then, under Dr. Jones in the early 1990s, put together the Citycaid license and several other small, prepaid programs that it had at the time and began a new effort to try and keep up with the rapidly expanding competition by forming its own corporate-wide managed care plan. The dismal failure of HHC's management at that time however was unsuccessful at this attempt, and thus added to the growing criticism of the public hospital system. They had set a target to enroll 19,500 patients into their managed care program by 1993. Despite nearly two years to plan and attract these patients in a system where they had a virtual monopoly on the Medicaid population, only about 8,000 patients were actually enrolled by the deadline. This put HHC in a very difficult position to compete with its voluntary counterparts (Interviews with several former HHC Senior Vice Presidents and Assistant Vice Presidents and former members of the HHC legal staff).

By 1993, HHC was a \$3.6 billion dollar operation. As noted in the Barondess Commission Report, "by size of its budget, geographic reach and services, the New York City Health and Hospitals Corporation dwarfs all other providers in the City" (Barondess 1992, xiii). That was true at the time. Since then, the merger of many of the large hospitals in the City has created systems that surpass the size and scope of HHC. HHC in 1993 was operating eleven acute care hospitals, five long-term care facilities, six freestanding diagnostic and treatment centers, two satellite clinic networks and the City's

Emergency Medical Service. Its role as a provider of primary outpatient care grew enormously over the years so that by 1993 there were some four million clinic visits and an additional one million emergency room visits a year. As had been the case since its creation in 1969, HHC 's mission was to provide comprehensive medical, mental health and substance abuse services to the City's residents regardless of ability to pay. In order to carry out this mission, HHC was employing 46,000 people, with an additional 5,000 staff working in HHC institutions through its affiliates (HHC Annual Report 1993-1994). The City, by law, provides the Corporation with support for care given to the uninsured indigent patients as well as members of the municipal uniformed services and prisoners. While the HHC enabling legislation determines a floor for the annual allocation, the specific amount each year is determined through the City's annual expense budget.

During the final year of the Dinkins administration, 62 percent of the Corporation's patient base was Medicaid, 18 percent Medicare, 3 percent Blue Cross 15 percent other third-party payers and 2% self paying patients. In its 1993 year-end audit report, HHC's accounting firm, KPMG recognized that managed care was likely to have an effect on HHC's financial performance. The audit report stated:

In June 1991, New York State targeted that 50% of all Medicaid enrollees should be covered under some type of managed care plan within five years. Because of implementation delays, year one did not begin until 1992. The effect on the Corporation's revenue has been minimal. However, because of the incentives in the system to encourage HMOs to enroll Medicaid clients, managed care is expected to impact future Corporation revenues. Since the outcome of this legislation is indeterminable, the Corporation is unable to estimate the effect on its financial position.

(New York City Health and Hospitals Corporation Annual Report 1994)

It was becoming evident that the poor management of the mammoth public hospital system was a major threat to the HHC system in a rapidly changing and increasingly

competitive health care delivery system. By the time Rudy Giuliani declared his candidacy for Mayor in 1993, he had empirical evidence that the system was ripe for privatization. In the words of management guru Peter Drucker:

To get at the new and better, you have to throw out the old, outworn, obsolete, no longer productive, as well as the mistakes, failure, and misdirection of effort of the past. To put it another way, think of the old medical saying: 'as long as the patient eliminates there is a chance. But once the bowels and the bladder stop, death does not take long.' If organizations cannot get rid of their waste products, they poison themselves. They must organize abandonment, a most difficult thing to do, because most organizations develop a strong emotional attachment to the products they make (Drucker 1992, 340).

Unfortunately, as this chapter has demonstrated, governmental institutions like HHC place significant constraints on policymaking. Governmental processes and requirements as well as structural roadblocks often make change painstakingly slow or impossible. In the words of Savas "The history of modern government is replete with efforts to improve government by centralizing, decentralizing, reorganizing, introducing performance budgeting. . .management training, worker incentives, shared savings. . .and numerous other techniques. Their overall impact has been modest . . .a more fundamental, strategic direction is needed" (1987, 5).

By the time Mayor Giuliani would take office there had been years of "softening up" with regard to identifying the need for dramatic change, as well as numerous failed attempts at changing the public hospital system. Moreover, the "coupling" of those years with the occurrence of a number of very significant "focusing events" just prior to Giuliani's taking office, allowed the public and the informed members of the policy community to prepare for Giuliani's "reinventing government" philosophy that included the privatization of HHC hospitals. These events, along with the more global changes in politics and mood

described in the next chapter, would allow privatizing public hospitals in New York City to climb to the top of the new Mayor's political agenda.

CHAPTER TWO

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CHAPTER THREE

THE POLITICAL AND HEALTH CARE DELIVERY LANDSCAPE IN NEW YORK

Greater than the tread of mighty armies is an idea whose time has come.
Victor Hugo

A significant component of Kingdon's theory of agenda setting relies on the fact that when the appropriate streams are coupled, "the window opens." It is then too late to begin working up proposals from scratch; they need to have been prepared long before that (1995, 227). He also maintains that a strong policy entrepreneur is often critical in moving an agenda item forward. This chapter will finalize the last piece of the "softening up" puzzle. It will detail how the national and local "mood," as Kingdon describes, came to a crescendo and allowed Rudy Giuliani, New York City's mayoral candidate in 1993, to raise the issue of privatizing HHC hospitals. Consistent with Kingdon's theory, Rudy Giuliani had prepared his agenda well in advance of the "focusing events" of the early 1990's. History (albeit brief) has already demonstrated that Mayor Giuliani has proven to be a strong leader with the tenacious personality to push ideas forward. Thus, he was an ideal policy entrepreneur for this policy agenda.

This chapter will also demonstrate the critical importance of the "political stream" and its influence on bringing an agenda item alive. The "national mood," as Kingdon refers to it, played a pivotal role in the HHC privatization initiative. The health care delivery system alone was undergoing a confluence of changes that together represented the greatest changes since the enactment of Medicaid and Medicare some thirty years before. The combination of: impending national health reform driven by the new Democratic president Bill Clinton, and, within just one year of Giuliani's first term, a total reversal to a

Republican-controlled Congress that not only refused to entertain health reform but, to the contrary, sought major cuts to the existing national health care programs through block grants, focused unprecedented national attention on health care. Despite these two related governmental health policy initiatives (which were, in large measure, policy failures), it was the private sector that brought the most sweeping change to the U. S. health care delivery system--managed care. Managed care would have the effect of changing New York City's health care system in a way that almost no government action in its history would have. The national focus on the health care industry helped rivet the public's attention on Giuliani's privatization dialogue in both a positive and negative way, as will be demonstrated. Moreover, the reality of the changes wrought by managed care--charges that were inconceivable only a decade earlier--and the efforts of the federal government to contain health care costs without doubt aided Giuliani in making his case for privatization. Finally, the fiscal crises of New York City and New York State, along with the resulting policy initiatives implemented to allay their effects, played a key role in influencing the policy making process of privatization.

RUDY GIULIANI: A REFORM CANDIDATE

Mayor Rudolph Giuliani campaigned for Mayor in 1993 as a moderate, reform Republican. His theme was fusion, an embracing of all interests. A dogged and determined candidate, he was relentless in calling for change, and demonstrated a strong willingness to shake up the status quo in New York City. Many disturbing issues, which New Yorkers had come to take for granted, were challenged for the first time in decades. Giuliani's reformist message was particularly striking given that his opponent, the incumbent David Dinkins, the City's first Black Mayor, was seen as the keeper of the status quo.

It was clear that New Yorkers were ready (in the "mood") for Giuliani and his upbeat message. Even the most hardened New Yorkers were feeling despondent about the City's future. Within the first two years of the Dinkins administration, The New York Times ran a front-page article on its Metro Section that reflected this sense of hopelessness. The feeling was so pervasive, the article posited, that it was causing business executives

to curtail investments in local operations and expand elsewhere. Longtime residents are making plans to move far away. Some even think this new pessimism is causing consumers to spend less (New York Times, 27 December 1991).

Giuliani's message addressed this sentiment head on, which only grew stronger over time. Moreover, as the Times noted, the lack of enthusiasm about the City spanned all ages and ethnic groups. Even Blacks, who were initially optimistic after the election of Dinkins, fell into doubt. New Yorkers were looking for leadership, and as the Times story reflected, there was a strong feeling that David Dinkins was not a leader.

What people seemed to yearn for was someone who could spell out how New York can get through its immediate financial crunch and how the City can remake itself to get into a more stable, long-term footing (ibid)

Rudy Giuliani seemed made-to-order. He had a clear agenda and hammered home a message that New York City should (and would) be restored to all its greatness.

The centerpiece of Giuliani's change message was crime. Intolerable crime statistics by all accounts left many New Yorkers feeling scared and frightened on the streets and even in their homes. Giuliani convinced New Yorkers that rising crime, which had deterred both tourism and businesses in New York City, was no longer acceptable. Rudy Giuliani took this crime message to a new level. His record as a prosecutor gave him heightened credibility. He not only talked about reducing violent crimes such as murder, robberies, rapes and muggings, he gave new life to New York's Sen. Daniel Patrick Moynihan's theory that dismissing minor crimes such as "squeegee" solicitation,

which negatively impacted the quality of life in New York City but did not *risk* life, was "defining deviancy down" and tacitly condoning the proliferation of such crimes.

Rudy Giuliani, while focusing primarily on crime and quality of life issues, also challenged the conventional thinking on the operation of many city programs and bureaucracies, often claiming that, when weighed against the high cost of these services, the citizens of the city did not reap adequate rewards. Public school education and the unwieldy, unaccountable structure of the Board of Education were a central theme, as were the climbing numbers of people on welfare. A little over one year into the Dinkins administration, "the growing welfare roll amount[ed] to about one-eighth of the City's population" (New York Times, 18 September 1991). What was equally disturbing to Giuliani and contributing to the public's sense of pessimism was the message sent by members of the Dinkins Administration. According to the New York Times, "City officials. . .expressed concern that it was a harbinger of socioeconomic problems that they would be confronting for years to come" (ibid). Few were willing to criticize the welfare system or further reject its growth. Rudy Giuliani was as adamant and vocal about this failure to criticize as he was about the system itself. The climbing welfare rolls, he claimed, were unaffordable, and the dependence of one out of every eight New Yorkers on welfare totaling 1.2 million by the end of the Dinkins administration only contributed to the declining quality of life. Welfare recipients held no jobs, Giuliani reasoned, and ceased to be productive members of our society. He vowed to dramatically reverse the growth in crime in New York, overhaul the monstrosly bloated Board of Education, and the sacrosanct welfare system and to change the quality of life in the City. He was on a mission to turn New York City around.

Giuliani talked also about privatizing city services. In one of the strongest union bastions in the country, privatization was not a popular topic. But true to form, and knowing full well that no New York City Mayor had ever been elected without the help of the well-entrenched labor unions, Giuliani talked about privatization. He proceeded to take his privatization message to a place that truly stuck a knife in the heart of the entire municipal labor force, as well as many community groups and other special interests. He began talking of privatizing the sacred public hospital system: the New York City Health and Hospitals Corporation (HHC).

In the Kingdonian approach, Giuliani had long been studying privatization and was convinced it was the solution for many of the ills that plagued the bureaucracies and over-inflated municipal workforce. He also believed that it was a method for getting the unions to negotiate more seriously. Recognizing that he had to get the City's severe budget problem under control, he determined that it could never again be "business as usual" with the unions.

Giuliani's bible for reforming city government was Osborne's Reinventing Government which placed a major emphasis on privatization. He spent time prior to his campaign visiting other cities, and their Mayors, where privatization had been successfully implemented. Most notable among his models was the City of Philadelphia which had undergone dramatic change under Democratic Mayor Edward Rendell. Among Rendell's self-acclaimed accomplishments was the closure of Philadelphia's only public hospital and transference of its functions to more appropriate care settings, such as ambulatory clinics.

In a similar fashion, Giuliani met with academics and others who had promoted privatization in NYC. William Eimicke and Anne Reisinger of Columbia University wrote an article for the City Journal entitled "Privatizing HHC". They laid out the case for Giuliani. From its very beginning, the politics of the institution had taken precedence over substance. The ensuing result was a strong history of unresolved problems. The authors also laid out the best privatization options and plans for the State to take over those hospitals not privatized. Hearing his privatization message, HHC staff and managers alike began grumbling about Giuliani early in the campaign. When the Eimicke-Reisinger article appeared, many tried to reach out to him through friends and advisors to warn him that such a step could be a political nightmare. Even his soon to be Health Advisor would suggest that he refrain from calling it "privatization." As Donahue believes " privatization is not only an inelegant term; it is also lamentably imprecise" (1989, 5). Giuliani's Health Advisor and many others, however, would learn that when this determined Mayoral candidate made up his mind, it was made up. He would call it as he saw it: privatization. Political unpopularity was rarely a reason to change course. In fact, Rudy Giuliani believed it was exactly what the City needed, more people willing to stand up and openly challenge the status quo. He continued to talk about privatizing HHC throughout the campaign.

The Election and Transition

Rudy Giuliani, the Republican, won the 1993 Mayoral election by a slim margin. The circumstances under which he won were remarkable. First, he was a Republican in an overwhelmingly Democratic City. No Republican had been elected Mayor since John Lindsey 28 years before. Further, he beat the incumbent, a Democrat who was also New York City's first African-American Mayor. And Giuliani was the first Mayor to enter office owing nothing to the major labor unions. They had not helped him get elected.

Regardless of the slim margin of victory, Giuliani got the message that the citizens of New York City were ready for a change. Obviously that meant more than just a change in the individual occupying the office. It meant New Yorkers were ready for a new approach to crime, an improvement in the quality of life, better fiscal times and a much-improved educational system. But were they ready for privatization? It appeared at first that they were. The climate seemed remarkably right. As John Kingdon describes, the events discussed in the previous chapter in the "problem stream" were now coming together with the "political stream"—at a time most thought privatization politically impossible (Kingdon 1984).

The economy in New York City was in its worst state since the now notorious municipal fiscal crisis of two decades earlier. The new Mayor was facing a \$2.3 billion budget deficit in the first year of his administration, and an even larger deficit projected for the second. Many were saying that another fiscal crisis was around the corner. This was clearly a focusing event as well as a known ingredient for agenda setting in Kingdonian terms—budget crises. If the new Mayor didn't get the budget under control, the Municipal Assistance Corporation (MAC) would take over, and the Mayor would lose control of the city. That possibility was well publicized in the media, so that all New Yorkers and certainly the unions who would be effected by moves such as privatization, were on notice that drastic measures were needed and would be taken. The unions, who could obviously be a formidable opponent of the Mayor, also knew that given the dire-straits of the economy, jobs were in jeopardy regardless of the new Mayor's philosophy. And when it came to one of the largest union groups, District Council 37 (DC37), there was a willingness to work with the new Mayor. DC37 had not fared well under the Dinkins Administration, including the fact that it had endured layoffs for the first time in a long time. Therefore, the foundation had been laid for the formation of an

unlikely bond between DC37 and the Giuliani Administration. The public was also well prepared for major action by the new Mayor.

The National Health Care Landscape

In 1994 when Rudy Giuliani took office, national health reform was the centerpiece of the Clinton presidency. With so much attention by the new president and the First Lady, it appeared that a national health insurance program might finally be adopted. Comprehensive health reform had been on the national agenda several times during this century. Clinton would be the fourth President to actually submit a reform plan to the Congress for adoption (Truman, Nixon, and Carter were the others), but it seemed that never before had the issue been so front and center on the national scene. The skyrocketing cost of health care services was driving the move for reform. Fortune five hundred companies as well as smaller businesses were tired of paying health care costs that were rising at twice the rate of inflation. In 1992, the year Clinton was elected president, private and public spending on health care equaled more than what the nation (public and private) spent on all of education, *plus* defense, prisons, farm subsidies, food stamps and foreign aid (Rosner 1993, 107). Moreover, the cost of health care to employers *alone* grew as dramatically. While spending on wages and salaries rose only 1 percent between 1970 and 1989, spending for health benefits rose 163 percent (Biacentini and Anzick 1990). Despite the fact that health care spending increased from seven percent of national output to fourteen percent over the two decades prior to Clinton's election, an estimated thirty-five million Americans still periodically lacked health care coverage (Rosner 1993, 107).

The combination of rising costs and lack of access appeared to make national health reform a winning combination for the new president. However, Clinton's health reform

plan, unlike previous national health reform efforts, was aimed at keeping costs down, rather than driving them up (Martin 1993). In earlier battles, corporate America rejected the notion of broad national health reform. As Lawrence D. Brown of Columbia University aptly pointed out, "The heart of business' enigmatic role in health policy is its wish to have its costs contained without much growth in the role of government" (Brown 1993, 352). Thus, by many accounts, organized business played a crucial role in getting health reform on the agenda but, by and large, was far less helpful in advocating specific reforms (Brown 1993, Martin 1993, Peterson 1993). The fact that national health reform was at the top of the president's political agenda certainly had important implications for the prospect of privatizing public hospitals. However, the very nature of the plan, which reflected the cost reduction direction in which the health care system was moving, would also have ramifications for Giuliani's privatization initiative. The plan "borrow[ed] heavily from a market-based emphasis on private based institutions, financial and service incentives, and price and value based competition" (Peterson, 1994, 1). The basis of the proposal that Clinton chose was called "managed competition". This methodology would allow the president to move forward with a national health reform plan typically identified with liberal Democratic values in a way that was acceptable to moderate Democrats and Republicans alike. This approach caused one political scientist to say: "The objectives of 'old' Democrats are thus to be secured through the means articulated by a 'New Democrat'" (ibid.).

Managed competition simply expressed is, price competition. It is

a purchasing strategy designed to obtain maximum value for employers and consumers. It uses rules for competition, derived from rational microeconomic principles, to reward with more subscribers and revenue those health plans that do the best job of improving quality, cutting cost and satisfying patients (Enthoven 1993, 7).

By its very nature and, as the name implies, the strategy introduced competition into a marketplace that was, particularly in New York City, non-competitive. Managed competition would intentionally place strong market pressure on providers to cut costs. It further presumes that organized systems of care successfully integrate financing and delivery systems that had operated separately for years (ibid.).

Managed competition was a popular idea, but its evolution was well underway before the Clinton plan. The marketplace, driven by the desire to control costs, had already begun to adapt to new norms in the absence of legislation, and enrollment in HMOs accelerated as employers began guiding employees into managed care plans. As a result, many areas of the United States had already succeeded in slowing the rate of growth in health care costs. This was an achievement rarely seen in decades of legislative attempts to contain costs, and one that the business community embraced as a harbinger of their growing role in shaping the health care delivery system of the future. As the debate surrounding health care reform continued, it underscored public disdain for excessive regulations as well as individual support for physicians and services. As such, while the health debate lingered on, managed care arrangements continued to evolve as purchasers of care relentlessly pursued market driven initiatives to control costs. In addition, market-savvy managed care companies began to address consumer desires for choice and developed products with multiple options for the range of coverage and point of service, allowing many enrollees to choose their doctor while remaining in an HMO. Obviously, this type of managed care plan was more expensive and thus not an option for everyone. It did, however, cut to the core of much of the opposition to managed care among a more "elite" group of influentials, and still managed to contain costs because of controls in the system such as the requirement of second opinions and necessary referrals.

The key players in the system were smart enough to see the handwriting on the wall. Health reform or not, the system was changing and cost cutting and competition were at the core of the change. Further, the once dominant medical profession, while still strong, was no longer enough to stop the progress of change as it had done so often in the past. While the old, traditional fee-for-service system held that the "authority over health policy was in the hands of the medical profession," the health care marketplace was changing regardless of protests from the medical profession or legislative debates (Marone 1993, 73). Moreover, it seemed that while the public was not inherently resistant to managed care as once had been thought, in fact resistance to governmental intrusion was once again appearing to take hold (Iglehart, 1995, 6). Even those convinced that governmental reforms were essential recognized that public sentiment could derail policy makers (Blendon, Brodie, Benson 1995, 12). It was becoming obvious that the entire health care delivery system was changing and that managed care was the agent of change. However, managed care evolved without a framework for managed competition. Managed competition is a system in which managed care plans are able to compete, based on price, quality, and service in the absence of patient risk. Without an overarching mechanism to adjust for extreme differences in patient risk, health plans must compete based on price and market share and they must take into account the health care risks of their potential enrollees. Without this overarching mechanism, market competition among health plans takes on very different characteristics than that envisioned by Enthoven, Elwood, and others. Enthoven and Elwood, for example, had a new vision for managed care that they thought could only be brought about through the managed competition among managed care plans.

Despite the fact that the original architect of managed care, Paul Elwood, was influential in the President's managed competition approach to health reform there were, in reality,

differences. One difference in particular would have a dramatic and fast moving impact on the New York City health care delivery system. Managed care, because of its more free market competition, forced the implementation of fully integrated delivery systems. That is, while the major hospitals might still control the marketplace, they could only do so by buying up, merging or otherwise incorporating into their newly formed networks, the whole spectrum of health care delivery services. That included health care services such as primary and preventive care, secondary and tertiary hospital care, and all the way across the spectrum to home care and long term care services. The only successful way to compete for managed care contracts was to provide the full array of health care services because it allowed a particular provider to give a discounted cost to the managed care companies whose major criteria, at least at that point in time was low cost. That was the driving force behind the mega-mergers of the health care system in New York City that would rapidly take place over the ensuing five years. Managed care created an element of competition that "managed competition" would not and one that had never been seen before in New York City. It also had the obvious effect of putting unprepared or less efficient hospital systems at a severe disadvantage. Clearly, HHC was one of the systems at a competitive disadvantage.

At the same time, optimism for the prospects of passing a national health reform proposal remained, managed care plans of all types were witnessing extraordinary growth throughout the nation. When Rudy Giuliani took office in 1994 there were over 50 million Americans enrolled in managed care plans, over half of the employed, insured population. By 1995 more than 95 percent of all health insurance plans would require an approval process for services in order to manage the care of enrollees. This was a stunning increase given that in 1988 only 29 percent of people insured by employer-sponsored plans were enrolled in managed care organizations (Davis et al. 1995, 100).

The New York City Health Care Delivery System: 1993-4

The New York health care community knew that despite the lag in managed care penetration in New York City, managed care or managed competition was on its way to New York. Hospitals were the dominant providers in the New York market and they were sophisticated enough to realize how the new competition would effect their marketplace. Experience around the country was instructive. An examination of managed care in the Twin Cities revealed the reason for the growth in managed care. When consumers there were offered a choice between paying higher premiums for unrestricted access to providers or lower premiums for "managed access" that restricted access, "a majority chose lower premiums and managed care" (Christianson, et al. 1995, 114). Researchers suspected this outcome, but were surprised with the study's secondary finding that providers as well as consumers were affected. The study suggests that

providers will respond to greater organization in the demand side with greater appreciation and organization of supply...Consolidation of providers could benefit consumers by reducing excess capacity and promoting efficiencies in service delivery (Christianson, et al. 1995, 128).

The onslaught of managed care was changing the provider community from all perspectives. To be sure, physician control of health care delivery had been turned upside down. Nationally, changes in the delivery system resulted in a dramatic increase in physicians as salaried employees, and a concomitant decline in the traditional solo practice model of delivering services. Other national trends reflected an increase in provider efficiency, with implications for the entire industry. Reflecting the experience of the Twin Cities, hospitals and providers had begun merging and consolidating in those markets with heavy managed care penetration. As a result, those markets began to see considerable decline in hospital patient days as well as lengths of stay. And in fact, as a

result of the frenzy of consolidations, other forms of integrated health care networks emerged (Davis, et al. 1995).

Parallel with the federal reform movement, the nation's states as well as the private sector were rapidly transforming the system. The acceleration to managed care nationally was no longer dependent on the federal government. By 1995 over fourteen states would be granted, or applied for, waivers from federal laws governing the expenditure of federal Medicaid dollars: these waivers primarily allowed states to require recipients to enroll in managed care plans. Between 1993 and 1994 there was a 63 percent increase in enrollment of Medicaid eligible individuals in managed care, from 14 percent of eligible individuals enrolled in 1993 to 23 percent enrolled in 1994. As the Wall Street Journal noted,

long outcasts of the nation's health care system, the poor are suddenly a hot commodity. State governments, battered by soaring Medicaid budgets, are rushing to move welfare recipients into managed care programs, where Corporate America already is realizing significant savings (Wall Street Journal, 12 April 1995).

Under the managed care banner, hospitals in the traditional single-institution mode were having trouble remaining financially viable. The old practice of cost shifting to private payors to offset losses by Medicaid and Medicare revenue was no longer possible as managed care companies demanded deep discounts from the hospitals. According to one researcher, payments to hospitals from the private sector decreased by as much as 30% during that several year time period (Serafini 1995).

In New York City, the managed care bandwagon arrived late, but it arrived furiously, hitting hard at the long entrenched status quo of America's teaching hospitals. In addition to the private sector moving increasingly toward managed care as a way of

curbing costs, the local government was looking to managed care to reduce the ever-growing cost of Medicaid. The New York State legislature passed a law in 1991 mandating that 50% of Medicaid patients be enrolled in a managed care plan by January 1998. New York City began a voluntary enrollment program and in 1992, implemented a mandatory enrollment demonstration program in Southwest Brooklyn. This unfamiliar, yet dramatic move to a competitive health care environment—including speculation that the New York State government, under a scenario where there may be a new, Republican governor would move to deregulate the hospital payment system in place since 1981—placed tremendous pressure on New York's public health system.

Despite the rapid changes, New York City still lagged behind all major cities in HMO enrollment, with only 14.7 percent of the population enrolled compared to Los Angeles with 35 percent, San Francisco with 39 percent, Philadelphia with 29.4 percent, and Chicago, with 21.8 percent enrolled in managed care. New York City had a correspondingly higher hospital occupancy rate and longer average length of acute care stay compared with the rest of the nation. Length of stay in New York City in 1994 was 9.9 days versus 6.9 in Los Angeles. And New York City had nearly three times the number of hospital inpatient days per 100,000 population as California. And a United hospital fund report, "Hospital Trends New York City 1983-93", cited as the most striking feature of its review of hospitals in New York and around the country--the "sharp contrast between the City and the rest of the country" (Krasner and Heisler 1995, 2).

Despite the vast difference between New York and the rest of the country, managed care was taking hold in the City faster than anyone would have believed. Accordingly, the national experience was repeated in New York City. Hospital providers in New York City moved to make the necessary changes in their systems in order to compete

successfully in the new world of managed care. Hospitals began to consolidate and form major networks in order to improve efficiencies. The major teaching hospitals were buying, merging or joint venturing with smaller hospitals in and around New York City in order to capture market share. The smaller hospitals were *willing* to be bought or merged with the larger institutions. The experience nationally demonstrated clearly that smaller community hospitals, individually, didn't have a chance of surviving the fiercely competitive world of managed care. Efficiency and market share were the buzzwords. Without them providers would be out of business.

In addition to the "merger frenzy" that was taking place, hospitals were reducing their lengths of stay, that is, the length of time any given patient would remain in the hospital was declining precipitously. In fact, the trend was to reduce hospital admissions overall and move patients to the outpatient setting. More and more surgical procedures for example were being done in those outpatient settings, and there was a corresponding growth in home care. Thus hospital occupancy rates were dropping and the New York health care delivery system was beginning to look more like the rest of the country. The speculation at that time was that utilization of hospital services would drop anywhere from 15 percent to 60 percent and occupancy rates up to 70 percent (Mitchell 1995). The outlook was that the City would see a reduction of 8,000 acute care hospital beds (Health Systems Agency 1996). That number was exactly the number of hospital beds in the HHC system.

As the new health care delivery system developed, there was another trend that would have a tremendous impact, on HHC in particular. The City's voluntary hospitals that once shunned Medicaid patients were now actively recruiting those patients. With the growth of Medicaid managed care, payment to hospitals for those patients grew substantially.

Moreover, when offered a choice of hospitals the Medicaid population was overwhelmingly choosing the voluntary hospitals. A study by the Health Systems Agency (HSA) of New York City revealed that between 1988 and 1992, Medicaid hospital admissions citywide rose by 86,000. Of those admissions, 92 percent were to voluntary hospitals while only 3 percent were to HHC hospitals (Gumbs 1993). Perhaps an even more remarkable shift was occurring. The quest for new patients led voluntary hospitals to actively pursue other patient populations that they formerly eschewed, such as psychiatric patients. Obviously now attractive because of a generous reimbursement rate, the psychiatric beds in the voluntary system increased by 12 percent, while at HHC psychiatric beds grew by only 2 percent (Report of the Mayoral Advisory Panel on the Future of HHC 1995).

These trends would continue over the course of Giuliani's tenure, however, the changes by his second year in office, were dramatic. An HSA report would actually refer to the changes as "traumatic." The report said the following:

New York's health care system is at a critical juncture. Managed care enrollment growth, network development, budget cuts, and other changes in the financing and delivery of health care services are causing precipitous drops in New York City's average length of stay and hospital occupancy rates. This situation threatens the financial viability of many local hospitals--particularly those that serve the City's low income communities . . . the HSA of New York projects that New York City could lose a third or more of its . . . acute care beds by the year 2000. Up to half of the City's existing medical/surgical beds may not be needed by the year 2000 (Health Systems Agency 1996, 1).

While it was a challenging time for the best of hospitals, it was particularly difficult for the public hospitals of HHC. The combination of changes in the marketplace, and the promise or the uncertainty of national health reform, presented HHC with an unusual dilemma. On the one hand, national health insurance would mean the loss of HHC's *raison d'être*. Absent health reform, the competitive environment was stripping HHC of

its major payer base—Medicaid. Either way HHC would now have to compete aggressively for patients, something it was ill prepared to do. Even the National Association of Public Hospitals (NAPH) wrote at the time: "Imminent health reform, as well as the many changes already occurring in the industry, necessitate a change in the way many public hospitals operate" (National Association Public Hospitals 1993).

National ferment around health reform suggested two distinct prospects for the privatization of public hospitals in New York City. First, the voluntary hospitals in New York had historically depended on the public hospitals to take care of the City's indigent population. Therefore the voluntary hospitals, particularly the major academic teaching institutions, could be a major force against privatization fearing they would be burdened with caring for the uninsured. But with health reform looming, that fear seemed to be dissipated, at least for the moment. Moreover, a program that assured care for the indigent would have further positive implications for privatization. There would be a whole new pool of patients with health insurance. While uninsured, these patients traditionally relied on HHC for their care. They would now, however, be presented with choices of service providers. For the voluntary hospitals, privatization was an increasingly attractive option; the public hospitals would provide a new avenue to expand their already growing networks. Moreover, even without national health reform, managed care was driving the system and the successful hospitals in a managed care environment would be those with the broadest, insured population base. HHC hospitals could provide the voluntary hospitals the expanded networks for that necessary market share. This would ultimately become a key factor in the success of Rudy Giuliani getting hospital privatization high on the agenda. Without the willingness—which stemmed from competitive need—for voluntaries to participate in the privatization process, there would likely be no privatization.

Secondly, the health care system's experience with the Medicaid population in New York City over the prior five to ten years, could be regarded as a reliable predictor of the outcome of national health insurance and how it would effect the health care delivery landscape. As cited above in the Health Systems Agency study, as payment to hospitals for Medicaid patients grew, that population became more and more desirable, so much so that the voluntary hospitals were aggressively competing for those patients. Now the unthinkable was happening. The public hospitals would have to actively compete for the once uninsured. In fact, they had already begun advertising to lure their traditional payer base, Medicaid, back into the fold.

If HHC were not successful in marketing and competing, HHC's sole market would be the non-paying patients left in the system viz. illegal immigrants. Given HHC's aging physical plants and its poor track record in keeping the Medicaid population, prospects were not good. In the new environment HHC was at a clear disadvantage. In the new highly competitive delivery system, efficiency would be paramount. But HHC was notoriously inefficient.

HHC already lagged far behind the voluntary hospitals in its effort to enroll patients in its Medicaid managed care plan. This was a telling result of HHC's poor management. HHC had a clear advantage at the outset with regard to Medicaid managed care. Not only did it serve 40% of the Medicaid patients in its system, HHC already held a licensed HMO left over from its earlier demonstration project--Citycaid, which was discussed in Chapter Two. Despite these advantages, up until mid 1995, HHC enrolled only 10 percent of the Medicaid managed care clients in the City. Moreover, HHC's Medicaid

admissions rose only 2.3 percent from 1988 to 1992 while voluntary hospital Medicaid admissions rose 50.5 percent during the same period (Gumbs 1993).

By most objective measures of hospital efficiency, HHC was under-performing compared to most of its voluntary counterparts. Occupancy rates were at an all time low. From a high of 91 percent in 1988 they were down to an average of 78 percent in 1994. Overall admissions to HHC dropped 10.3 percent while overall admissions to voluntaries rose 4.5 percent (Gumbs 1993). The system's acute care discharges, probably the most significant indicator of a hospital's financial health, had steadily declined since FY87, a 14 percent drop. There was a 7.5 percent decline in discharges from 1992-93 alone. In addition, a 1993 HHC case mix analyses revealed that much of its inpatient treatment could be done on an outpatient basis—a critically negative finding under a managed care scenario, meaning that HHC was ill prepared for managed care. Indeed, it was this data that led the Barondess Commission to report in 1992 that "a number of long-standing key institutional and organizational constraints have inhibited the ability of HHC to function as a competitive and uniformly high quality health care provider" (Barondess 1992).

These data, which reflected poor management and had serious financial implications, were only part of the story. As discussed in Chapter Two, during this "pre-Giuliani" period, quality indicators also revealed serious trouble in the massive public hospital system. In addition to the fact that five of eleven acute care hospitals failed to achieve full accreditation between 1989 and 1992, Woodhull Hospital had been refused JCAHO Accreditation twice in the prior six years for poor care and management failures. Other chronic problems in quality continued to plague HHC. Waiting times at HHC clinics were up to forty days for prenatal visits, while at several facilities it took six weeks to sixty-

three working days-almost a full trimester-to receive an initial prenatal visit, and three-four months for a first gynecological visit (Report to the Mayor on the future of HHC 1995). While these problems had serious implications for the patients served (or not served) by the HHC system, they also meant trouble for HHC under a managed care system. New York State law mandated times within which patients were to obtain appointments. If they were not met, the state would close Medicaid managed care enrollment to that provider, meaning a loss of revenue to that provider as well as corresponding loss of confidence in that plan by its patients. Loss of confidence in the marketplace obviously translates into a decline in business as well. HHC would have to close its enrollment at least twice over the ensuing three years.

Capital projects were another ongoing source of problems. During the several years prior to the election of Giuliani, most of the large capital projects at HHC faced major deficits and missed completion deadlines. The most notorious was of course Kings County, discussed in Chapter Two, where there was an expenditure of \$119 million, the project was halted, and there was almost no progress on-site. The disastrous Kings County capital project was not insignificant in helping Rudy Giuliani make his case for hospital privatization. Adding to the Kings County Hospital debacle, other major reconstruction projects also presented serious problems:

- ❑ Construction of the Brooklyn Long term Care Facility was \$6 million over budget
- ❑ Remodeling Jacobi Hospital's ambulatory surgery service was thirty months late and \$1 million over projections
- ❑ Renovations of North Central Bronx Hospitals neonatal delivery rooms and OB/GYN services were running three years late
- ❑ Harlem Ambulatory Care Project was far behind schedule

- Modernization of Elmhurst Hospital center was \$65 million over its original budget and two years behind schedule (Report to the Mayor on the Future of HHC 1995, 9-10)

HHC's other key problems competing in a managed care environment included the following:

- Overstaffing at HHC facilities: after factoring in HHC's greater outpatient volume, J.P. Morgan, in its analysis of the system, found that full time employees at HHC facilities were significantly higher than the average of the peer group.
- Poor financial performance. HHC experienced a negative \$231 million in operating cash flow in 1994 prior to the City subsidy, meaning that HHC facilities were not generating sufficient operating revenue to pay for current capital and were unable to fund plant replacement. (This was a particularly sensitive issue in a time when the City was experiencing huge budget shortfalls—\$2.3 billion in 1994 and \$2.7 billion in 1995).
- Affiliation Contracts/Inefficient management. HHC often failed to hold the affiliates accountable in meaningful ways for the quality of their services or the productivity of their service delivery. HHC was spending about \$500 million annually and only half went directly to patient care, the remainder to affiliate administrative costs and research
- On average, HHC visits per provider were 2,500 to 2,800 annually, compared with the national HMO standard of 4,000 visits per provider per year (Mayoral Advisory Panel for the HHC 1995, 11).

To be sure, HHC was seriously disadvantaged in the fiercely competitive operating environment. Coupled with the fact that HHC was in a non-competitive position, the

ensuing two years would bring even harder times for the Corporation. The ultimate failure to achieve consensus on national health reform in 1994 forced governments with reduced resources at every level to assume responsibility for controlling costs. [Health expenditures were an obvious place for all levels of government, even New York City, which unlike other municipalities paid a full 25 percent of the Medicaid tab (2.3 billion in 1994).] The Medicaid program, for example, had become a growing burden to governments: over the past decade costs more than quadrupled, from \$31 billion to \$131 billion (U.S. General Accounting Office 1995, 18).

The fiscal situation of the city, along with an equally disastrous financial picture at the state level, deprived HHC of its traditional ability to rely on City subsidy. Further, the threat of significant cuts to Medicaid, the financial staple of HHC, was looming very large. And only two years after the first discussions and the optimism of Bill Clinton's national health reform effort, the federal scene would change dramatically as well. The Congress of the United States would shift to a Republican Congress for the first time in years, and there was no more talk of health reform. Rather, the discussion shifted to the enactment of block grants for Medicaid, and the New York hospitals were sure losers under such a scenario. The federal government's goal was to cut Medicaid spending at the federal level. Given that New York had one of the largest Medicaid budgets in the country, it was clear that New York would be hit hard under any block grant scenario. This only further increased the competitive furor among the voluntary hospitals, adding to the positive reception of privatizing HHC's hospitals.

In summary, the national climate as well as the condition of HHC at the time Giuliani took office contributed greatly to making the possibility of privatizing one or more of its hospitals a reality. But certainly, events during the very first weeks of the new

administration were paramount in setting the stage and tone for the privatization effort and the ensuing debate.

Facts emerged at the opening weeks of the Giuliani administration that demonstrated all too clearly the fundamental flaws in the then \$3.6 billion bureaucracy. The key events were: several days into the administration, a \$166 million-dollar deficit was discovered at HHC, a fact that had been withheld during the transition. To make it worse, when it did come to light, the President of HHC and a Dinkins holdover made it clear that he expected the City to make up the deficit. Apparently, part of the problem stemmed from an incumbent City Hall's free spending on initiatives during an election year (Brecher and Spiezio 1995).

Neither the fiscal state of the City nor the new Mayor's intolerance for inefficiency would accept the idea of the City picking up HHC's tab. Such firmness on the part of City Hall would send a powerful message to the rank and file of HHC, as well as to its Board, still controlled by Dinkins' appointees. It was the first time in HHC's history that a Mayor had done such a thing; and it was apparent to those at HHC that it was no longer business as usual. The episode also marked the beginning of a profound estrangement between HHC's Board and the Mayor as well as the emergence of an embedded hostility within the ranks of HHC toward the new Administration.

This enormous budget deficit exposed two basic flaws in the historic management of HHC. First, there was constant overspending with an expectation that the City would make up the difference. Because the City was ultimately accountable for HHC, management at HHC was never forced to manage effectively. Even though HHC was a health care system of last resort for the uninsured, it had a sufficient budget allocation

and revenue stream to operate appropriately. However, HHC rarely managed within its resources. The second phenomenon demonstrated by overspending was that HHC was frequently exploited for political purposes. The Dinkins Administration had used HHC's resources and spending flexibility for political purposes during an election year (while HHC has to live within certain spending caps without needing the approval of the HHC board, it is not subject to anywhere near the same spending restrictions as city agencies). Most Mayors before Dinkins had done the same. In fact, one of Giuliani's biggest complaints about HHC was that it was used as a jobs program for political patronage, a fact never really disputed because it had been so broadly accepted.

Another startling fact, a "disastrous focusing event" (Birkland 1997), that came to light during those first weeks was the gross mismanagement of the rebuilding of Kings County Hospital Center in Brooklyn. As discussed earlier, nearly \$120 million dollars had been spent with little to show but a gigantic hole in the ground. It made great press, and the new administration used it to its advantage. The story was on the front page of the New York Times on February 11, 1994, providing the Giuliani administration with yet another very public example of the ongoing mismanagement of HHC. Again, the Kings County issue served to highlight HHC's historic and seemingly fundamental management problem. It was clear that politics had again interfered with the substance of the work at hand. It was impossible for such run-away check cutting to have occurred without the approval of the HHC Board. Certainly the Board was responsible for monitoring progress on a project for which it was authorizing such massive expenditures. Accordingly, it was impossible for even the most virulent foes of the Administration to argue with the moratorium that the Mayor imposed on the rebuilding of Kings County.

The very serious problems at HHC that were exposed to public scrutiny within the first month of Giuliani's term only gave more credence to the criticisms the Mayor had leveled against HHC during the campaign. He brandished the derelictions as his major reasons for privatization, and as an optimal solution for dealing with the problems that had long plagued the public hospital system. He talked about HHC as a patronage mill and a jobs program, but he also talked about the poor quality of care provided, demonstrated by the loss of accreditation at so many of the HHC hospitals. The confluence of these events was making the Mayor's case.

While it was clear that such severe problems at HHC warranted a solution, there were distinct and fundamental differences among the policy community, advocates and other policy actors about the ideal solution. Rudy Giuliani, however, clearly articulated his ideal solution--privatization. Given the long-standing indecision about rectifying the problems at HHC, Giuliani's privatization message was actually welcome in some circles. And, demonstrating that the proverbial "window had opened", there was an air of reluctant acceptance even among the most would-be ardent opponents of privatization.

As Birkland points out "problems and proposed solutions move higher and lower on the agenda as a result of conflicting interpretations of facts and trends and with changes in the ideological tastes of the electorate. More 'liberal' electoral trends lead to periods of more extensive governmental activity, while more 'conservative' periods lead, perhaps to a retrenchment of government and, perhaps, to a reduction in the number of tasks government undertakes. These trends may take years to be recognized and even longer to have an influence on policymaking, and in these cases it is difficult to identify one or a few points in time as critical in the life cycle of these issues" (Birkland 1997,1).

It is clear from the last three chapters that one of those unusual, critical junctures in policymaking had occurred. There was a distinct national shift toward the more conservative agenda. Health care delivery was becoming more competitive than ever before, putting the municipal hospital system in grave jeopardy. The fiscal state of New York City, as well as that of New York State mimicked most states and localities around the country and were in perilous condition. Years of "softening up" had occurred both in the area of privatization as well as in the area of the historical problems of HHC. Finally, there were a number of clear, and unusually severe, focusing events at the end of the Dinkins administration. With the culmination of all of these agenda setting characteristics, along came an elected official who had both the will and tenacity to further his vision for the future, a vision that would have been unthinkable only a few short years before. The time for Rudy Giuliani's "idea" for privatizing HHC hospitals seemed to have arrived.

CHAPTER THREE

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CHAPTER FOUR

THE NEW YORK CITY HOSPITAL PRIVATIZATION

"The desire to understand the world and the desire to reform it are the two great engines of progress, without which human society would stand still or retrogress."
Bertrand Russell

In the classic text, Governing New York City, Sayre and Kaufman discuss the frustration of leadership in New York City, and while they admit that leadership is difficult to define, they propose two elements of successful leadership. They are: 1) the coordination of the system and 2) the main responsibility for innovation (1960). Coordination of the system refers to assuring that all facets of the system and its operations are appropriately related in order to avoid conflict and confusion. Innovation, on the other hand, is imperative so that the system does not become obsolete or lose its efficacy and relevance for its time. The authors contend, however, that "neither of these elements appears to be promoted by the multicentered system of politics and government in New York, and they may, in fact, be positively discouraged" (Sayre and Kaufman 1960, 720). While much about New York City has changed since this classic was written nearly forty years ago, their words remain insightful and relevant.

This chapter tells the story of the leadership of Mayor Rudolph Giuliani in taking responsibility for innovation in a city that was by most accounts bereft of innovation. It provides an accounting of the struggle and the unwillingness of the participants to be "discouraged" by the system Sayre and Kaufman describe. They were intent on privatizing several of the municipal hospitals in an effort to save institutions that were on their way to becoming obsolete in a rapidly-changing health care delivery system. As Kingdon reminds us, however, the policy making process is not under the control of any

particular policy entrepreneur, rather, the process is often controlled by events and structures (1995, 225). This story will detail the Giuliani hospital privatization process and portray how the individuals involved tried to anticipate and bend with the events and structures that would often attempt to control the process.

In telling the policymaking process of the HHC privatization, it is important to characterize the mindset of the administration in those early days and to depict the goals that guided the privatization effort. It is not difficult in reviewing the complex analyses for one to lose sight of the objectives that drove the process, just as it was easy for outsiders to lose sight, or obfuscate, those goals as the process unfolded. Donahue quotes Abraham Lincoln as he outlines the objectives of privatization. Lincoln said "The legitimate role of government is to do for a community of people whatever they need to have done, but cannot do in their separate and individual capacities" (1987, 17). Donahue then goes on to question how we know what the right arrangements are, or when will we know to strike the right bargains (ibid. 17)? As is argued in the previous chapters, HHC was a system in failure, and commission after commission had bemoaned the shortcomings of the municipal hospital system. The history of health care in New York City (and the lessons learned from the effects of policy making during other times of fiscal crises) illuminated those issues that are important for the people of New York to "have done for them." That history also provided some guidance in how to go about "striking the appropriate bargains." The historical perspective was instrumental in developing the HHC privatization goals.

For the purpose of appreciating Mayor Giuliani's motives with respect to HHC privatization, it is instructive to note at the outset of this case study that Mayor Giuliani entrusted his administration's health policy initiatives to a clinical health care

professional, a pediatric nurse practitioner. She was the first nurse to have held such a position in the City of New York. Most previous mayors appointed Health Advisors who were not health care professionals at all. It is significant that he designated a nurse, in that nurses are, by training, patient advocates. Thus she brought the clinical background and the patient perspective that was important to understanding and maintaining the objective of improving patient care through the privatization effort. This was a key factor in appreciating the privatization initiative in that the Mayor could have easily delegated this responsibility to a financial advisor or other policy expert. Rather, it was to a nurse who understood the HHC system and the importance of advocating for the patients involved, as well as someone familiar with the New York City health care system and politics overall that he entrusted his initiative. As it will be described in the coming chapter, the association of the Mayor's Health Policy Advisor with nurse/patient advocates was diluted as the privatization debate intensified. It is, however, an important contextual factor in comprehending the relevant dynamics.

The administration's goals in privatizing the HHC hospitals then were to:

1. Above all else, retain the same level of access to care for the uninsured population.
2. Improve the quality of care at the privatized hospitals.
3. Assure that any privatization arrangement achieved favorable financial terms for the City and HHC.
4. Retain some kind of public accountability by the privatized entity, and a method to objectively measure improved performance.
5. The privatization solution had to be politically acceptable.

The Privatization Analysis Begins

Against the backdrop of a dramatically changing health care delivery system and a City in fiscal and management chaos, Giuliani's chief Health Advisor began to analyze the options for privatizing the public hospitals. Giuliani made it clear in the discussions central to her being hired, that the responsibility was a priority for him, and a major focus of the Health Advisor's job. Mayor-elect Giuliani had articulated clearly to her his desire to change the system. He believed that patients were the biggest losers in the system, and the City was spending countless millions of dollars on a system that by all objective measures wasn't working. Giuliani believed that New York possessed some of the finest hospitals in the nation and that the City should look to talent such as theirs. That is, turn to the professional private hospitals to help salvage the dismal failure that had become HHC. He also theorized that HHC was an anachronism. It was no longer necessary to provide the bricks and mortar and actually run the operations of a mammoth delivery system to assure that the poor were cared for. A responsibility that the New York City municipal government had taken on a century ago, a responsibility larger than any municipality in the nation, was no longer relevant in 1993. A more modern financing approach could assure the same outcome of caring for the uninsured. Giuliani's Health Advisor, despite a history of working in, and supporting the public system, agreed. Time had demonstrated too clearly that the structural flaws in HHC and the political winds that drove the public hospital system had, despite the best intentions and years of hard work, destined it for failure.

A problem that existed from the outset was that no one in the administration ever really defined the type of privatization that should take place. As is made clear in the privatization literature, there are many kinds of privatization. For example, there is outright sale of an asset, with complete termination of control over the asset or its

functioning. There is a contract. There is a lease arrangement. However, there really was no good guide to determine the best alternative for privatizing HHC. The one real consistent message in the literature or in anecdotal information from other cities that had completed privatization initiatives was that government should retain some kind of monitoring ability, at least for some period of time. There were no truly useful hospital privatization initiative models elsewhere in the country, as there is no comparable public hospital system in the country. Although the National Association of Public Hospitals had at that time just published a document describing how many public hospitals were reconfiguring into private models, many of those models were evolving into an HHC-like system—as the City of New York had done some thirty years before. Nevertheless it was determined that between 1983 and 1994, 128 public hospitals were “privatized” in some fashion. That is, they entered into various arrangements such as joint ventures with not-for-profit or for-profit hospitals and others as discussed in Chapter One (National Association of Public Hospitals 1995). Moreover, most of those examples were the single public hospitals in a major City that didn't have anywhere near the large constituency that HHC would have in New York City.

Giuliani's Health Advisor conducted her stewardship of the privatization effort with one unshakable criterion—whatever type of privatization model was ultimately chosen, there had to be an enforceable commitment that the uninsured would be cared for. Most of the public fears surrounding privatization concerned the loss of access to health services by the poor and uninsured. The Mayor resolved that diminished access was not acceptable. That principle remained.

The goals had been discussed publicly and privately by the Mayor during his campaign. Beyond that, his Health Advisor spent time reviewing the privatization experience around

the country and receiving input from various constituents around the City. The goals were: first and foremost, full access for the uninsured, second, improved quality of care, third, favorable financial terms to the City and HHC, fourth, regardless of the alternative chosen, some kind of public accountability by the privatizing entity, and a method devised to objectively measure improved performance, and finally, a politically acceptable situation. For example, there were some hospitals that had labored under poor relationships with their medical affiliate, which would make it very difficult for that affiliate to take over the institution. Despite the substantive reasons such a take over might make sense, the strained relationships would make such an effort impractical to even think about. There were other hospitals or communities that wouldn't give privatization any chance at all, regardless of the merits.

The Mayor's Health Advisor had worked at HHC some ten years prior to her joining the Giuliani Administration. Her experience benefited the privatization process in several ways. Number one, it gave her a real basis for comparison. One simply couldn't evaluate an organization as well on paper as knowing it first hand. Secondly, she had retained relationships with many former colleagues who still worked at HHC, thus giving her more and better information than was generally available to City Hall. There was an historic lack of trust between HHC and City Hall, and giving incomplete or no information to "The City", as HHC insiders refer to it, was not uncommon. Ironically, even Giuliani appointees to HHC were caught up in its culture and would eventually sabotage the flow of information to City Hall. The biggest stakeholders in keeping HHC from being privatized were certainly those whose jobs at HHC depended on a sprawling bureaucracy.

Her former relationships also allowed the Executive Directors of the various hospitals to go directly to her with their thoughts on the privatization issue. What people often did not appreciate was that many individuals who ran HHC hospitals were anxious for them to be privatized. For years they had been complaining that the central HHC bureaucracy kept them from running their hospitals in the most effective way. Obviously it would be easier to privatize a hospital if the hospital administration were supportive, so these discussions with the various Executive Directors assisted the Health Policy Advisor in making choices. The Executive Directors of Elmhurst and Coney Island Hospitals both aggressively pursued the Health Advisor about privatizing their hospitals. Coney Island Hospital was always an obvious candidate. Even during her prior tenure at HHC there was talk of spinning off Coney Island Hospital. It functioned very much like a community hospital, and its Executive Director was always one of those who claimed it was exceedingly difficult to do his job working within the constraints of HHC's Central Office. Elmhurst, on the other hand, was chosen because it was well into a major reconstruction project, which would make it virtually a new hospital, and recovering the capital resources expended on it would be a tough problem to work out. Despite the outstanding debt associated with Elmhurst Hospital, the new building would also be attractive to potential buyers.

During her first weeks in office, the Health Advisor held a meeting with most of the deans of the Medical Schools in NYC and a number of hospital heads. The Mayor had met with them during the campaign and they wanted to know the Mayor's plans for privatization. There was no shortage of interest, yet a frequently asked question in those days was "who would want one of these hospitals?" These discussions obviously informed the decision making process. The Health Advisor needed to know for a fact that there were potentially interested parties.

Three months into the new Mayor's term, the Health Advisor was ready to recommend to the Mayor which hospitals should be privatized. In reaching her recommendations, she had consulted with elected officials, and reviewed bed need analyses around the five boroughs. The latter was important because, at the time, New York City had far too many hospital beds, in large measure owing to the rapidly progressing trend toward managed care, as discussed in Chapter Three. She had carefully analyzed the marketplace, the players, and community need. The conclusions reached were that HHC was over-bedded and financially unable to support the level of services of eleven acute care hospitals. Other not-for-profit hospitals would find these hospitals attractive as they sought expansion opportunities in the marketplace. There was also significant discussion with key decision-makers in City Hall to determine the best hospital privatization route to pursue.

A complicating factor was that the hospital privatization initiative was not being controlled out of the office of the Mayor's other Senior Policy Advisor, who was in charge of all of the other Mayor's privatization initiatives. At times, the Mayor's Senior Policy Advisor sought to take control of the HHC initiative, adding to the complexity of final decision making by the Mayor. Further, the new HHC President also made efforts to take control of the process. (It was probably a legitimate concern for either of them to see that from their perspectives the control might lie with either of them.) In fact, it's possible to make an argument in either case. The Mayor himself had, however, decided otherwise. Privatizing a hospital was very different than privatizing a public radio or television station, the other two big privatization efforts at the time. The hospital privatization effort required someone who knew and understood the very complex health environment and delivery landscape. That eliminated the Senior Policy Advisor as the chief architect.

While he may have had many talents, and a good understanding of reinventing government, he did not know the health care system. As for the new HHC President, who had spent the prior year as Commissioner of Health in the State of New Jersey, he was a medical doctor and knew and certainly understood the larger health care system. However, he was quite young and new to New York City and to HHC. Learning to run and manage that system alone would take all of his time, particularly since he had no experience in running a delivery system. There would also be an inherent difficulty in trying to privatize a system that he was simultaneously trying to manage and control. After all, a successful privatization effort would lessen that individual's domain, and in a political environment, giving up power was not something that too many people do willingly. Consistent with Kettl's philosophy on privatization it is also important for government to know what its buying, "the lack of a smart-buyer capacity trades off important public interests for private interests" (1993, 17). Knowing the New York City health care system and the players put the Health Advisor in the position of being a smarter buyer. The Mayor also believed strongly in competition. It would become clearer over time that he believed that the "cream rises to the top." If there was competition among his key people, it might have very well been that he believed that would produce a better outcome. Certainly that is a management style of many good political leaders, including FDR. It was not without its frustrations.

The Health Advisor knew that if the project were to go forward, there would have to be consensus on direction by all of the key City Hall players. Those players included the Director of the Office of Management and Budget (OMB), the Corporation Counsel, the Senior Policy Advisor, and the Deputy Mayor for Operations. The President and the Chairman of HHC were necessarily part of the process of the administration. The internal discussions went on within the top ranks of City Hall and consensus seemed to

emerge with agreement on a final recommendation. In those last discussions, the participants found it instructive to look at the historical problems that plagued HHC. In particular, the parties to the deliberations pointed to the Piel Commission Report that had made the original recommendation to then Mayor John Lindsey to create the quasi-public Health and Hospitals Corporation. Many of the 1965 Piel Commission's findings of problems in the public hospital system still existed at HHC. This helped make a strong case, as had already been made by others that HHC was unable to sustain any long periods of doing well, or finding long term solutions to historic problems (Brecher and Spiezio 1995).

Both the Health Advisor and the Deputy Mayor for Operations believed it was important to have swift progress on the Mayor's privatization initiative. Moreover, as Kingdon emphasizes, a chief executive's resources are "never greater than at the beginning of an administration...if that policy opportunity is not seized...it disappears and advocates must wait for the next window to open" (1995, 211). The only option that could be successfully completed within the first year of the Mayor's first term was a management contract. Moreover, a former Deputy Mayor had also advised the Health Advisor that whatever was going to be done should be accomplished in the first two years of the Administration, because after that time they would be back into an election mode and all policy initiatives become politically difficult, if not impossible, to implement. Accordingly, consensus was reached to seriously explore the idea of a management contract. While a management contract per se is not a term included in the literature, it was a form of contracting out, only it was somewhat more restrictive because of New York State law. Moving to a full contracting out, such as described in the literature, would have been much more expensive and time consuming. Thus, the management contract was concluded as a viable option. It would be, in essence, contracting management services

only to another hospital. However, even changes in high level personnel would have had to been approved by HHC. However, other, more complex types of privatization could be pursued either simultaneously, or at a later time.

A management contract with already existing affiliates could shift the major responsibility of day to day management to the affiliate hospital or medical school. In essence, under the medical affiliation agreements, the medical services had been privatized a long time before in an effort to improve the quality of care. In fact, most would agree that the quality of care had improved, but those agreements were not without cost. A long-standing criticism of the agreements was that the affiliates were neither held accountable by the particular HHC hospital, nor were they always acting in a responsible way. A management contract might provide an opportunity to improve the entire affiliation system by building greater accountability into the HHC system. Having the affiliate institution run the hospital and making that voluntary institution the sole responsible party for the complete spectrum of services would remove excuses often rendered when challenged about the quality of performance. It would make the affiliates more accountable, and they would have to deliver a quality of service comparable to that provided in their own institutions. If the management contract were successful over time, the City or HHC could explore more dramatic options. This route also retained the one acknowledged ingredient to all successful privatization initiatives, the ability of the City to monitor and control the contract (Hirsch 1991; Donahue 1989).

The Health Advisor and other staff outlined three different options based on the existing affiliation agreements and made one final recommendation; to move ahead with the exploration of regionalizing Queens and Elmhurst Hospitals under a full management contract, while simultaneously, "spinning off" Coney Island into a freestanding community hospital. Doing so would allow two different types of privatization to move

forward, one more quickly than the other. It would also provide an opportunity to evaluate two different privatization options for future purposes.

The Mayor supported the recommendations, and his Health Advisor moved ahead to determine the best way to accomplish the goals. A number of things happened. The Health Advisor continued holding meetings with various City Council members, many of whom were publicly on record as being opposed to privatization. She was clear that the Mayor was going to move forward with his intent to privatize, but needed to know what kinds of things were important to the local elected officials in such a process. Interestingly enough, many of the Council members admitted that they were not necessarily opposed to privatization, but either wanted the City Council to have more control, or they could not admit publicly that they liked the idea. Almost all agreed that HHC was in need of major reform. Despite the fact that the Health Advisor met with virtually every member of the City Council health committee as well as many other key members, and continued second and third rounds of meetings over the ensuing months, they always maintained publicly that they were not adequately consulted. This will be discussed at length in Chapter Five.

Once the decision was made to move forward on the particular hospitals, the health Advisor began meeting with the Queens Borough President. The two Queens hospitals had been selected because of a number of factors. First, it would be possible to regionalize the two under one affiliate, thereby saving dollars. Also, one was a brand new facility and the other had an old physical plant. It was believed that by keeping Queens and Elmhurst together, regardless of the status of the Elmhurst rebuilding project, it would keep the system more rational. The Borough President was not opposed to privatization. She had one very clear goal: rebuild Queens Hospital Center.

She believed that the people of Queens should not have to travel to Manhattan every time they needed sophisticated treatment, particularly for cancer. She also wanted to make sure that a major medical school would remain affiliated with the hospitals to assure the best quality of care. The Borough President never changed her message. Of all of the players over three and a half years, she remained the most consistent in her goals. Within those two parameters, she was flexible. The Health Advisor and other City officials also met with the Brooklyn Borough President, Howard Golden and his staff very early on in the process, as well as later on. Early in the process the Brooklyn Borough President seemed open or non-committal. It would be later in the process that he would become much more of an opponent.

The Health Advisor and members of the Corporation Counsel's office worked together to pursue the implementation of a management contract option and sought to outline the role and responsibilities of each party. As they investigated the law relevant to a management contract, they discovered it would not buy very much. At the same time, the Health Advisor learned that the HHC President was quietly talking to the Mayor's Senior Policy Advisor about the initiative, and looking for different options. As a result, the Health Advisor began to hold a new series of meetings with the key City Hall players to make sure everyone was still on board with the current plan. She realized that, politically, the project could not succeed if there was not consensus internally. It seemed clear that these two players might have been changing direction.

As the meetings to discuss the planned effort proceeded, a reporter from the Daily News learned, which hospitals were to be privatized. An article appeared in that newspaper naming the hospitals (Daily News, 28 October 1994). That report started what was to become a three-year outcry from foes of privatization, that they were not consulted about

the process and that the plans were being developed in secret. The other thing that happened on a simultaneous track, was that each time a meeting was held on this project, the same reporter would learn what happened in the meeting and write a story about any routine internal disagreements in policy. Those who did not want the project to go forward were leaking the story to the press to try and sabotage the plan. Moreover, internal memoranda at HHC warned the HHC president that "HHC seems to be without allies facing powerful enemies--the Mayor, the Governor, and those institutions that stand to profit from dismantling the Corporation" (Martin 1994).

Now that the privatization initiative and the opposition to it were becoming known, some City Hall players were becoming apprehensive. The apprehension prompted further discussions about various new privatization options. The Corporation Counsel was promoting, for example, an outright sale if the administration were actually going to move forward with the effort. That really had never been considered. The Health Advisor had up until that point considered a sale option to be unrealistic. It thus appeared that getting something done in the Mayor's first year was nearly impossible and that the management contract was no longer a viable alternative. Giuliani's Health Advisor advised him that having abandoned the original management contract idea, the Administration could not sell the hospitals in a time frame of less than two years.

By the beginning of July 1994, the Health Advisor completed a new round of meetings with experts from around the city and country, in an effort to determine the best options for privatization. She also formed and met with an ongoing work group consisting of OMB, HHC, Corporation Counsel, the Mayor's Office of Operations, and the Mayor's Office of Contracts. As a result of those meetings, she prepared a new and

comprehensive briefing for the Mayor to inform him of all of the legal options, as well as a number of models from other hospital transactions around the country.

All interested parties from within the Administration had been at the table and had been part of the development of options and recommendations. There was a consensus that a virtual sale was the best option. The advantages of this more aggressive approach seemed to outweigh the political downside. The advantages included: 1) its potential to reduce costs, eliminate duplication, and improve quality and access; 2) easier control of labor costs by a new owner (which were then an astounding 85% of HHC's costs) 3) assuring full access to care was continued and thus moving away from a two-tiered health care system in which the poor and uninsured are cared for only at public facilities which on average have more substantial quality problems and deteriorating physical plants, leaving the poor to a lesser quality of care, 4) the move away from a direct provider role would permit the City to focus on broad health care policy, monitor the quality of care and achieve greater flexibility in effecting change. The disadvantages were included in the warnings of a 1991 report that government not relinquish too much control to contractors (Kettl 1993). Moreover, they had to be mindful of the advice of Kettl. "In its eager pursuit of the competition prescription, government has--for a remarkable variety of reasons--too often surrendered its basic policymaking power to contractors' (1993, 13). The Health Advisor was cognizant that this was a particularly important issue in New York City politics. It could also be argued, however, that providing direct health care services was not a core government function.

It was decided that the City would move forward with an effort to sell or lease the three hospitals under discussion. Given that the move was in such a drastic direction, it was clear that outside expertise was required to do much of the financial work necessary for

determining the best deal for the City. Initially, the Mayor's office of Operations circulated a "Request for an Expression of Interest" (RFEI) for an accounting firm. Ernst and Young was chosen but refused to agree not to work on the other side of deals with other potential clients. They indicated that they had already been approached by hospitals who might be interested in buying the HHC hospitals, giving the City further indication that there was outside interest in the deal.

Ultimately, it was decided that one of the firms that the City had contracted with to work on the other Mayoral privatization initiatives, including the sale of the U.N. Hotel and the City's radio and TV stations, would be approached to work on the hospital privatization effort. Of the firms that were on the list, (the City had earlier that year issued a generic "Request For Proposal" [RFP] out of the City's Economic Development Corporation [EDC], only J.P. Morgan had relevant health care experience. His experience included a hospital privatization initiative in Louisville, where a public, University hospital was sold to a for-profit entity. Thus, J.P. Morgan was chosen to become the City's financial advisor to the Asset Disposition Program, the initial phase of the privatization project. The role of J.P. Morgan was to do a valuation study; that is, to determine the worth of the hospitals. In addition, it was their role to conduct a market analysis to determine the likely buyers.

It was at this point that the serious detail work on selling the hospitals began. Previously, the work had been conceptual, political and practical. Now it was time to get into questions about "can we really do this and does it make financial sense to go this particular route?"

In the middle of September, J.P. Morgan started on lease/sale options. The Corporation Counsel's office also began looking at the legal and regulatory issues. Another very important issue which heretofore had been little discussed, and which would prove to be quite important, not only in and of itself but for political reasons, was the issue of the tax-exempt debt which had been issued for the HHC hospital construction program and renovation projects over the years. Elmhurst Hospital presented the biggest problem. At the end of the reconstruction project, there would be attributed to that facility over \$270 million in tax-exempt financing issued for Elmhurst Hospital. This had several important implications. First, it had to be determined under what, if any, circumstances the IRS would allow the tax-exempt status of the outstanding bonds to be preserved in the event of a lease or sale to another entity. Without getting into the complicated minutiae of IRS rulings, it was clear, or seemed clear at the time that any deal would have to be with a not-for-profit institution, given that the bonds were tax-exempt. Second, would the IRS allow the debt to be transferred at all? Both the City and HHC's bond counsel had to be involved because the City and HHC had both financed debt attached to all of the hospitals, further complicating matters. Both bond counsels had to agree, which they did not always do. And if they did agree, they still needed a ruling from the IRS. It was not until this point that the Health Advisor found out that an IRS ruling would take about a year to obtain. This was now nine months into the administration; in another year, they would be half way through the Mayor's first term, making initiatives more politically difficult. One thing was becoming very clear. This extraordinarily complex deal was going to take a very long time to complete. There was no choice but to push ahead and keep pushing every one forward. Every day presented a series of riddles. And every day, any number of people were ready to tell the Health Advisor why this project was never going to come to fruition. [Many days she wondered

herself, but she kept pushing the participants to move forward to find solutions to the myriad problems that arose.]

At the end of September 1995, J.P. Morgan, now fully engaged, began its due diligence (fact gathering and obtaining any pertinent information, especially financial) request of HHC in order to put together a formal offering memorandum for the sale of the three hospitals. This began another round of HHC foot-dragging. Many at HHC, understandably, did not want privatization to happen. This was an organization where many of the staff had committed their careers, and depended on its existence for their livelihood. And as Kettl reminds us "the literature on public bureaucracy is filled with tales of self-serving bureaucrats who go their own way instead of following the path defined by superiors" (1993, 21-2). It also did not help that the HHC President was encouraging them not to be helpful. After he had left HHC, many of the HHC staff would confide that he had indeed discouraged them from full participation (Martin 1994).

It was also difficult for many of the HHC staff to fully support privatization because they believed that it would be the voluntary not-for-profit hospitals that would take control of the HHC facilities. They had an historic distrust of the voluntary hospitals. The Health Advisor knew and understood their feelings from her days at HHC. The "voluntaries" were often thought to be and were sometimes guilty of sending patients who were unable to pay and who did not have Medicaid or other insurance to HHC hospitals. The view was that the voluntaries would then turn around and fight, successfully, for the biggest piece of the pie in Albany and Washington, much of which was designated for care of the poor. HHC staff did not trust the voluntaries to pick up the appropriate share of indigent patients in any privatization arrangements.

Many people at HHC had been there for a long time and understood the Mayor's privatization discussions during the campaign. He talked about the bloated bureaucracy that employed most of these people. The arguments he made for privatization necessarily condemned to some degree the system in which many of them had spent their professional lives. They were unable to separate his remarks from themselves personally. They were also in a state of shock, because, privatization had previously been all talk. They never believed real steps would be taken. Many of them did not believe that privatization was the right thing to do, under any circumstances. There was certainly nothing in it for them. Many had lived through a number of administrations and believed they could wait out another Mayor and his designs on the institution.

The municipal unions were, understandably, against privatization, but for the most part had been fairly quiet. The Health Advisor along with the Labor Commissioner held several informal meetings with the head of the unions just to keep the key people apprised of what was going on, and always agreed to let them know in advance of anything happening. One union group, the Committee of Interns and Residents (CIR), however, had already spent a lot of time and money putting together a public relations campaign against privatization. Aimed at the general public, the ads were not effective. Throughout the ensuing two and a half years, it became clear that the general public did not care a great deal about privatization. The special interests and the press seemed to care more than anyone.

One CIR initiative, however, was effective and will be discussed in detail in Chapter Five. They funded an organization called the Campaign to Save Our Public Hospitals. It was never obvious that it was a union-backed organization. It had the public appearance of a concerned consumer group, largely serving as a coordinating center for opposition to

privatization. CIR was always present to raise opposition at public forums and events. While their stated concern was for care of the indigent, the union backing for the group suggested that maintenance of jobs was the dominating influence. This situation was an ongoing source of frustration to those working on the project, because the focus was not on the merits of privatization from the perspective of the health care system. The issue of what made sense for putting together a health care system that would effectively care for the poor in the next decades at times seemed impossible in the intensely political environment. But there was tremendous commitment by those working on the project who had studied the problems closely, to move forward.

Corporation Counsel had written a memo describing the legal and regulatory issues involved in moving forward, which were substantial. The fact that there were major issues to work out was not a surprise to anyone, but those issues needed to be spelled out clearly so that there was a road map to follow. Yet an article appeared in the Daily News that made it sound as if, because of all of the obstacles (such as delivering the correct approach, the issues of the IRS and tax-exempt bonds, for example), the deal would never go through (Daily News, 30 November 1994). Another pattern was emerging. The same Daily News reporter had access to all of the internal information. Later on, when the Chairman of the Board of HHC resigned, and leaks stopped, it was all too clear who the source was. It wasn't easy to make unpopular changes in New York City.

Another arena of growing opposition encircled elected officials. In December 1995, the City Council Speaker wrote to the Mayor to assert his position that the Council had a legitimate role in any privatization initiative. That circumstance would become the biggest obstacle to privatization. Under the HHC Act, the defunct Board of Estimate

approval was needed for the lease or sale of hospitals. The City Council and the Mayor, even under the previous Mayor, had argued over who was the legal successor to the Board of Estimate under state law. The Corporation Counsel under both Dinkins and Giuliani argued that it was the Mayor; this legal conclusion, however, had never been directly tested in the courts. The disposition of the hospitals raised the issue again, because the HHC statute contained an artifact conditioning a lease of HHC real property on the consent of the "Board of Estimate", which no longer existed. The Council also argued that the transaction was subject to the City's Uniform Land Use Review Procedure (ULURP), a process in which they play a significant role. Finally the Council argued that the HHC was without legal authority to privatize its facilities. The Mayor had two choices. He could either work out a deal with the City Council or go to court. Consistent with this Mayor's previous actions, he elected to take a lawsuit from the Council rather than to submit to its importunities. He believed, and was supported by the Corporation Counsel in this regard that the disposition of HHC property for continuing health care delivery purposes represented a management prerogative that the Council, as a legislative body, had no right to intrude on.

During this period, J.P. Morgan was hard at work on its valuation process as well as looking at potential buyers. Its study was to have been completed in November 1994. But it would not be completed until the following February 1995. Morgan maintained that the slowness with which HHC complied, or did not comply, with their requests, dragged the process out much longer than necessary. In fact, it required repeated written memoranda from both the Mayor's Health Advisor and the First Deputy Mayor to HHC's President to get HHC to comply. Despite many attempts by HHC bureaucrats to sabotage the effort, Morgan finally finished its work in mid February 1995 (See Appendix 2). Their report included the following:

- ❑ Financial information from HHC Central Office pertaining to each of the three facilities
- ❑ Evaluations of site visits and management discussions with individual hospitals
- ❑ Research on developments nationwide and in the New York City market
- ❑ Review of the financial performance and strategic objectives of competing institutions and potentially interested parties
- ❑ An analysis of financial information and relevant market information to determine financial ramifications of various options.

Their major findings were the following:

1. The New York City health care environment is a uniquely difficult one for hospitals, and HHC had not performed as well financially as competing institutions.
2. The three HHC hospitals, Elmhurst, Queens and Coney Island required over \$180 million of financial support in 1994 from the City, and the expected long-term cost of running the hospitals is staggering.
3. Other entities may see value in taking ownership of the assets depending on the structure of the transfer.
4. The City does have the ability to transfer ownership of the assets, if it chooses to do so.
5. An analysis showed that the estimated present value of future support including future capital expenditures required would be enormous if the current trend continues, a total of approximately \$1.7 billion over 10 years including both operating and capital expenditures.
6. Despite operating losses under HHC management, potential buyers would have numerous opportunities to improve operating performance and margins, specifically in the area of labor (J.P. Morgan 1995). (Appendix:)

This financial analysis was also taking place at the same time the State and the City were proposing very large cuts in Medicaid. That meant two things. The J.P. Morgan staff had to make its projections contingent on a number of different scenarios, rendering those projections highly speculative in the political environment in which J.P. Morgan was conducting its analyses. Secondly, the Mayor's proposed Medicaid cuts only further exacerbated the charges that he didn't care about the poor and that privatization was a

callous act. That was in this milieu that the announcement was made to sell the three public hospitals.

The Mayor also decided that with the announcement about the sale of the hospitals, he would simultaneously announce the formation of a Blue Ribbon Panel. The charge to the Panel would be to determine the future of the remaining public hospital system once the three hospitals were sold. There was already criticism that those three hospitals were among the best in the system, which was not true. Queens hospital in particular was not only in very poor physical shape, its patient base was rapidly eroding. Privatizing Queens Hospital Center was actually an attempt to save it through the infusion of much needed capital and operating support by a private entity. While the existence of the panel was meant to blunt criticism, it ultimately wound up fueling the fire of opposition.

The Mayor asked his Health Advisor to bring together a group of experts in the field whose opinion would be respected. One person the Mayor himself wanted on the panel was Dr. Martin Cherkasky, whom the Mayor had met during the campaign and was a well respected elder statesman in New York City's health care arena. It was not an easy task to bring together respected members of the health care world in New York City who did not have some conflict of interest. Most of the well-regarded individuals were part of one of the major academic health centers; the major academic health centers all had affiliation relationships with HHC; and thus each of the individuals would have a conflict of interest with HHC. It was also difficult to find "experts" who were at least neutral about privatization, would agree to be open to it as an option, and who would not mind being associated with the Mayor's initiative. Health care politics in New York City involves the

same liberal politics as anywhere else. Moreover, there was almost no one who wanted the status quo disturbed.

Press coverage at the announcement was fairly benign. Most of the reporters gave factual accounts. There were the usual comments in the press by dissident HHC board members who said they weren't consulted, thought more board members should be on the panel, etc. but otherwise leveled no major criticisms. The panel, however, drew criticism right from the start. An article appeared in the New York Post about Martin Cherkasky's being a supporter of privatization for years, and that he was, as its former head, too closely associated with Montifiore Medical Center, one of the voluntary hospitals that might potentially gain from privatizing HHC.

The press also started focusing on J.P. Morgan. The Daily News carried a story that only two weeks prior to the announcement the City had reviewed Morgan's analysis and had rejected it because it did not adequately take into account the pending Medicaid cuts (Daily News, 30 November 1994). The same insiders who wanted to stop privatization seemed to think that they could simply continue to create controversy and kill the initiative. In fact, the New York Post ran a story that the HHC President was "stunned" by the news that the Mayor wanted to privatize more hospitals notwithstanding that the Mayor had been on record on the issue for many months (New York Post, 17 August 1995). Indeed, the Mayor had been all over the news and very excited and aggressive about privatization. The very week of the announcement he had talked about the real possibility of selling many more, if not all of the hospitals. The HHC President's comment was accordingly quite mystifying.

When all was said and done, no substantive arguments had been made against any of the privatization measures. The major criticisms were of the voluntary hospital system and their perceived lack of attention to the poor. One story about a major teaching hospital separating Medicaid maternity patients and those with private insurance was written and talked about at length. While that was a very disturbing incident, it was not a fair representation of all private hospitals in New York City, and none of the accounts had discussed the measures that hospital had taken to correct the situation. If substantive criticisms about privatization itself had been made, the press coverage, bad as it was, would have been far more critical. Most important, no one could dispute the fact that HHC was in terrible shape and had been for some time. Moreover, nobody could say that the quality of care received in an HHC hospital was superior—there was too much objective evidence to the contrary (i.e. loss of all or partial national accreditation-of five HHC hospitals in four years). The most that opponents of privatization could do was to create controversy *around* the issue, or within the Administration. They did both, but it didn't kill privatization. There was a determined Mayor and an equally determined Health Policy Advisor.

In fact, there was some good press, including positive editorials from both the New York Post (18 August 1995) and the Daily News (20 August 1995). The Daily News editorial, in retrospect, was rather prophetic. It described the hospital sale effort as good for “pushing the ever so reluctant system toward change” (ibid.). It would become clear that is exactly what happened, and, the New York Times ran a story about all of the progress at HHC during the Giuliani tenure, quoting the Mayor as attributing much of the change to the privatization process (New York Times, 16 August 1995). (see Chapter Six for fuller explanation). It also didn't hurt that, only several weeks after the announcement, the New York Times ran a story that had been in progress for some months about

unusually high mortality rates among newborns at HHC hospitals compared to their voluntary counterparts (*ibid.*). The Mayor, of course, was able to respond claiming that it clearly underscored the need to privatize the system. The opponents of the effort had no crutch to lean on. The facts were truly on the side of the Mayor. There was too long a history of poor quality, poor financial performance and mismanagement at HHC to create real arguments against privatization.

Opponents on the City Council and elsewhere used such arguments as, why doesn't the Mayor use the same approach with HHC that he's used in turning around the Police Department and OTB? They painted the Mayor as unsympathetic to the poor, despite the fact that any time he or his Health Advisor spoke about privatizing, they guaranteed that the indigent would be covered under any agreement. The other argument was that the Mayor was carrying out the whole process in secret. The HHC Board was becoming increasingly antagonistic toward City Hall, and claimed that the HHC Board was being totally left out of the discussions. There were rumors that both the HHC President and Chairman were fueling that fire. The decision not to issue the J.P. Morgan study, because of the competitive nature of the sale as well as the competitive information related to HHC, fueled that fire. Because the report was so critical of HHC management, with facts such as HHC 's maintaining over three to four times the number of full time equivalent employees as its voluntary counterparts, the Board and HHC personnel continued their efforts to generate antagonism toward the Mayor. The former HHC chair under Mayor Dinkins remained on the Board, as did the most strident opponent of privatization, the president of the Community Service Society. The two began to use the Board meetings largely as a public forum to criticize the Mayor and his policies.

At the end of March 1995, an event turned the tide from loud internal HHC rumblings and throwaway articles about privatization to a very open and aggressive hostility toward the Administration. This change occurred because of and was fostered by the Mayor advocating for Medicaid cuts in Albany. His thinking was that if the State didn't make major changes in the Medicaid budget, the City would never get its finances under control. Because the City contributes 25% to the Medicaid budget, if the State makes cuts in Medicaid, the City saves money. One can only imagine the outrage among the more liberal members of the HHC Board. Thus, on the day of the March HHC board meeting, the Chairman, a Giuliani appointee, informed the First Deputy Mayor that he was about to bring a resolution to the Board calling on the Governor not to go forward with the pending Medicaid cuts. After, a conversation about this took place between the First Deputy Mayor and the Chairman, where the Chairman was debating whether he would publicly oppose the Mayor or resign. The last conversation took place at about 3:00 P.M., and the board meeting was scheduled for 4:00 P.M. At 3:45, the Chairman called the Deputy Mayor to let him know that he was resigning, because he could not support the cuts. The Health Advisor was with the Deputy Mayor at the time, and they went to inform the Mayor about the decision. The Mayor turned to his Health Advisor and asked her to be the acting Chair.

At 4:00, the Deputy Mayor and the Health Advisor went to HHC, accepted the resignation of the Chair, and entered the Board meeting. The Health Advisor called a stunned Board to order and began the meeting. It was as if the worst fears of the privatization opponents had come true. The leader of privatization was now *leading* the charge from inside the organization. It would totally change the way the press and the opponents viewed privatization. Now things were really getting serious, and the stalling tactics would no longer work. Further, the press was deprived of a major source of

information. For the Health Advisor, it meant the beginning of constant, inordinate attention and scrutiny from the press and being made the subject of a misinformation campaign on a level that few political appointees ever get to experience.

During the next several months, the "privatization team" that the Health Advisor put together, consisting of all of the relevant City agencies, worked through the hundreds of issues that needed to be sorted out to move forward with the sale. For one thing, a new financial advisor had to be hired to move to phase two of privatization. A Request for Proposal (RFP) was let, and interviews took place. J.P. Morgan had become a lightning rod for criticism, because its valuation study had not been publicly released. On its face, a demand for release of the J.P. Morgan study was fatuous for when determining the value of an asset, intended for disposition one would be misguided to make that information available to the competition or to those who may be in the bidding. If the City were truly interested in getting a good financial deal, why would that information be made public? Opponents cried foul and continually exploited the "secrecy" argument, because they remained without substantive arguments to gainsay this initiative. The Health Advisor sat before the City Council for four and one half-hours while members asked the same question over and over again: when would they see a copy of the analysis? She answered the question the same each time; Morgan was preparing a version that would not vitiate the competitive position of the City in selling the assets.

J.P. Morgan staff and City Hall staffs did individual briefings for all Council Members, HHC board members or other elected officials who were interested. It was never clear if they honestly believed that information was being withheld, or if they just wanted to harass the administration, for no matter what information was given to them they

ridiculed it and would publicly denounce privatization and the Mayor. There was clearly a lot of personal hostility directed at the Mayor for his strong views.

The Health Advisor was working during this time with the Blue Ribbon Panel (see note on this, p. 142) to try to bring that group to consensus, which was not an easy task. They were supposed to have completed their work in three months, which would have been May, 1995. They finally completed it in August, 1995. The Mayor signed off on the report, but while it was being printed for release the next day, a Daily News reporter called and revealed that he was in possession of the entire report and was going to write a story about it for print the following day. The Mayor's press office distributed the report to all of the papers, rather than to allow one paper an exclusive.

The Report was a comprehensive analysis of the state of the health care delivery system in New York City (Mayor's Advisory Committee on the Future of HHC, 1995). It addressed the serious over-bedding issues, the detrimental impact that managed care could have in the City if the right steps were not taken, as well as the potential effects of pending deregulation on the system. It also took the position that while each of the HHC hospitals should be looked at carefully for solutions appropriate to that particular community and hospital, the system itself--as a system--should be dismantled. Privatization was suggested as only one of several options that should be explored for the individual hospitals.

According to the press reports, the panel had never deliberated or conducted any analysis. The press reported only the panel's conclusion that the public hospital system should be abolished (Daily News, 4 December 1994). The New York Times health reporter at the time was a personal friend of the HHC president, an unenthusiastic

member of the privatization team and most of the Times' stories reflected his biased point of view (New York Times, 16 August 1995). It was obvious even to the Times editorial writers. When Panel members met with the editorial board, a member of the board admitted that he was embarrassed by his paper's coverage of the issue. He said at the time "the Wall Street Journal managed to tell a better story in three paragraphs than we told in two pages."

The Mayor, despite the fact that he had so adamantly spoken out on the need to privatize the hospitals, clearly felt chagrined by the story. So chagrined was he, that he had his Health Advisor hold a press conference that day to announce the report, so that he could distance himself from it if necessary. As it turned out the press accounts on the second day were much more balanced and accurate, but by then the New York Times story was on page B2 instead of the front page and many fewer people would see the more positive story. There were some positive editorials (Daily News and New York Post, 18 August 1995), and even Ed Koch, the former Mayor who was by this time battling openly with Giuliani, wrote a favorable column in the Post encouraging the dismantling of HHC (New York Post, 18 August 1995).

The issuance of the report also brought a new level of acrimony to the HHC Board. In particular, the Mayor's Health Advisor, now the HHC Chairperson, was constantly pitted against HHC Board member David Jones, the President of the Community Services Society. For example, when the Daily News asked for point-counterpoint op-ed pieces on the issue, it was Mitchell vs. Jones (see Appendix 3). This would set the tone for all future Board meetings. At every subsequent meeting, Jones would invariably go off on a five to ten minute diatribe about the Mayor's policies, the secrecy of the Blue Ribbon

Panel¹, the lack of consultation with the Board, and the Board's fiduciary responsibility to oppose the Mayor. Much of this was to curry press attention and to ultimately create a record for the lawsuit he would bring against the Mayor.

Another key event at the end of that momentous August 1995 had an impact on the future course of the privatization initiative. A top-level female employee of the President of HHC brought a serious sexual harassment complaint against him. After an investigation by a highly reputable outside law firm, the President resigned. Many in the press as well as others thought that he had been forced out because his views on privatization publicly differed with the Mayor's. This was irrefragably false, but the entire incident served to create more tension between the supporters and opponents of privatization.

With a new President on board, it became clear just how much the former President had done to sabotage privatization. The new President found a memo in his files from a highly paid consultant, also a former HHC employee, whom the former President had hired for advice on how to run a system with which he was so unfamiliar. In the memo, the consultant stated that the Mayor was the "enemy" and he had to do all he could to stop the Mayor from destroying HHC (Martin 1994).

During this period, the Corporation Counsel's office research into how to best accomplish the sale of the hospitals continued. The conclusion was that the hospitals should not be sold, but should instead be leased in a long-term lease arrangement. The Health Advisor, and now, the new HHC Chair, had also worked with the Economic

¹ Mayor's Advisory Panel for the Future of the Health and Hospitals Corporation, hereafter referred to as the Blue Ribbon Panel or Advisory Panel, interchangeably.

Development Corporation (EDC) and the Corporation Counsel's office to pursue hiring an investment-banking firm for phase two of privatization. Ultimately, because their experience in privatization transactions was so much greater than the other firms interviewed by the City, J.P. Morgan was again hired. By October 1995, they were finished with "Offering Memorandum"--the document that would be sent to all interested potential lessees.

The Offering Memorandum was the document that described in detail those hospitals proposed for disposition and the relevant outlook and opportunities for growth that potential buyers should consider. They included descriptions of the hospital facilities, current and projected financials, operating statistics and expectations of the buyers in the transactions etc. The privatization team had been working for months on the "deal points", as they were called. These were the key items from the City's perspective that would make or break the deal. They also happened to be the most politically sensitive components. They included:

- ❑ Indigent care and access
- ❑ Reimbursement
- ❑ Labor
- ❑ Transaction structure
- ❑ Malpractice/litigation
- ❑ Bond issues/debt/timing of sale
- ❑ Affiliation issues
- ❑ Future capital expenditures
- ❑ Continuation of City services (e.g., prison health, EMS etc.)

The privatization team, which included J.P. Morgan, had to be careful about how to approach the issues in the document. Those issues would be part of a major policy statement by the Mayor and how he would handle them. Obviously, the most significant would be indigent care. Could the Mayor keep his commitment to assure services for the uninsured and still be able to sub-lease the hospitals? The document had to be clear that the hospitals would continue to care for the uninsured at current levels, assure access and yet allow for the offer to remain attractive enough to potential buyers. Along with the other political hot potatoes, such as labor, indigent care had to be shaped carefully. The framework of a deal had to be presented to encourage potential buyers as well as to provide them with as much flexibility in making operational changes in order to enable them to achieve required efficiencies. It was also essential that the document assure the public and various constituents that the Mayor was not going to sell them out. That meant walking a very fine line. On the one hand, it had to be clear that the new owner would have to be responsible for indigent care. Did that mean the new owner would pay the full indigent care tab in perpetuity? And how would that major obligation affect other aspects of the deal, such as the assumption of debt payment? It was necessary to carefully frame the deal points elastically so that a reasonable businessperson would not be discouraged from proposing.

It was important that prospective proposers not make unwarranted assumptions. An extreme example of such an assumption would be: if a particular entity were to pay the \$200 million of outstanding debt for capital improvements and reconstruction associated with Elmhurst hospital that it would also still be expected to pay for all of the indigent care costs. And, what if that same buyer agreed to take all of the employees of the hospital and accept the union agreements for two years. This would require them to make no changes for those two years, which would obviously make it much easier,

politically, to do the deal. It would also save jobs and City money if the City didn't have to pay costs such as severance or other expenses that may have been associated with job loss but such a criterion would have been fatal to a successful disposition. The point is that it was impossible to spell out in detail what a deal should look like without all of the pieces together, and without a particular entity to negotiate with.

Yet many of the constituent groups expected to see that kind of detail. It was similar to the original valuation study by J.P. Morgan. The public wanted all the information. But it's impossible to get a good deal if the entire negotiation is carried out in public. Indeed, this is an overall issue in any government privatization. As discussed in Chapter One, competition is critical to successful privatization (Donahue 1989) (Kettl 1993) (Salamon 1989). How does one balance the public's right to know, with the need to carry out deal making and negotiations privately in order to get the best deal for the government? How much exactly does the public have a right to know? And how much do they empower elected officials on their behalf when they vote them into office? Sayre and Kaufman speak to this point as it relates to elected officials in New York City. Though clearly broader than the privatization issue, it was a relevant and ongoing issue. They say "in many ways, the electoral mechanisms of popular control are predicated on the assumption that the officials voted into office are in full command of policy and program, and that the other components of governmental machinery are little more than executors of their collective will. The preferences of the general populace, registered through the medium of elections, thus have an opportunity to impress themselves on what the government--all the public officers and employees--actually do. In New York City elected officials have not achieved full command of policy and program (1960, 720).

This public issue was underscored at a meeting held to brief the unions on the Offering Memoranda that October, when a major union official stated, after finding out the terms of the document "If I were a buyer, I'd want to see the lease in shape". He also stated that he needed to see more specifics in order to "deal" with the issues. From the City's point of view, that was impossible without all of the terms laid out on both sides. If the City were to make all of the information public, it would have been at a severe negotiating disadvantage and in effect would have been negotiating with itself.

The group worked for months trying to strike the right balance on these issues. Internal City constituents also had varying points of view. The budget office would naturally be concerned that the City not enter into an agreement that would lock them into a deal where they would pay more for indigent care than they currently paid. Those who represented labor would make sure no misleading signals were sent to the unions, or signals that would in any way disrupt other labor negotiations. At the same time, the group had to prepare for other legal and regulatory requirements. Ultimately, the state would have to approve any deal through the Certificate of Need (CON) process.

Many important but mundane activities were also being performed, although even the least of them could cause political problems. Financial audits of the hospitals had to be completed. Audits of individual hospitals within the HHC system had never been done before. Audits had only been performed on HHC on a consolidated basis. This required dissecting each hospital operation for the first time in the standard audit fashion. The very fact that for thirty years HHC hospital executive directors had been managing their hospitals without true knowledge or control over their finances further illustrated the folly that these hospitals were managed like other private sector hospitals. And consistent with prior behavior, conducting the audits invariably set off disagreements between HHC

and J.P. Morgan, or HHC and OMB. HHC never wanted to look bad, and they also didn't want OMB to take advantage of them, which was an ongoing issue for both agencies, even outside of the privatization arena. Presenting a complete and accurate financial picture of the hospitals may have, HHC believed, put them at risk of having these funds reallocated to another hospital within the system throwing their budgeting into turmoil. But it was important for the financial picture to be as accurate as possible to elicit the broadest interest on the part of potential buyers. As such, there were all kinds of legal and financial due diligence activities being performed to assure that the City came to the table with the most complete information. Working groups were set up to deal with each of the deal points (discussed previously) and their associated activities. The issue of indigent care, how to pay for it, and the expectation of buyers vis a vis other parts of the deal was the subject of many peoples work for months. It included examining indigent care arrangements in other cities around the country, studying a role that the community might play in monitoring access including holding focus groups with hospital users in each of the communities where the hospitals were to be privatized. The privatization team knew that assuring full access would ultimately be the requirement to making privatization work. They would only consider a privatization contract that continued full and complete access for the uninsured.

On October 26, 1995 the HHC board was briefed in executive session about the Offering Memorandum, and it was subsequently released. The Offering Document was then sent to virtually all interested parties in and outside of New York City. Over the months, each time an article about privatization appeared in the press, the City would receive calls of interest from groups around the country. Each of those parties was sent the document. One such entity would become a major player in the privatization arena, Primary Health Systems, a small, new, for-profit hospital company headquartered in Philadelphia.

During this time members of the privatization team began meeting with the various proposers about their responses to the Offering Memorandum. Over those few months numerous articles appeared in the daily papers speculating on the identity of the proposers. The stories carried accounts of rumors, of trouble getting proposers, and the implications of who was in and who was out. For example, the Daily News falsely wrote about N.Y. Hospital's bidding on all three of the hospitals. The change that came about was that all of those closely involved on the City side were supporters of privatization, so the press stories were losing their impact. They were also stories coming from bidders themselves.

During this period, one of the major teaching hospitals that was affiliated with the two public hospitals in Queens that were to be privatized, began complaining to various members of the Administration about requirements or expectations in the anticipated deal that they viewed as onerous. They lobbied to get certain provisions changed, and there was speculation that they would pull out of the process. In fact that particular hospital, that was expected to be a key player in privatization, was having trouble with the City's expectations. It hinted that it would drop out of the process if some changes were not made. This hesitation engendered rumors that the City would have trouble privatizing any hospitals under the terms it was asking. Most players in the hospital world believed that the Mayor wanted to privatize the hospitals at any cost. Many of the bids reflected that attitude. They also reflected the non-competitive nature of the hospital delivery system in New York City up until that time.

A particular fact that underscored the non-competitive environment, and also made hospital privatization different in New York City than it would have been elsewhere in the

country, was the fact that New York State law did not allow publicly traded, for-profit hospitals to operate in New York. That meant that the major national for-profit chains were prohibited from bidding on the hospitals. These large, for-profit chains would, in any other market, be a significant competitive threat to those in the existing market. They are also the ones with the kind of money, and the ability to more easily raise the capital that was necessary to do the deal that the City wanted. No one in the City, however, had anticipated doing a deal with a for-profit company. Until looking at the situation more seriously, it was assumed no deal with a for-profit company could be done. And, despite the fact that there was interest from a non-publicly traded for-profit, the issue of the IRS and HHC's tax exempt bonds further complicated the matter. For a long while, it wasn't anticipated that a bidder might pay down all of the debt on the bonds required to satisfy the IRS. That, however, turned out to be a false assumption, and one that changed all other assumptions.

Ultimately, Mt. Sinai Medical Center, a major contender for the Queens hospitals, dropped out of the process. They did so very publicly, reinforcing rumors that the City's options were limited and that it was unable to privatize the HHC hospitals on its own terms. Nobody knew at that point that discussions were well under way with a for-profit company that was willing and able to meet the City's terms and conditions. It was said at the time that the other bidders all believed that they would acquire the City's hospitals on their own terms. They had good reason to believe that. For years they had basically gotten all of HHC's medical affiliation contracts on their own terms. And this was not necessarily a product of their own doing. While those at HHC felt that the voluntary hospitals had a "you need us more than we need you" attitude, HHC had for years unwisely negotiated affiliation contracts that reinforced the belief.

In the midst of this process, the Mayor announced the recommendations of the Blue Ribbon panel on Indigent Care (Mayor's Advisory Panel for the Health and Hospitals Corporation 1996). The Mayor had requested the report largely to allay the Queens Borough President's fears about privatization. It would also allow her to support a privatization effort of the hospitals in her borough if she had a concrete answer about how the indigent would be cared for. It would do the same for others with that concern.

The Panel recommended that the State set up a public insurance program for the uninsured to pay for indigent care up to 200% of the poverty level. The financing would be through changes to Medicaid that would bring about savings as well as small assessments to provider rates and insurer premiums. Those who did not participate in the new insurance program could continue to have their care financed through a bad debt and charity care pool. The Mayor actually supported the idea of offering insurance to the indigent--whose care was notoriously fragmented, dependent on emergency rooms with little access to primary preventive care. However, the Mayor was nervous about taxing providers and payers, although it had been done for years to support the existing method of providing charity care, through New York State's bad debt and charity care pool.

When his Health Advisor briefed him, she advised him that under no circumstances would the legislature ever take this document and pass it into law. The report, however, provided the beginning of a discussion about how to deal with the issue of paying for health care for the uninsured--which was obviously a much larger issue than privatizing one or two hospitals. If the Mayor wanted to privatize many more hospitals, or if something were to seriously be done about dismantling HHC, the broader issue needed to be dealt with. It was not the City's issue alone. It was also a State issue, and a

national one. The likelihood of getting anything done at the national level was non-existent given the Hillary Clinton debacle, so the panel had to focus on a City/State solution.

At the press conference announcing the Panel's recommendations, the Mayor said many positive things about the report. When asked if he supported it in "total", he repeated the Health Advisor's words "it was a good start; the legislature would not pass it as it was." As reported, the media failed to accurately reflect the Mayor's positive reception to the report, and it appeared that he did not support any of the Panel's recommendations.

Many speculated that those in the press that disagreed with privatization were now trying to drive a wedge between the Mayor and his Health Advisor as a way to get her to leave the administration, that would be a major stumbling block to the privatization effort. That tack would not be successful. Moreover, serious negotiations were under way with an out of state for-profit company, Primary Health Systems (PHS), which had submitted a proposal far superior to that of any of the City's voluntary hospitals. So the prospects for a successful privatization were looking very good. Primary Health Systems was a fairly new company with the mission and experience of taking over urban, community hospitals. It was an unusual strategy for a for-profit company. But the chairman and CEO of the company, and many on his team, had a long and successful history in the hospital business, particularly in the for-profit hospital business. They stated at the outset a strong commitment to taking care of the poor and uninsured. The initial due diligence proved that boast to be correct. The due diligence also showed that they had a positive track record in dealing with existing unions in their other hospital acquisitions. This was an important factor in the City's negotiations with PHS.

The City informed the other proposers that a successful proposer had been chosen, and it was not any of the City's voluntary hospitals. However, PHS itself decided that it should have a clinical affiliation with New York University Medical Center for tertiary care and a community affiliation with Brooklyn Hospital Center, which had also been a proposer. Many in the voluntary hospital community were displeased with and surprised by the development. Those that had the most to lose, from a geographically competitive standpoint were the most displeased. None seemed upset about the fact that a for-profit company had won the bidding. In fact, after the company was made known publicly, a number of the major academic medical centers called PHS to try to work out a deal with them on the other two hospitals. The biggest complaint came from those hospitals that felt they had not been given an opportunity to deal directly with PHS. PHS preferred, however, to seek and strike its own partnership deals--a position that the City supported.

On June 26, 1996 the Health and Hospitals Corporation and Primary Health Systems signed a letter of intent with respect to a 40-plus year sub-lease for Coney Island Hospital. The terms of the letter reflected everything the City and the Mayor had hoped to accomplish. The key terms of the deal, were as follows:

- ❑ *Providing indigent care:* PHS-NY will guarantee and assume in full all current indigent care obligations, including providing the financing for care.
- ❑ *Improving quality care:* PHS-NY has committed to enhance current services and to demonstrate ongoing improvements in the quality of care. This will be accomplished through implementation of a proprietary Quality Outcome Management System and other proven quality management techniques.
- ❑ *Maintaining access to care:* PHS-NY has committed to provide access to care for the Coney Island community, regardless of ability to pay. It also included a commitment to the expansion of community based primary care.

- ❑ *Preserving Community Involvement:* Continued involvement of the community in the governance structure of the hospital will be provided.
- ❑ *Minimizing Labor Transition:* PHS NY has committed to meet with the unions that currently represent CIH employees to achieve a smooth and orderly transition. PHS-NY will meet its staffing needs substantially through the use of current employees of CIH.
- ❑ *Assuming Malpractice Costs:* Any liability for malpractice occurring after the closing of the transaction will be assumed by PHS-NY.
- ❑ *Assuming all Debt Service:* PHS-NY will provide for payment of the outstanding CIH debt to be paid off now with the remainder of the debt service payable by PHS-NY as rental payments under the lease.
- ❑ *Requiring No City Subsidy:* PHS-NY has committed to provide full access to care for the indigent at current levels without conditioning access on continued City funding through tax levy subsidy or contributions to the State Bad Debt and Charity Care pools.
- ❑ *Upgrading the Physical Plant:* Much needed capital infusion in the physical plant of CIH will be undertaken by PHS-NY through a capital commitment of no less than \$25 million, in addition to routine maintenance costs (Letter of Intent 1996).

The Mayor announced the proposal that same day at a Chamber of Commerce meeting in Coney Island. His public announcement read:

Mayor Rudolph W. Giuliani announced today that the City's Health and Hospitals Corporation had entered into final negotiations for transferring control and operation of Coney Island Hospital to Primary Health Systems, Inc. PHS-NY plans to form a health care delivery network with New York University Medical Center and Brooklyn Hospital Center to expand and improve health services available to the Coney Island Community. (Giuliani 1996)

With his Health Advisor by his side, the Mayor spoke about the deal in glowing terms. It was good for the people in the Coney Island community. PHS would improve the quality of health care services. PHS guaranteed continuing to provide, and pay for care to the uninsured. They would pay the \$50 million outstanding debt on Coney Island Hospital, relieving the City and HHC of an enormous burden. The Mayor also said it was good for New York's economy given that the City had attracted an out of State Company to expand business in New York.

Many in the health care field were congratulatory. A very important policy initiative had been accomplished, one that very few thought was possible. Even though the deal was not yet done, most thought getting to that point itself would never happen. It was truly an historic event. And the deal was almost too good to be true in many people's eyes, with many indicating that the deal was better than anyone could have expected, and certainly difficult to criticize.

The City's privatization team knew that the opposition would try to discredit PHS as a company as well as its principals. The City and HHC had conducted a fairly extensive background check prior to the announcement, but more extensive scrutiny was to come.

The summer months of 1996 were dedicated to conducting the due diligence process on PHS as well as actually turning the details of the letter of intent into contractual documents. The goal, as stated in the letter of intent, was to have signed contractual documents by August 30, with a 30-day extension possible. That was an ambitious goal given not only its complicated nature, but the politics that would likely intervene. Now that the agreement was public and because there actually seemed to be a realistic possibility of something happening, there was increased public scrutiny. While the letter of intent was difficult to object to on the merits, it was clear that the time had come for opponents of privatization to inflame public opinion against the Mayor's initiative. The for-profit candidate to lease and manage Coney Island Hospital provided the opponents with particularly good grist for their mill.

The City took many steps, not only to try to assure a smoother road, but to improve the substance. Among those efforts had been ongoing meetings with community groups. In

particular, focus groups had been held with members of the communities served by the to-be-privatized hospitals to assure them that access. Members of the hospital community advisory boards were included, as were members of the Community Boards. The City even asked the Community Board President to appoint the members of the focus groups. The groups would deliberate over many months, including that summer. The City also began to brief important individuals on the State level, particularly the Commissioner of Health, on the terms of the transaction. Their support would be critical later on when a formal Certificate of Need (CON) application would be submitted to the State for their review and approval.

There was also a legal requirement under State law that HHC conduct an environmental assessment prior to the finalization of any long term lease or sale of the hospitals. The New York State Environmental Quality Review Act (SEQRA) requires that any "action" by a government agency (HHC being such an agency) which may have an impact on the "environment" must be predicated on the agency's first having taken a "hard look" at any such possible impacts. A disposition of land by lease or sale by definition constitutes an "action" and the "environment" includes the phenomena of population concentration, distribution and growth, neighborhood character and "Public Health". "The results of the environmental "hard look" would not disable any agency from taking the proposed action, but SEQRA requires that the action have considered the environmental consequences.

Accordingly, the City had to do an assessment of the current health care environment in the CIH community. There had to be an assessment of current access and services available and a projection of the community's demographics and of health care needs twenty years into the future. The study had to determine the effect privatization of the

hospital would have on the community, and in particular, the effects that this transaction would have on access to health care. Consistent with prior practice, HHC hired an outside consultant to assist with the study. Obviously a neutral party was necessary to determine whether the proposed transaction would have a negative impact on the community. The advocates would never trust the City's findings. Indeed, HHC Board members complained that the proposed consulting firm had a conflict in the Queens area. HHC wound up choosing another consultant. That took additional time, and the findings had to be in place prior to the signing of the sublease. The SEQRA research and analysis became a significant activity during that period.

One of the first action steps the City took immediately after signing the Letter of Intent (LOI) was to set up a meeting with the unions. The City wanted the PHS principals to meet the union officials right away and to set up a process for negotiating the role that the unions would play in a PHS hospital. Several introductory meetings went well. Union leaders did not refuse to cooperate. Moreover, the PHS Chairman made it clear that he knew the unions were an integral part of the deal and that PHS wanted to work with them. Indeed, by August 12 there was a letter from PHS's outside labor counsel, Skadden, Arps, Slate, Meagher & Flom stating: "In the June, 26, 1996 Letter of Intent, PHS-NY agrees to "meet its staffing needs substantially through the use of current employees of CIH." Consistently, PHS-NY agreed in principle that it would recognize and negotiate with the unions representing employees of Coney Island Hospital. PHS-NY also agreed with the principle that the collective bargaining agreements presently in effect at CIH should remain in effect pending PHS-NY's negotiation of new contracts with the unions.

That positive and significant step by PHS, eliminated what could have been a large impediment to the entire process. By agreeing in principle to recognize the current unions, PHS addressed the unions' biggest fear that PHS or the City was trying to get rid of the union, or bring in other unions. DC-37, the municipal labor union, may also have viewed it as positive, given that it had the power to bargain on behalf of most of the unions in question. It was clear that PHS was very serious about coming into New York. Further, most believed that it was only a matter of time before NYS law was changed to allow publicly traded for-profit hospital companies to operate in NY. Such companies might choose to do business without union representation or with 1199, the union representing the voluntary hospital sector. By entering into an agreement with PHS, DC-37 got a leg up on organizing any new arrangements. Thus, rather than viewing privatization as a potential loss of members, DC37 could view it as an area of potential gain in membership.

The process of due diligence was ongoing. The privatization team concluded that it was important for members of the HHC senior management team and the HHC Board to visit PHS's hospitals in Cleveland. Their current and past systems had to be assessed from many different perspectives, but it was important that the HHC staff participate in the disposition process in order to engage them positively in the privatization effort. If they were to find problems, the City and HHC certainly had to know about such problems at the earliest possible time. Contrary to what the critics believed, the City was fully prepared to walk away from the deal at any time. If the due diligence on the company or its senior management were to disclose problems with PHS at the community relations or service delivery level, or if the deal terms proved not to be in the City's interest, the administration would not go forward.

It came as no surprise that only two HHC board members accepted the invitation to go to Cleveland. The biggest critic did not attend; rather, he made accusations that the City didn't make it convenient for him to attend. A large, interdisciplinary team of HHC top managers did, however, spend several days at the hospitals in Cleveland. They were instructed to be completely honest about the findings, and for the most part the findings were very good. The senior physician from HHC made one potentially negative finding among other generally good findings. He indicated that one of the PHS hospitals might have had some quality of care problems. His conclusion was based on the results of a Cleveland study of the quality of care at all hospitals in Cleveland conducted each year. The study, sponsored by Cleveland's business community, was complicated and abstract, and even required specialized training to accurately interpret the results. That did not stop the press from reporting both on the report itself and the HHC memo that was leaked to the press (Millock 1996)

Ultimately, HHC's President, who by this time was thought by many to be against the privatization deal because of the public pressure, and the Chairman of the HHC board's quality assurance committee traveled to Cleveland to determine the facts. They concluded that there had been a misinterpretation of the facts. Further, they met with Cleveland Quality Choice, the business group that conducted the annual study, and received the latest results that indicated an improvement in many of the areas studied. These visits added time to the process. The City and PHS were unable to meet the deadline for reaching the terms of the sublease. Outsiders misinterpreted the delay, and the press reported that the deal was in trouble.

At this time, three HHC Board members filed suit against the City and HHC, claiming that HHC had ignored procurement rules and regulations and, more particularly, that the

City had failed to develop detailed criteria for the proposed contract or to appoint an expert evaluation committee; nor did they maintain public files, or hold a public hearing. The thrust of the lawsuit was that the selection of PHS to lease Coney Island Hospital essentially violated HHC's competitive procurement regulations because the terms which PHS was "bidding against", as it were, were not clear nor constant, thereby offending classical procurement dogma. The fact was that the proposed transaction did not involve procurement of services by HHC or by the City. Instead, it involved a long-term disposition by lease or sale of hospital property. In any event, even as a procurement the challenge must have failed because HHC was not bound by City procurement constraints. The claim that they were denied information was also demonstrably fallacious. Numerous written and oral briefings had been given to the board. Those board members missed many of those briefing opportunities. The judge ultimately agreed. The Board's dissident members knew the facts about HHC's procurement process because of their collective tenure on the board, including one as past chair. Further the current Chairperson of HHC had responded to their earlier charge, in writing, very clearly explaining the City's and HHC's procurement rules (Jones et al. V. Giuliani et al 1996; Commission on the Public's Hospitals et al. V. Giuliani et al. 1997).

Their claim of not holding a public hearing was also unfounded. There had been a public hearing at Coney Island Hospital only several weeks before. The hearing was held, as required by law, and set period prior to the signing of any sublease. Therefore, the City made a summary of the terms and conditions of the draft sublease available to the public prior to the hearing and scheduled a briefing for the Board. Given the complicated nature of the deal, deadlines were again passed, and the public was led to believe there was trouble and that HHC Board members were not supporting the deal. In fact, important aspects of the deal remained to be completed. The Cleveland quality

study was making some Board members nervous, and until those facts were completely investigated, the privatization group did not want to go forward. Two full board briefings were scheduled on October 23rd and October 31. Two weeks were allowed between briefings to research and answer any questions that might be raised. The Chairperson also offered individual or small group briefings for those who had additional questions.

The day before the first board briefing, the New York State Assembly held a second hearing on the actual terms of the deal. Almost as controversial as the deal itself was the fact that HHC's Chairperson did not attend the hearing. The Assembly had given very short notice of the hearing, and she had other important commitments. The City's outside counsel, Peter Millock, who had served as the General Counsel to the State Health Department under the Cuomo administration, represented the City at the hearing. The next day's story in Crain's Health Pulse, a daily fax update on the political happenings in the health care business, read "...Gottfried railed against the absence of . . . Maria Mitchell at yesterday's hearing on Coney Island Hospital...the City sent Peter Millock who spent his time deflecting assembly questions." (Crain's Health Pulse, 23 October 1996)

After weeks of hearings, board briefings, and individual meetings with board members to answer questions, the Board meeting to vote on the sublease was scheduled for November 8. The final sublease that had been negotiated was true to all of the privatizing goals set from the outset. (see Appendix 4), and positively answered all of the questions critics had raised. This November 8th Board meeting was acrimonious, nevertheless. The unions and other advocacy groups were present in full force. From the time the chairperson called the meeting to order, there was shouting and heckling, and it was almost impossible to hear board members speak. As was expected, Mr.

Jones and the members who were suing the City gave indignant speeches about the evils of the deal, while the Deputy Mayor for Operations, a new Board member, tried to calm the crowd, only to incite them further. Pandemonium reigned. When it became clear that no discussion was possible, the chairperson called the vote. Amidst the shouting and chaos, the HHC Board voted to approve the proposed sublease. The Chair asked for a second show of hands because the vote count was more in favor of the deal than anyone expected, and the crowd was yelling to see again exactly how each of the members had voted. Of particular concern was the City Health Commissioner, a Dinkins appointee whom Giuliani had retained. She was known to be fairly liberal, and quite independent. She voted in favor of the deal, a disappointment for the advocates. So it was done. The sublease was approved.

The New York Times cited it as a milestone for Giuliani but said the vote had drawn angry protest. But the deal was done, subject to State approval. The major problem left, however, were the lawsuits threatening to kill the entire initiative. The City Council, certain HHC Board members, and a community group each filed lawsuits challenging the legality of the initiative on several fronts: claiming the Board vote was conducted without proper time for briefing, that the SEQRA review was faulty, that HHC and the Mayor did not have the authority to sign a sublease agreement, and that the procurement process was not conducted according to law. As the lawsuits moved through the appeals process in 1997, all but one issue was ruled inconsequential to the legality of the sublease: the authority of HHC to sublease a facility. More than one year after the HHC Board approved the sublease, that issue has yet to be finally decided by the Court of Appeals, and the transfer of Coney island Hospital awaits a court's decision.

CHAPTER FOUR

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CHAPTER FIVE

POLICY ACTORS IN PRIVATIZATION

“Every performer plays to the audience that applauds him most.”
Henrik Ibsen, from Enemy of the People

It is the aim of most leaders to “deinstitutionalize” the status quo if they are pursuing change. In other words, those in leadership positions seek to expand their discretion in making the desired change. Institutionalization thwarts such efforts (Rockman 1994). DiMaggio asserts, in fact, that “institutionalization is a product of the political efforts of actors to accomplish their ends and that the form that the resulting institution takes depends on the relative power of the actors who support, oppose, or otherwise strive to influence it” (In Zucker 1985, 13).

The previous chapter discussed, primarily, the efforts of those actors under the leadership of Mayor Rudy Giuliani, who supported the HHC privatization initiative. This chapter will identify the key policy actors who opposed, or at best remained neutral, about the privatization effort and the dynamics of the relationships between the actors. It will reinforce the notion that actors tied to the bureaucratic municipal hospital system expend great energy in assuring that the status quo remains. This is not surprising, for we know that political institutions have a life of their own and as such endure over time. History, as has been demonstrated here, becomes necessary in politics because patterns are repeated within institutions and it takes great acts of will to stop them from repeating themselves (Rockman 1994,150). Sayre and Kaufman long ago recognized that the political system in New York City is biased toward the keepers of the status quo (1960, 716). The jury is, quite literally, still out on which set of actors were precisely more successful in promoting their respective interests in privatization and whether or

not the institution will prevail. It is vital, however, to this case study to understand the position of all of the key policy actors and the motivations behind their positions.

As Kingdon maintains, interest groups "loom very large indeed" (1995, 46) While we think of policy actors or interest groups as advocating for proposals, in reality much of their time is spent in "negative blocking of proposals" (1995, 49). We will see that this study is consistent with that notion. Finally, Kingdon affirms the theorists above. His research found that most of the time "a balance of organized forces mitigates against any change at all" (1995, 151). This study will demonstrate that a great deal of energy and resources was spent in blocking change.

The Unions

There were numerous policy actors who were active in the privatization process from the outset of the new administration. All of the groups opposing privatization were predictable. At the core of that opposition were the unions. It is probably fair to say that without agitation from the unions, other stakeholders would have been far less interested in, or at least less vocal about, the privatization effort. As described in earlier chapters, the state of HHC at the time Rudy Giuliani took office was so appalling that it was difficult to argue against drastic measures. To be sure, privatization was an extreme measure given the normal politics of HHC and the City.

District Council 37 (DC37) represented the majority of HHC's employees. A significant portion of employees were represented by several other unions such as the New York State Nurses Association, The Doctor's Council, and the Committee of Interns and Residents (CIR). The hospitals also had affiliation agreements with private institutions

that provided physicians and other professionals pursuant to these agreements. Local 1199 represents employees of most hospitals in the private sector.

The first tangible sign of special interest organization came from the Committee of Interns and Residents (CIR), the union that represents intern and resident physicians in HHC facilities. If there was any one union that had the least likelihood of continuing in a privatized HHC it was the CIR. As noted in Chapter Two, virtually all other teaching hospitals in the country classify interns and residents as students. In the 1970s the National Labor Relations Board determined that interns and residents were in fact students, as opposed to employees, and as such were not able to enjoy the benefits of collective bargaining. Once this decision had been made, most institutions in the country decertified residents as union members. Under any privatization scenario it would be highly unlikely that any hospital likely to take over an HHC facility would let CIR remain. The Doctors Council and CIR would likely cease to be a force in private facilities. Moreover, it would be unlikely that CIR would prevail upon public opinion as some other unions might. A public sympathetic to the plight of the uninsured is not likely to feel the same sympathy to physician salary issues.

The CIR started its campaign early in the Giuliani administration, and for the most part was smart in the way it developed the campaign. It never appeared as though the fight against privatization was a union or a labor issue. CIR organized and funded a group called the "Campaign to Save Our Public Hospitals." During the first year of the administration, and before there was much public debate, CIR ran a subway and bus poster campaign aimed at the users of HHC hospitals. The campaign was designed to scare those without health insurance into believing that if public hospitals were privatized, they would no longer have a place to get care.

There were two ways for the administration to view the CIR campaign. First, it was the view of many in the administration that it was wasteful for CIR to spend hundreds of thousands of dollars on a scare campaign when the Mayor and administration officials repeatedly and publicly insisted that regardless of the ultimate privatization outcome, access to care would never be jeopardized. However, the CIR campaign sent the message that they had no inclination to compromise on privatization. The CIR did not want privatization to happen--period. Their strategy was to stop it at all costs. And, since they were not under the umbrella of DC37, CIR had little to lose in using these tactics and severing relationships with City Hall. The flip side was that they did not necessarily have the support of the larger unions, and therefore they had to use different strategies.

If it was the CIR strategy to stimulate public opposition to privatization by scaring people into thinking that access would be cut off, a tactic viewed by the administration as hypocritical, it was not as though their jobs were in jeopardy. They were, after all, essentially transients in the institutions. They were students by definition, and therefore they were never intended to work in the hospitals permanently. It was not difficult to be cynical and view the campaign as an effort to keep the CIR in business. Moreover, if CIR believed so strongly and purely in its position, why not present an honest public campaign?

The effect of the CIR campaign seemed minimal. The campaign was taking place during the period when the administration was determining its strategy for privatization, so there was little if any public discussion emanating from the Mayor. Privatization was not the subject of day to day news coverage, as it would later become. Furthermore, it

seemed then, and throughout the privatization effort, that the general public cared little about the issue. This was consistent with the findings of Sayre and Kaufman many years before who found that "most decisions are shaped by a small percentage of those who engage actively in its politics--because only the participants directly concerned have the time, energy, skill, and motivation to do much about [those decisions]" (1960, 71). The fact is that the patient community of HHC has never had a real voice. HHC has been controlled by a variety of special interests, but the people it is intended to serve--patients--have, by and large, not been among them.

This belief was confirmed later in the process when the Coney Island Hospital privatization was well under way. The Giuliani administration was holding a public meeting, not one required by law, to inform the public about the privatization initiative and answer questions from the community (See Appendix 5). For weeks prior to the public forum, notices were put up all over Brooklyn and ads placed in local papers, not only by the City, but also by opponents to the initiative. The opponents worked very hard to get the community out in large numbers. Even church officials were encouraging people to turn out to voice opposition. Regardless of this great effort, only about 100 people showed up for the meeting, and most of them were from the union and other groups organized around privatization. There would never be any evidence that the general public, or even those in communities around the hospitals, were genuinely agitated over the issue.

Other than the CIR's initial poster campaign, special interests were generally quiet until J.P. Morgan was brought in to do the valuation study of HHC at the end of 1994. Obviously, this represented the first serious step forward in the privatization process, and it was understandable that such a step would set off alarms for the unions. Prior to

the acknowledgement that J.P. Morgan was involved with the privatization process, the administration met a number of times with representatives of DC37 and some of its major locals, in particular Local 420, which represents nurses aides, orderlies and entry-level technicians. It was difficult to deal with the unions during this first year of the administration because absent an actual party to negotiate the specific terms and conditions of a contract, the discussions remained at a theoretical level. Their demands were of a much more specific nature. Absent a real "deal" on the table, there was not a lot to meet about. The administration knew and appreciated the fact that the biggest stumbling block to privatization was the union concerns. As described in Chapter One, the literature is very clear that the key opposition to any privatization initiative comes from the unions (Savas 1987; Donahue 1989). On the other hand, it was clear that much of the inefficiencies in the HHC system had to do with personnel. Obviously, the unions were at the heart of the personnel issues, as labor has the greatest financial interest in maintaining the status quo.

While it was the clear intention of the administration to try and structure a deal that reflected union concerns, it would be impossible to attract bidders if those successful bidders did not have the flexibility in dealing with labor issues. Furthermore, consistent with the privatization literature, the administration had to struggle with the dichotomy of the political importance of the unions and the reality that any true savings would be achieved only through labor. As Donahue describes it: "Two facts are equally evident: Delegating certain functions to private firms usually saves tax dollars, and much of these savings comes at the expense of public employees. What remains to be done is to weigh the joint implication of these two facts. A proponent of aggressive contracting out declares that 'the purpose of local government is not to provide jobs; it is to deliver services to the people'. A critic insists upon government's 'socially important role of

providing good jobs to people who might otherwise not get them'. Is local service a good thing, or not? The question is as political as a question can be" (1989, 145). That question and the potential answers were the underpinnings of the privatization issue and the relationship of the administration to the unions. But, there was no mistaking the Mayor's position that HHC was not a jobs program, and that the municipal hospital system had for too long been based on the notion that it was. Notwithstanding the Mayor's belief, the administration had to work cooperatively with the unions in order to achieve their desired goal.

It would not be until October, 1995 that the City and J.P. Morgan released the offering document that was meant to attract "buyers" for the three hospitals. However, for the year and a half prior to that time, the unions requested frequent meetings and assumed that they had the right to bargain with the City over the *decision* to privatize. The City and HHC are granted broad management rights under the New York City Collective Bargaining Law (NYCCBL), including the right to determine the methods, means and personnel by which governmental operations are to be conducted. It was inconsistent with these laws to expect that such a decision making process be subject to bargaining. The Union honestly believed that the City had no right to make this *decision* without their approval. Consequently, there were numerous meetings held with the City's labor commissioner, Health Advisor and HHC staff during this period with little material outcome other than for the City to assure them that they would be advised of any decisions. The labor commissioner repeatedly told them that under the City's collective bargaining law, they enjoyed the right to bargain over the impact of the decision and that specific discussions would take place in the context of that bargaining.

It was, in fact, close to one year into the administration, (late fall 1994) before J.P. Morgan had been requested by the City to begin work on the hospital privatization effort. At that juncture, the CIR, as well as most other interest groups, became more visible. The CIR went public under the guise of the "Campaign to Save Our Public Hospitals." CIR founded and financed this new organization whose sole purpose was to organize opposition to privatization and have it appear as though the CIR-backed group was primarily a citizens group organized against privatization. They also brought under their umbrella the traditional "health advocate" group in the City, the Commission on the Public's Health. This group was professionally organized against most of any incumbent administrations' policies. They opposed many policies of Mayor Dinkins as well as Mayor Koch and had been visible as far back as the closing of Sydenham hospital. They were old and familiar faces in the HHC board meetings.

Without doubt, the ultimate publication of J.P. Morgan's valuation study of HHC in early 1995, (the first report released by J.P. Morgan and discussed in Chapter Four), mobilized interest group opposition in earnest. Understandably, the unions became very concerned. Job security would be a priority in any take over or change of management. But what was at the core of their concern? There was general consensus that privatization would ultimately result in a reduction in jobs, yet the union's demand was for ongoing representation. Thus, it was not necessarily the case that union and individual employee agendas were the same. The distinction between the two was illustrated clearly in a Coney Island Hospital newsletter at the point when privatization became imminent. At that time the unions held a rally at the hospital. DC 37 Local 420 President James Butler demanded, "This hospital belongs to the community, so we must continue to fight to the last. Health care is a right, not a privilege" (Allen 1996). In an issue of the Public Employee Press, hospital employees were asked to raise their

concerns. The remarks of one employee, Daniel Bennet Reed, reflected the general feeling.

I've been at Coney Island for six years. I worked for private companies for 16 years. If the boss doesn't like you, you're out. That's why I finally joined civil service: I knew I'd have security. That's what I'm most afraid of losing. The question that is uppermost in my mind is whether or not I'll still be represented by the union. I want the union here to protect me. (ibid.)

While the employees' fear of losing job security was clear and understandable, the union had other, more parochial issues as well. The threshold issue for them was continued representation; that demand was simple: The unions representing the Coney Island (or any other privatized hospital) employees before the management change must be the same unions representing the employees after the management conversion. That would mean that the new management team would have the same forty-four unions to deal with that the City and HHC were mandated to bargain with. For the unions that would mean losing their membership, or a portion of it, the dues that were paid to the unions directly, and ultimately, the jobs of union leaders and the supporting bureaucracy.

Privatization as a new mode of operation in the municipal services delivery system threatens many of the institutional rules that unions now play by in the structure of city government. Union leaders hold powerful seats on pension boards, allowing them to influence the policy-making investment decisions over billions of pension dollars. Unions also oversee more than half a billion dollars in funds which flow from the coffers into benefit organizations which were set up to provide employee training and health and welfare needs (e.g., dental and vision services). By virtue of this oversight role, they control the scope of services delivered through these benefit funds. Privatization, then, was seen as a specter of a system that would lead to the erosion of this power base by removing segments of the employee base from the public sector world.

These fears were a worst case scenario until there was an actual privatization deal to examine. It was unlikely that the Mayor would choose to or be able to privatize all of the HHC facilities, but both the fears and the strategy of the unions were based on that possibility. The release of the Mayor's Blue Ribbon Panel Report did not allay their fears. While not recommending privatization as the outcome for all HHC hospitals, as the press indicated, the panel did recommend the dissolution of HHC as a central bureaucracy. Further, it was troubling to the unions and other advocates that the Mayor's Health Advisor chaired the panel. From their perspective, it meant that the Mayor wanted to see an end to the public hospitals. The real rationale, as discussed in Chapter Four, was to eliminate a two tiered health care system while assuring that access to care for the uninsured remained intact. But for the unions, that meant a loss of jobs and an end to their union structure. Like CIR, however, that was not the public battle they fought.

In a press release denouncing the Panel's report, Local 420 President Jim Butler decried the perceived lack of commitment to the poor. He stated that the public hospitals were created to serve the poor and that those hospitals never asked for money from the poor (which was not accurate) and questioned where those people would get health care. He announced one more in a series of "sunrise services" at Gracie Mansion to pray for "hundreds of thousands in our City who will suffer from the elimination of access to affordable care" (Local 420 1995). The J.P. Morgan valuation report was unquestionably a source of concern and consternation for those that opposed privatization, and for anyone who was of the belief that the Mayor and his administration did not care about the poor. The union strategy to keep the focus on the likelihood of decreased access under a privatization scenario and not talk about the jobs issue was effective.

The “Campaign to Save our Public Hospitals”, the front group for the unions, all but denied that jobs were even an issue. In a flyer broadly circulated, they stated “The Mayor and his staff say that hospitals are ‘jobs programs’, have too many employees and run themselves inefficiently”. The group retorted that the system was inefficient because “the City had not kept up with renovations of the hospitals for years”. In addition, they claimed that: HHC had more clinics than the private sector which only made it look as though HHC had too many employees; that under the existing affiliation agreements the City had already privatized much of HHC; and, the affiliates ignored much of what needed to be done. Their concern for the poor was an absolutely legitimate argument to make against privatization. But there was no real response to the Mayor’s criticism of an overstaffed, inefficient institution. Neither the unions nor the fringe advocacy groups ever really addressed the labor issues in a meaningful way. That was unfortunate, because a meaningful dialogue about a very important issue would have been useful in the rapidly changing health care delivery marketplace. In fact, the Blue Ribbon panel had recommended a Citywide labor advisory committee, understanding that the labor force in the municipal system, as well as the voluntary system, was going to be downsized dramatically because of the shift to managed care and the decreasing acute care bed need. This was indeed a very important economic issue as well as a political issue. Many HHC hospitals, like many hospitals in communities around the country, were the primary source of employment in their neighborhoods. It was an issue that needed to be studied and addressed. But it was not a health care issue.

The point, however, that the administration was very serious about downsizing the HHC workforce seemed to be missing from the union’s understanding, until much later in the

privatization process. That goal was real for all of the HHC hospitals, not simply those that were to be privatized. The union appeared to be unaware of the fact that for the administration, privatization was a means, not an end. The Mayor's belief was that the hospitals were inefficient and provided substandard care, and if HHC couldn't get to a point of improvement on its own, than privatization seemed to be one answer. Moreover, the J.P. Morgan report documenting the fact that there were too many employees per HHC hospital bed was not the only information guiding the administration. Two consecutive presidents during the Giuliani administration would come to the conclusion that the only way to substantially reduce costs in the HHC system was to drastically reduce personnel. With increasing cuts in Medicaid and Medicare, and the threat of a mandatory Medicaid managed care environment and the resulting decreased reliance on acute care hospital beds, there was simply no other way to make the municipal system more efficient. At the time Mayor Giuliani took office, personnel accounted for nearly 80% of the budget, compared with a voluntary hospital number of approximately 65%. Ultimately, prior to the privatization deal at Coney Island, over 7,000 employees would be eliminated through offers of early retirement, severance packages, and unlike any place else in the City system--layoffs. Privatization had set the tone for tremendous change, and it appeared as if even job reductions were preferable to privatization.

From the administration's perspective, they would heed the advice of those with experience both in privatization and experience working with the unions. Both the City and HHC fully believed that a fair and equitable labor policy was essential to the success of the agreement. Therefore, representation was ultimately settled very early in the final Coney Island privatization effort. As discussed in Chapter Four, by August 12 1996 only two months after the original letter of intent was signed, PHS had written a letter stating

that they had “agreed in principle” to “recognize and negotiate with the unions representing employees of Coney Island Hospital” (Connery 1996). Once the letter was signed, many of the other union issues disappeared. It also quieted much of the related opposition.

The Advocates

Advocacy groups such as “The Campaign to Save our Public Hospitals” persisted in their tactics to frighten communities into believing that their access to care would be severely curtailed. In their flyer opposing privatization they stated the following:

Privatization and budget cuts are not the only things that should concern us. Mandatory managed care will drastically change how we all get our health care. The privatization of HHC is just one way that the change to a managed care system of health care is changing what we have come to expect from our doctors and hospitals. Beds will be closing all over the City, doctors will have their decisions about how to treat you reviewed by companies who will make or lose money depending on how expensive a patient you are. This change means you will have to become very assertive in getting the care you need.

(Campaign to Save Our Public Hospitals 1995)

The advocates were using a potpourri of health care issues to scare the public. The national trends in managed care, for example, had little to do with privatization. The group was also linking budget cuts with privatization. The history of HHC clearly demonstrates that its problems, while they may grow worse at times of severe budget constraints, are much more structural in nature. One could argue, in fact, that the great difficulties in making changes in the entrenched bureaucracy are made much more difficult by the groups using misleading information and scare tactics to frighten the public, thus impeding any progress that HHC could make. Again the words of Peter Drucker cited in Chapter Two come to mind. Organizations need to change to advance.

The strategy of the “fringe” advocates, as opposed to the more established groups opposed to privatization who were by and large more responsible, continued as they

followed the Mayor and administration officials around the City. As Sayre and Kaufman had observed many years before, New York City, with the many traits that may be viewed negatively by its citizens, also maintains qualities that are quite rewarding to many of those who live there, particularly those who are politically active. "One of these qualities is openness. No part of the city's large and varied population is alienated from participation in the system. The channels of access to the points of decision are numerous, and most of them are open to any group alert to the opportunities offered and persistent in pursuit of its objectives. All of the diverse elements in the City, in competition with each other, can and do partake of the stakes of politics; if none gets all it wants, neither is any excluded" (1960 720-721).

Consistent with the observations of Sayre and Kaufman, HHC was legally required to hold one, annual, open public meeting. Over time, tradition dictated that there be one held in *each* borough. That meant holding five public meetings each year, as opposed to the one annual meeting required by law. These meetings became a place for advocates to voice their opposition to the Mayor's policies – specifically privatization. The special interests from elected officials to the unions to the advocates were there, typically the same hundred to two hundred people. Always represented were Local 420 and the Campaign to Save our Public Hospitals. They were consistently contentious and the speaker's remarks were generally aimed at stirring up the crowd. An Annual Public Meeting sponsored by the HHC Board in October of 1995 at Woodhull Hospital is a good example. There were no plans even announced for privatization at that point, and Woodhull was never a consideration. Yet the crowd was very angry, and their anger was personal. Mr. James Butler of Local 420 started the meeting with the following remarks:

Dr. Giuliani, Dr. Pataki, and the Republican Klan represented by Newt Gingrich must understand that health care is a right. The workers that I represent are very concerned about their jobs. They are concerned about the patients that they care for. They are very disturbed with the crisis, and they're fired up, and they just can't take no more of this nonsense from Dr. Giuliani. Who is better known as a butcher. . . The big question I have for you this evening is what will happen to the poor, disabled and the elderly if public hospitals are sold off? My answer to you is that the poor, elderly and the disabled will die at the steps of the public hospitals. (Butler 1995)

Mr. Butler then went on to ask why the City was picking on Woodhull. The fact was that Woodhull was chosen as the site of the public hearing because a different HHC hospital in Brooklyn had been chosen a year before. Woodhull, moreover, had been earmarked by the HHC Chairwoman, working in consultation with the local Council member Victor Robles, for major improvements in management, physical plant and medical personnel. The chairwoman had learned that among other things, not a single medical record had been purged from Woodhull's medical record department from the day the hospital had opened twelve years prior. That meant that every time a patient came to the clinic to be seen by a doctor, they had to wait until their record was found. Sometimes it took hours, sometimes it was never found. The result of that medical records disaster was that patient had to wait literally, for hours to be seen by a doctor until their record was found. At times, they were even sent home and asked to come back. That was only one of the longstanding problems that had existed at that hospital for years. Woodhull had long suffered a reputation for very poor quality (much of it deserved at the time), so together they were working on major improvements at Woodhull, which were ultimately successful. The people at the hospital knew that. Yet Mr. Butler's remarks and the remarks of others often obscured the facts. A second speaker continued.

I, in representing Cumberland Diagnostic and Treatment Center, must first explain. . . I am a veteran who served in Vietnam and Korea. I am a community leader, I am a warrior. . . I want to say this, some of you who made decisions to talk about cutting make me sick. You make me sick, you make my whole community sick. Because you sit in high exalted positions making the decisions that determine the lives of my community,

and we won't allow that to happen. . .I sit here and listen to the idea of cutting and closing Woodhull. (Carter 1995)

No one but Mr. Butler had ever mentioned closing Woodhull.

Finally, at that meeting a representative of the Campaign to Save Our Public Hospitals spoke.

Ms. Mitchell, you keep complaining that public hospitals give such lousy care, you have to wait for hours to see a doctor and us poor mothers who have to breast feed our babies while waiting for our doctors to call us. Of course, you'll never have that problem as you are too inhuman to be a mother...it is yours and the Mayor's fault if us women have to wait for hours at a City hospital clinic while breast feeding our babies. (Grief 1995)

That was the general tone of most of the public meetings, a loud, negative view voiced by a small minority. One is reminded of Olson's view that there is an inclination for the special interests of a few to more easily organize into interest groups than the broader interests of the whole (1965 and 1982). While not nearly on the scale that Olson discusses, the HHC arena and related interest groups appear as a microcosm of Olson's larger view. That is a view in which Andrew McFarland concludes that "with time, the growing influence of special interest lobbies destroys markets, competition, and economic development, leading to a condition termed here interest group stasis, at best static" (1992). HHC was certainly in a prolonged state of stasis.

To apply the theory of the power élites here may be overstating the case and perhaps gives more credence than appropriate to the so-called "fringe" interest groups. However, it must be remembered that much of their work was done in conjunction with labor--a major force in the New York City economy as well as New York City politics.

HHC Community Advisory Boards

The HHC Community Advisory Boards (CAB) exist at each of the HHC facilities pursuant to the HHC Act. They serve, by law, strictly in an advisory capacity, and it is the

responsibility of the facilities' executive director to keep them informed of the significant issues relevant to that particular facility e.g., the affiliation contracts--as informational items. The advisory boards vary in their degree of support for a particular institution, or antagonism toward a particular hospital administration. Their level of support, or more traditional polemical advocacy role, is dependent typically on the executive director and how she/he keeps them informed and involved, but also on the tenure of the director. Some HHC facilities have extremely high turnover at the top, and those institutions tend to have more discontented boards.

In the case of privatization there was a vast difference in the community advisory boards. Both Coney Island and Elmhurst Hospitals had Executive Directors in place for many years that were supportive of privatization. Accordingly, their boards varied from quiet to actively supportive in the case of Elmhurst Hospital; at least for the first fifteen months of the administration. Early on in the process the Elmhurst board wrote a paper supporting the idea of privatization and asked to be involved in the process in order to be informed and have input. The Health Advisor met with them early on, and the relationship remained a good one throughout most of the process. Later in the process the Coney Island board would become more actively antagonistic to the process, clearly at the instigation of the Campaign to Save our Public Hospitals. The fact was that privatization of Coney Island Hospital was becoming very real, and the CIR had a lot to be nervous about. They needed to drum up community opposition, and they used scare tactics about decreased access to do so. The community advisory boards were a good base of support for them.

It was the Queens CAB that from the outset was extremely disputatious toward the administration and privatization. There was a very different history at Queens Hospital

than at the other hospitals slated for privatization. It was one of the oldest facilities in the HHC system, one where twenty and forty-bed wards remained. Its long time executive director had been asked to leave and run a larger HHC hospital during the Dinkin's administration. Replacing that director caused a great deal of community struggle. The discord played out in local politics, with most locally elected officials weighing in. It was a contentious battle and not all were pleased with the outcome. Moreover, during the same period, the hospital's long-time medical affiliate withdrew from its relationship with the hospital, and it took the Dinkins administration several years to find a replacement affiliate. Both processes were riddled with racial politics as the previous director was white and the affiliate institution was primarily non-ethnic, and the community had over the years become largely, an ethnically diverse community and felt they had the right to more balanced representation in their caregivers--a very valid point. A final issue for this hospital was that the hospital had been slated for rebuilding since the early Koch years, and their rebuilding project was continually put on hold. At the same time other projects moved along, including the major reconstruction of Elmhurst Hospital. The Queens Hospital community justifiably felt as though they continually got short shrift. And, in the end, after a prolonged search to find a minority medical affiliate, with the search even going far out of state, Queens wound up with Mount Sinai, a Manhattan based medical center as its medical affiliate. It was a fine medical school and teaching hospital, but not what they had fought for or expected throughout their struggle.

It was with this background that Mayor Giuliani announced that Queens Hospital would be one of the hospitals to be privatized. The history of the hospital was integral to the way the privatization process played out. In part, it was believed that a buyer would be willing to rebuild Queens if they were getting a brand new hospital in Elmhurst. There was an untapped market in southern Queens where a new operator could set up clinics

and attract those patients to a new Queens Hospital some twenty minutes away. The irony is that privatization of Queens was an attempt to save the hospital. With the new managed care environment and the hospital's aged physical plant, it was becoming an increasingly unpopular place to go for care for the Medicaid patients who had new choices about where to go. The census at the hospital was declining rapidly; the fact was, the hospital was slowly closing itself *and* costing HHC a lot of money. The Queens Community Advisory Board saw it very differently.

The Queens CAB from the outset opposed privatization rigorously. They were immediately active with the Campaign to Save Our Public Hospitals and wrote letters repeatedly to the Mayor and his Health Advisor. They ultimately brought a lawsuit against the City claiming that in their role as advocates they were "entitled to information and inclusion regarding policy decisions affecting their respective hospitals." (Lancman 1995). HHC and City officials met with them on numerous occasions, yet they would write a letter after each meeting claiming that it was unsatisfactory. They wanted, for example, to be involved in the writing of the Offering Memoranda that would be, as described in Chapter Four, the selling documents for the hospitals. A typical response from the CAB's chair after a meeting in an attempt to illuminate the details of the offering memoranda was as follows: "Thank you for meeting with the Community Advisory Board and for your letter inviting our input. Your entreaties are refreshing, if nonetheless unsatisfactory. We cannot offer constructive consultation in a void, in the abstract, without reference and text. We cannot meaningfully consult you on the offering memorandum without access to the language and structure of the offering memorandum itself. You ask us only about the forest; we need to talk about the trees." (ibid.) In the end, the Court upheld the City's position that the CAB's had received "meaningful" input from the City and had ample opportunity for input in accordance with their legal role.

Established Group Interests

Confounding the view that business élites would play a major special interest role, they did not. In the case of privatization, the business community, while holding a very similar opinion to the Mayor with regard to privatizing HHC, was not motivated to be aggressively involved. The New York City Partnership and Chamber of Commerce did publish a report on the health care system in New York City as well as several documents on privatization at the end of the Dinkins Administration. They were clear advocates of privatization. In their report, a key recommendation was to consider privatizing all of HHC. That was well in advance of the Giuliani's Blue Ribbon Panel suggesting the devolution of HHC.

The Partnership called upon the City to fundamentally reconsider its health care mission. Specifically they stated that "a local government, even one as big as New York, can no longer seriously contemplate solving the problem of universal access to health care, and New York City must rigorously re-think its health care mission." (New York City Partnership 1993, 133). They also discussed many of the same issues cited in the numerous reports done by outside experts on HHC discussed in Chapter Two. For example, with the inception of the Medicare and Medicaid, New York is no longer the primary funder of the poor. They also cited the emergence of Medicaid managed care as a threat to the public hospital system because of a long-standing record of quality health care problems. They further stated, in direct contradiction to the special interests cited above, that

no informed observer would say that the uninsured in New York City have universal access to appropriate health care. Resource limitations have simply compelled the City and HHC to limit facilities and services, providing a very real cap on services available to the uninsured. (New York City Partnership 1993, 135)

The Partnership expressed a very negative view of the City being able to turn around a system that needed major transformation. They finally recommended the following:

- Transition mayoral agencies out of providing patient care services directly
- Restructure HHC governance to a more independent authority and change the relationship to a vendor basis
- Immediately explore opportunities for greater partnerships with the private sector in the operation of some of its facilities through sale, lease or management contract.

The Partnership ultimately recommended a long-term review of HHC with short term and intermediate steps. But they concluded with the long-term objectives (2-5 years) of eliminating non-essential services and facilities and consideration of privatizing all of HHC (New York City Partnership 1993, 159). It was significant that they reached these conclusions during the Dinkins Administration.

The Partnership, and the business community in general, remained proponents of privatization throughout. However business really did not have a stake in making changes at HHC. They had, of course, a major interest in the local economy. Therefore, to the degree that HHC was running large deficits and draining valuable City resources, they were more actively interested. At the time of the Partnership report, that threat was very real. In its August 1993 review of the City's budget, the state Financial Control Board found: "Our analysis suggests that the City's exposure to an HHC operating deficit may be significant in FY 1994 as well as in subsequent years. In 1994, we project that the City's liability may be as much as \$150 million higher than planned." (New York Chamber of Commerce and Industry and New York City Partnership Privatization Task Force Chairman Frank G. Zarb 1993). But from day one Mayor

Giuliani very publicly made it clear that he would no longer fund HHC's inefficiencies. In a letter to then HHC Chairman Luis Miranda, only several weeks into the new Mayor's term, Deputy Mayor Peter Powers wrote:

as you proceed with the process of identifying means to close the HHC budget gap, I want to be assured that absolutely no cuts in services are contemplated until all other options have been exhausted. That means redoubling efforts to maximize third party reimbursements; streamlining the central office as an example for the entire system; and reducing costs for greater efficiencies. It is important to remember that, given the severe budget problems the City is facing, you will be unable to turn to OMB for assistance. This is a new era for New York City and HHC. (Powers 1994)

All of Mayor Giuliani's future actions with regard to HHC reinforced this early stance so that the business community had a level of comfort that the City's health care system was not going to bring financial disaster. The Mayor's advocacy of Medicaid cuts in addition to his push forward with privatization convinced the business world that the new Mayor was serious about getting HHC under fiscal control. It was not unlike the national health reform movement and the Clinton administration. In that case, big business clamored for change; but as the market, in the wake of managed care, began to ameliorate the problem, they were no longer active in the battle (see Chapter Three). Moreover, by the time Giuliani became Mayor, the economy was in such bad shape, that the business community had a great many things to focus on; so health care was not at the top of their list. The positive view that the business community held of privatization did allow the Mayor to move ahead with his plans unencumbered by any opposition from that group. Ironically, when the Coney Island privatization deal was complete, the Mayor made the announcement at the Chamber of Commerce in Coney Island, and the plan was met with great enthusiasm.

The Citizen's Budget Commission (CBC) represented yet another interest that might be classified under the rubric of social politics as "fiscally responsible liberals" (author's

term). CBC was not as generally conservative as the business community, but obviously concerned about the fiscal state of the City. The Commission published a report in March of 1995 in the height of the privatization debate entitled Privatization and the New York City Health and Hospitals Corporation (Brecher and Spiezio 1995). The report of the CBC, in this author's opinion, presented the views of the principal author, Chuck Brecher. He had been a professor of public health administration at the NYU Wagner School of Public Administration for some time and had a longstanding interest in HHC. Further, it is this author's view that Brecher's opinion reflected that of a large group of health policy "watchers" in New York City who knew well that the HHC was in drastic need of change but believed that there was no way to privatize such a system without limiting access to the poor.

The Brecher report agreed that major changes were necessary at HHC and that it was appropriate for the administration to be challenging the City's role in health care. Brecher critiqued the Giuliani administration's plans of privatizing and looked at what happened around the country when public hospitals closed, in other words what happened to the poor? The report made three main recommendations, they were:

1. There should continue to be a publicly sponsored organization providing health care in New York City. Reasons:

- A. Cities without public hospitals provide less hospital care to the uninsured.
- B. Subsidy to voluntaries for indigent care may not work because
 - ❑ On a purely political level, an identifiable public institution may be better able to generate and sustain local subsidy.
 - ❑ Voluntaries may be unwilling to care for undesirable indigents.
 - ❑ Voluntaries may not accept below-cost public subsidy.

2. That public entity should be drastically restructured from the existing HHC

- A. Reduce HHC Board to 4-6 appointees (half State/half City) like the MTA.

- B. Base subsidy of specific payments for specific services with the volume determining the actual amount
 - C. Organize HHC as an HMO rather than a network
 - D. Reduce inpatient capacity according to a drop in census
3. **Promote efficiency through competition and privatization (not necessarily of hospitals but services within hospitals).**

Dispose of excess capacity through

- ☐ Sale of Coney Island, Queens and Woodhull, or
 - ☐ Rent blocks of beds to HMO's or other providers
- A. In place of affiliation agreements, seek bids from different centers for each type of care needed (specialty and primary), and pay on basis of productivity.
 - B. Competitively bid for support services (nurses, housekeeping, food, and laundry).

CRITIQUE OF GIULIANI ADMINISTRATIONS'S PRIVATIZATION PROPOSAL

1. **If the goal is lower cost, equal access and better quality, then it is possible the strategy will not work**
- A. **Quality of care will improve, but physician services will not.** Some services will improve (housekeeping, nursing, and ancillary) but not physician services since the doctors are already from the voluntary hospitals.
 - B. **Cost of care will be higher.**
 - ☐ Voluntaries have higher unit costs due to: higher quality, more nursing and administrative staff, and higher administrative salaries.
 - C. **Access to care for the uninsured will likely be reduced.**
 - ☐ Voluntaries often limit care to indigents to attract middle class patients.
 - ☐ Voluntaries provide much less bad debt and charity care, e.g. Mt. Sinai: 5.5% of total expenditures versus 27.7% at Elmhurst and 22.4% at Queens.
 - ☐ Voluntaries have discriminated against Medicaid patients, e.g., Mt. Sinai maternity ward problem.

D. Therefore, privatization should be viewed as an *experiment*

- ☐ Mechanism for insuring access to indigent should be tightly designed and enforced.
- ☐ Impact on utilization should be monitored.
- ☐ Impact on unit costs and public expenditures should be monitored.
- ☐ Only after credible evidence is gathered should further privatization be initiated.

2. If goal is to shrink HHC to more appropriate size then:

- A. The number of beds being sold is appropriate.
- B. There is strong logic to selling entire hospitals rather than contracting beds.
- C. **BUT**, selection of hospitals fails three logical criteria:
 - ☐ To reduce need for tax levy, City should select hospitals with the greatest operating deficits like Kings County and Woodhull, not Coney Island
 - ☐ To reduce impact on uninsured, City should select hospitals with the fewest uninsured, not Elmhurst and Queens.
 - ☐ To reduce the impact on future capital, City should select the oldest facilities, not Elmhurst (Brecher and Spiezio 1995)

The report reflected a thoughtful view, but one resistant to the fundamental changes that the Mayor was trying to make. It was consistent with the innumerable reports over 30 years that recognized the inherent structural problems with HHC. There were, however, some basic misassumptions about the report. Most importantly, the authors never considered any new hospital owner other than the existing City voluntary hospitals to take over for HHC hospitals. Other assumptions in their report could, at minimum, be disputed, and likely proven wrong. On the issue of voluntaries having higher costs, for example, both the voluntaries themselves, as well as J.P. Morgan, provided data demonstrating otherwise. In one instance, in a letter to the HHC Chairwoman reiterating Mount Sinai's response to a Daily News article discussing the same issue, the hospital's president wrote:

We have told the News that as a leading tertiary-care teaching facility, Mount Sinai provides highly sophisticated care to patients with the most difficult complex medical problems, and that when the severity of illness of our patients is considered, the cost of a day's care at Mount Sinai actually is lower than at Queens or Elmhurst. Applying case-mix adjustments to the figures cited in the News article, the per diem cost of care at Mount Sinai would be approximately \$596, compared to \$673 at Queens Hospital Center and \$608 at Elmhurst. (Rowe 1995)

Some of the recommendations were politically naïve. To assume that the state would be willing to take on the burden of sharing HHC in an MTA-like fashion was optimistic at best. For years, HHC had been a no-win political institution for mayors. No governor of sound political judgement would willingly take on that responsibility. Moreover, Brecher's recommendations were made in a fiscally strained environment. The perils of a red tape municipal hospital system was certainly not something a new Republican governor was at all likely to risk. He was in the midst of trying to deal with his own ballooning state deficit.

The suggestion that a hospital like Kings County, because of its dilapidated physical plant, its severe budget problems and its high-uninsured population be one of the hospitals to privatize was unrealistic. In fact, the City had been working to get the state interested in sharing the rebuilding of Kings County, and that alone was proving impossible. Finally, with regard to the capital issue, Brecher et al. suggest that the goal should have been to have a buyer pick up the debt service to relieve HHC and the City of that debt. In the end, that's what happened. The final Coney Island sub-lease required PHS to pay \$45 million up front and the remaining \$10 million over the course of the lease. That is, PHS was responsible for the full debt service on Coney Island Hospital.

In summary, it was clear that few of the traditional health policy professionals who were advocates of the HHC system were willing to agree that despite all the failed past attempts at reform, privatization might just be an answer. It seemed unthinkable that perhaps HHC was beyond repair. Their voices were never loud in opposition. Primarily they were "sources" in a newspaper quote. At times they were on the record. But in their own way this group of professionals was a part of the status quo that made change in New York a difficult thing to achieve.

Elected Officials

The Comptroller

New York City Comptroller Alan Hevesi played the most active and vocal role of any elected official outside the City Council in the privatization debate. In the end it would be the City Council speaker through his lawsuit that played the most pivotal role, but Hevesi was the active voice of opposition. Despite any legitimate questions that Hevesi may have had (and there surely were some), it was not unusual for the Comptroller and the Mayor of the City of New York to be at odds. Former Mayor Ed Koch relays a number of stories in both his memoir books, Mayor and Politics, about his often stormy relationship with then Comptroller Jay Goldin (Koch 1985, 20; Koch 1984, 123)

Hevesi, like the other opponents of privatization, began his public attack on the process in mid-1995 subsequent to the release of the J.P. Morgan report. His initial opposition was very much related to his role as Comptroller and concern about the fiscal effect on the City from any privatization deal. Like the others who opposed the deal, he made baseless assumptions. A source of ongoing frustration to both sides was that, without a deal, it was very difficult to discuss specifics. The administration would articulate its goals, but were invariably not trusted. The basis of the mistrust was discussed in Chapter Four; that is how much is reasonable to divulge in the middle of creating a

competitive environment and/or negotiating a specific deal, and how much is appropriate to keep as confidential information? Moreover, the administration's goals embodied most of the goals that any reasonable opponent would want out of a contract. Those goals seemed unattainable, and those outside the administration didn't appear to believe that the articulated goals were realistic.

Finally, when assessing motivation, it was a long standing tradition in New York City politics for the unions to play one elected official off the other. In the case of the Mayor and Comptroller that certainly held true. Koch, for example, discusses in Mayor, a situation where the operators of the tugboats in Manhattan were going to strike to "secure a prevailing wage agreement for members of their union who worked for the City" (Koch 1984, p.123). This would have had a big impact on the removal of garbage from New York, and could cause a health emergency. The union wanted "prevailing" wages. That was inappropriate from the City's perspective because City workers have much better benefits, particularly pension benefits. Koch denied their request. He relates the story in the book and says:

It never would have happened in previous administrations. A deal like that one would have been the subject of a sweetheart negotiation between this relatively small but powerful union and the Mayor. And the Mayor, whoever he was, would have paid what the union wanted, and the deal would have been blessed by the Comptroller—who in this case was Jay Goldin, and he certainly would have blessed the special deal because he was very close to and fearful of the unions – and the whole thing would be done quietly before anyone knew it. (ibid.)

Specifically, in the case of Hevesi and Giuliani, by the time Hevesi was attacking privatization, it was clear that he and the Mayor had a major rift, despite their congenial early start. It was also widely speculated that Hevesi was going to run for Mayor. The rift was widening. Under those circumstances then, it was easy to see that the unions would not have had a difficult time convincing the Comptroller that privatization was not

a good thing. While the Comptroller and the Mayor would, ultimately, make peace and once again work well together, there was a several year period where that was not the case. The privatization debate raged during that "off" period.

Many believed that there were several staff members in the Comptroller's office who particularly did not want privatization to happen, and fueled any concerns the Comptroller had. If the communication or the trust were better, the Comptroller's staff would have understood that Giuliani's plans for going forward were not limited to one or two hospitals. It would have made sense for the unions at this point to call on their political allies--the elected officials.

Comptroller Hevesi first raised his concerns about privatization in a letter to Mayor Giuliani in August of 1995. His initial concerns were related to the City's General Fund as it related to capital debt. Hevesi stated that:

I am concerned that the proposed sale of Elmhurst, Queens and Coney Island hospitals will, in all likelihood, result in the unanticipated and costly necessity to issue taxable General Obligation Bonds. This taxable bond issue would be necessary to repay the General Fund for certain outstanding and partially un-reimbursed capital construction and improvements on these three hospitals (Hevesi 1995).

Hevesi was concerned that the City's General Fund was not being reimbursed for capital improvements ongoing at those hospitals cited for sale. The issue was only relevant to Elmhurst Hospital, which was finishing a long-term reconstruction project. Because of a pending IRS ruling with respect to bond sales, HHC was not reimbursing the General Fund for some several months. None of the other hospitals was under construction, so that it was not relevant. Finally, as it was the City's goal for the ultimate buyer to acquire the debt associated with the purchased hospital, it would ultimately become a moot point. As the City's fiscal monitor the Comptroller had good reason to raise such issues. It was frustrating, however, when the dialogue between the Comptroller's staff and

members of the Mayor's staff were not relayed back to the Comptroller either at all, or accurately.

In such a case, it would also be true that no bond defeasance (or sale) would have been necessary--another issue raised by the Comptroller citing it as an added cost to the City.

In the case of the final Coney Island sublease, PHS in fact took full responsibility for the capital debt. To digress, this should have been a particular accomplishment in the Coney Island privatization agreement favored by Chuck Brecher and the Citizen's Budget Commission (CBC). CBC is consistently on the record referring to the City's outstanding capital debt as a major factor in the City's structural budget problem.

Hevesi's next public complaint to the Mayor came shortly after the Mayor's Blue Ribbon Panel released its report on the future of HHC. While still in his purview as Comptroller, the issues outlined in this letter regarding policy preferences at HHC, brought Hevesi more into the "political" field of privatization, and one might speculate, closer to the issues at the heart of the union concern. It is clear that the Blue Ribbon panel's report, coming only months after the release of the J.P. Morgan analysis, must have certainly secured the notion that the Mayor was very serious about the privatization initiative.

Hevesi's September 13 1995 letter to the Mayor stated specifically:

While the report is very clear about the policy preferences for HHC, it does not deal with a number of significant questions related to selling off the public hospitals. Nor does it include a plan for attaining its goal of abolishing and privatizing the existing system of public health care for the uninsured.

These were most reasonable responses to the report. They did not however accurately reflect the report's intent or recommendations. The report never stated that all of the

hospitals should be sold or privatized, as the Comptroller implied. *The panel's report also very clearly made the recommendation that all of the hospitals should retain the mission of serving the uninsured, and that each hospital network should be studied by the hospital with members of their community in the context of their community.* Only after a strategic planning process had taken place should a determination be made about the most appropriate future of each facility. The only true dismantling of the system that the report was very clear about was the elimination of the monolithic bureaucracy that bound the institutions into an irrational whole.

The Comptroller raised another valid point, one that could be argued either way. His major point was that the Mayor should have released a report that contained a full, clear, long term vision for HHC, as opposed to a more general, broad direction. That would have given the public a clearer sense of where the Mayor was going, as well as more of a sense of his commitment to the poor. One only need review all of the multifarious reports that detailed very clear recommendations for HHC to speculate over how much difference yet another set of long-term recommendations might have made. Only several years before, the Barondess Report spent \$250,000 thousand dollars over the period of a year making very clear recommendations that went nowhere. The Giuliani team was guided by history in "fixing" HHC. The Comptroller also kept to the approach of asking pointed questions that he must have known could only be answered once there was a successful bidder chosen and a specific contract to negotiate. This tactic, used by most of the privatization opponents, was effective because it allowed them to raise important and sensitive issues such as "Who will provide health care to those now served by HHC?" The administration could respond that all current care would continue to be paid, the Comptroller and others wanted details that couldn't possibly be filled in without another party or purchaser.

Ultimately the Comptroller's questions and the issues he raised related directly to the Coney Island sublease itself (Hevesi 1996). The administration staff offered to, and in fact did, brief the Comptroller and his staff on several occasions about the Coney Island /PHS sublease. Nevertheless, he and his staff continued to raise multiple questions. A typical question, one that reflected the voice of advocates and others, is a good example of the dialogue that ensued over the next months. In the letter of intent signed by HHC and PHS, the latter was obligated to spend a minimum of \$25 million during the first five years of the sublease to finance major capital improvements to maintain the physical plant. During the period between the Letter of Intent and the final negotiated sublease, it was up to HHC and the City to work out any details related to that point and others, and work them out in the context of all of the other details of the sublease. Despite the fact that the Letter of Intent was signed on June 30 1996; on July 30, after a full briefing of the letter of intent and its background with his staff. Hevesi wrote to the Mayor:

Since the lease term is 49 years, a five-year commitment on capital improvements appears to be an insufficient guarantee for long-term maintenance of the physical plant of CIH. How will the physical plant of CIH be maintained in lease years through 49? What is the estimated cost of capital improvements to be made during lease years through 49? What type of capital improvements will be necessary over this period?

These questions would seem inappropriate to an objective observer given that the Letter of Intent stated "a minimum of \$25 million in the first 5 years" and there was no final contract. Moreover, it should be noted that HHC had removed Coney Island Hospital altogether from its 10-year capital plan. So, despite the fact that CIH was a very old physical plant, no money was slated to be spent by the City. Therefore, PHS's \$25 million was more than CIH was guaranteed to get from the City or HHC. It was also somewhat inconceivable to predict the capital needs of any hospital 50 years down the

road, when in fact the changes in the health care system made possible the notion that hospitals as we know them today would not even exist.

Finally, Hevesi raised multiple questions about the draft of the sublease when it was circulated (the sublease was broadly circulated in draft form prior to the final signing). He wrote numerous letters to the Mayor, his staff attended multiple briefings with HHC and City officials, and he spoke out at many of the public hearings and meetings. Hevesi raised issues that were discussed at some length in Chapter Four about the quality of care provided by PHS as it related to the Cleveland quality study. This was an area that was somewhat troubling by the manner with which it was dealt. Again, it was clear that a few members of the Comptroller's staff were behind these "concerns". Some of the Comptroller's staff knowingly provided the press with distorted information. The issue had to do with quality, as well as the level of indigent care that PHS provided to its hospitals in Cleveland. They asserted that PHS provided less indigent care than other area hospitals. Officials from OMB and the City's outside counsel had spoken at length to the same Ohio officials that the Comptroller's staff had spoken with. They were told very clearly that the Ohio Department of Human Services personnel had given the Comptroller's staff unaudited figures, and they stated to Hevesi's staff that they were most likely incorrect numbers. These numbers related to patients with incomes above the poverty level. The Ohio officials stated that the figure was such an anomaly that it almost certainly had to be an accounting error. The Ohio officials went on to say that they had provided the Comptroller's office with trend data which gave a very different, and much more positive picture of PHS. Unfortunately, those staff in the Comptroller's office completely ignored this data in the press briefings. Additionally, his staff reported numbers at another PHS hospital that was under prior ownership for most of the period in question, another fact they declined to share with the press (Mitchell 1996). It also

seemed very clear that the Comptroller himself was completely unaware of the duplicitous behavior of his staff, because other more senior members of his staff were very interested in getting at the truth and apologetic about the "confusion." The Comptroller himself was also an opponent who was known to argue on the merits and always direct and above board.

His office, however, argued that the City and HHC did not know enough about the quality of care to be provided by PHS. In addition to the due-diligence performed by HHC and the City, discussed in Chapter Four, there were provisions in the final sub-lease that required the City to monitor the quality of care and that included graduated sanctions for both poor quality care and denials of access. Those sanctions went as far as the City's repossessing the hospital. The City's point of view was that they couldn't account for every eventual problem that could occur over the course of a 49 or 99 year lease, but that monitoring mechanisms to assure that PHS honored the terms of the contract was the most prudent avenue to follow.

The Comptroller remained committed to his opposition until the day of the Board vote on the Coney Island sublease. On November 7, 1996 Hevesi put out a press release to urge the HHC Board to delay the vote on the Coney Island deal. It read in part:

It is irresponsible to turn over a public hospital to a for-profit company for 200 years without understanding the effect of the deal on the care and costs," Hevesi said. "Many of the details of this proposed deal have still not been made public and most of those that were revealed only in the last two weeks. The public review process took place before the contract was distributed, making it an empty exercise (Office of the Comptroller 1996).

He went on to reiterate questions that he had asked repeatedly, including that of care for the poor. It was difficult not to view his documents as political. The answers to his questions had been provided many times and were expressly addressed in the

sublease. Like the capital issue, PHS was committed to paying more for the care of the indigent than the City.

A recent quote by Dr. Luis Marcos in the New York Times in an article on the rising numbers of uninsured illustrates that very point. The Times article discusses the issue of the rising uninsured in New York City. When asked to comment about the effect of the growing uninsured on HHC, Dr. Marcos remarked:

For public hospitals to survive, we cannot simply treat patients who cannot pay. In the end, it will be more inefficient and costly to the taxpayer. We cannot go back to the days of the almshouse. (New York Times, 12 February 1998).

Surely PHS's contractual agreement to pay for the uninsured at current 100% of levels and 25% beyond was a much greater commitment.

THE BOROUGH PRESIDENTS:

Given that Coney Island Hospital was in Brooklyn, Borough President Howard Golden also played an active role in opposing the Mayor's policies once the privatization of the hospital became much more realistic. Like others, he began his dissent in earnest after the Mayor's Blue Ribbon panel released its report on the Future of HHC in August of 1995. He wrote to the Mayor in September 1995 expressing his concern about the lack of public input into the report. He said:

The series of actions taken during the past year regarding HHC, including the decision to hire J.P. Morgan to investigate the sale of HHC facilities, announcing the intent to sell the three HHC acute care facilities, appointing an advisory panel to identify disposition alternatives for HHC without formal involvement of the HHC Board and, most recently, news that a memorandum for the lease of HHC facilities would be released by the end of October—even as a furious debate has emerged over the future of HHC—indicate to me that the voices of those who would be affected by the dismantling of HHC have not been heard.

Golden was one of many who would talk of a lack of openness in the privatization process. This was both a difficult and a frustrating issue. It is no exaggeration to say that there were over one hundred meetings held with the various elected officials and community groups (see attached lists of a representation of some of those meetings and efforts to communicate, Appendices 6A and 6B). These included community focus groups *chosen by* the Hospital Community Advisory Boards, not the Administration. These groups were convened to get an honest view of how the community, the real users of the hospitals, thought a monitoring system for access could work *for them*. It seemed to the administration officials that no number of meetings could satisfy the opponents of the process if the outcome was anything other than forgoing privatization.

On the other hand, the officials recognized the frustration of responsible groups, pro and con, who wanted more openness in the process. The issue of open meetings in government can be a complicated, as a recent article in Governing describes.

A quarter-century after the first wave of open-meetings laws, it is clear that the basic premise is settled--in theory if not always in practice. At least publicly, just about everyone accepts the idea that openness is a worthy goal. Now, however, another question is coming to the fore: Just how much openness is enough/or practical (Mahtesian 1997)?

The article refers to those meetings that are required to be open to the public, which the Giuliani team always went out of its way to accommodate. But the issues are similar. Mahtesian reviews a number of municipal and state governments that are trying to curb open meetings laws because of the inability to get business accomplished. A situation in Baltimore epitomizes some of the difficulty. It deals with the new difficulties around electronic mail. A county attorney there issued an opinion that County Community College Board members could not engage in certain official actions or make official decisions or held certain discussions via e-mail. The result was that the board voted to

return \$25,000 worth of computers to foster better communication among members. Texas, perhaps, is a more relevant example. According to their law, there are no exceptions that allow governmental bodies to meet privately to discuss personnel matters, pending litigation or other potentially sensitive matters. They use a staff-briefing loophole as a way to conduct such business. While the HHC privatization did not run into legal issues related to openness (although the Queens CAB did sue over the right to be involved in the process, but lost) the issue was continually raised. As discussed in earlier chapters, much of the privatization process was a competitive one, and in order to protect the City's interest and get the best deal possible for the users of the hospitals as well, discretion was certainly in order. The outcome of the process and the excellent deal that the City got for the Coney Island Hospital bore out that belief.

The Brooklyn Borough President also held hearings on the proposed privatization. Again, Golden, like the other elected officials acted in concert with others. In his case, he held hearings jointly with the Community Advisory Boards of the Brooklyn HHC facilities. The Mayor's Health Advisor testified at that hearing and stated clearly, as she did many other times--always on deaf ears--the Blue Ribbon Panel report was meant

to open debate on possible ways to restructure health care in New York City and HHC over the long run.' She went on to say that privatization would only work if the City did its job...we must negotiate a contract that holds the new proprietor accountable for offering full access to the community, including the indigent, and for offering the highest quality care. As we have said over and over, these issues are not a sideline concern, but central to it (Mitchell 95).

Golden ultimately recommended that privatization be done on a test basis only, and that the process chosen include more public participation, and that any cost savings be returned to the community (1996).

The Queens Borough President, as discussed in Chapter Four, was very invested in the privatization process. But her concern came from one place--she wanted a new Queens Hospital Center, and she wanted to make sure that the new owner/operators of the Queens hospitals were of the highest quality. She saw no reason why her Queen's constituents had to travel to Manhattan to get the best in health care. She did not oppose privatization, but she wanted certain benefits for her borough. She never wavered in her objective, and she got what she wanted.

THE CITY COUNCIL:

The New York City Council was less visible on the issue of privatization than was the Comptroller. The Chairman of the Health Committee, Enoch Williams, was the most adversarial and consistently vocal. He held numerous hearings on the issue. The Mayor's Health Advisor spent hours at a time testifying before the Council. As with the Comptroller and his staff, the Health Advisor and her staff spent hours meeting and communicating with City Council members and other elected officials and their staffs. There were even discussions between the Health Committee chair and the Health Advisor that they would just have to agree to disagree. It made sense that if they were acting at least in part on behalf of the unions, nothing short of ending the privatization process would satisfy them. The issues and the questions were very similar to those of the Comptroller, and like the Comptroller, in the end, there was no way to satisfy those who were opposed on philosophical grounds. Like all of those opposed to privatization, once the J.P. Morgan report was released, Vallone and Williams would comment on many of the same issues as the others had. They were the issues of cost-benefit analysis, access and persistently asking the specific questions that were unanswerable in detail in the absence of a final negotiation of a sublease.

It was the City Council speaker, presumably on behalf of the Council in general, and perhaps at the behest of the unions, who would ultimately have the only real impact on the privatization process. As explained in Chapter Four, the Council brought a lawsuit against the Mayor on the ground that it was the Council, and not the Mayor, who inherited the role of the old Board of Estimate under the new City Charter. Their opposition, at least on the face of it, was not privatization itself, but involvement in the process. In fact, Speaker Vallone, in a joint letter with Health Committee Chairman Enoch Williams, first wrote to the Mayor in August of 1994 stating "The City Council supports privatization as an effective delivery system for municipal services, we are concerned with the lack of public oversight of the process" (Vallone and Williams 1994). As discussed earlier, if the Council was deemed to have inherited the BOE role, the process would be subject to the public land use law and there would be many more public hearings about the proposed privatization. The Speaker went on to say, "We consider this an issue in which we must be informed and in which we inevitably are involved" (ibid.).

There was clear indication, however, that Vallone and Williams were acting at least in part at the behest of the unions as well as the HHC CABs. In the same 1994 letter they state,

The Health and Hospitals Corporation has had a unique success in the New York City hospital industry in diversifying its workers at every level, including management. Under new management contracts, the Council would hope to see this diversity maintained at privatized facilities, particularly for its value in bringing the concerns of the City's varied communities to the highest decision-making levels in health care. (Vallone and Williams 1994)

Vallone and Williams indicated their willingness to discuss the issues with the Mayor and his staff. As indicated earlier there were numerous meetings held with Council staff at all

levels. In the end it was really an issue between the Mayor and the Council about the Council's having a legitimate role in approving the deal.

Giuliani's Corporation Counsel, Paul Crotty, upheld the earlier opinion of Mayor Dinkin's counsel Peter Sherwood, that the City Council had no formal approval authority in the sale or lease of the hospitals. The particular issue in which Sherwood identified mayoral power related to the dormitory authority. On this issue, which was similar in nature to the hospital sublease, he concluded,

It is our opinion that consistent with both the Public Authorities Law and the City Charter, the approval of the Mayor alone is sufficient to authorize the proposed lease agreement with the Authority and that the approval of the Council is not required under the statute. (ibid.)

Mayor Giuliani would respond to Vallone--on numerous occasions--that, contrary to Vallone's opinion, implementation of hospital privatization would not require formal approval from the Council. He would always agree to keep the Council fully informed, but he maintained that consistent with the HHC Act, HHC itself would be responsible for entering into agreements with health care providers. Vallone would respond in writing that the Council was not persuaded by the analysis supporting the proposition that powers granted to the BOE in state legislation are of an executive nature and as such exercisable by the Mayor (Vallone 1994)

Members of the legal community would frequently argue that the issue was reflective of the unique amalgamation of administrative, executive and quasi-legislative powers exercised by the Board of Estimate that made the delineation of duties after Charter reform difficult to determine. It was clear that no single City officer or body acted for all purposes under the charter as the successor to those powers.

In summary, it was only the City Council that had a direct impact on Mayor Giuliani's ability to privatize HHC hospitals. They brought suit against the Mayor on three counts:

- That the Uniform Land Use Review Process (ULURP) was required for the disposition of HHC property.
- That it was the City Council, not the Mayor, who succeeded to the role of the Board of Estimate with respect to the consent required by the HHC Act.
- That the HHC Act does not in any event allow HHC to privatize health care facilities (New York State Public Health Law, Section 7385. General Powers of the Corporation (5,6 and 8). The Council argued this point notwithstanding that the HHC Act expressly provides that it is within HHC's powers.

The City Council brought the suit to the State Supreme Court in the County of Queens. This would be a more sympathetic milieu for Speaker Vallone who was very powerful in Queens County, where judges are nominated to run by the county's Democratic machine. Nomination is tantamount to election. This included the presiding judge, Judge Posner. It was no surprise, therefore, that Judge Posner ruled in favor of the City Council on all three counts.

The City appealed the decision to the Appellate Division, Second Department. The Appellate Division affirmed the finding that HHC does not have the authority to sublease its facilities when the intent is to give up operation of the facility. The court vacated the other two counts, saying that the lower court should not have ruled on them because given the finding that the HHC Act does not allow subleasing of facilities, the other two points were moot.

The City argued, and still maintains, that the HHC Act clearly states that HHC has the authority to sublease its facilities, and that the court read more into the Act than its plain meaning. On Tuesday, February 24 1998, the City submitted its request to the Court of Appeals asking them to hear the case. A decision on whether they will hear the case is expected by May 1998.

Despite the Court's previous decisions, Mayor Giuliani has pledged to pursue his privatization initiative, and he reiterated this in his 1998 State of the City Address.

CHAPTER FIVE

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CHAPTER SIX

PRIVATIZATION POLICY ANALYSIS AND EVALUATION: THE CONCLUSION

That perilous run down the rapids of reform, with sharp rocks standing ready to wreck the fragile vessel at every turn, reminds us of the fluidity and unpredictability of the process and prompts us to be satisfied with probability rather than certainty in our predictions, explanations and understandings.

John Kingdon

This chapter will review New York City's effort to privatize its public hospitals at the outset of the new mayoral administration of Rudolph Giuliani in 1994. The events of the previous chapters will be discussed in the context of the actual agenda setting and policy analyses as outlined by John Kingdon in his book Agendas, Alternatives, and Public Policies (1984, 1995). The reality of Kingdon's notion of ideas coming together around events that help to shape an agenda, and ultimately making policy making, will be discussed in depth. Kingdon's model for agenda setting in a policy process is instructive in determining how Mayor Giuliani's privatization initiative held firm for over three years. Kingdon's model, revised from Cohen, March and Olson's "garbage can" model for understanding organizational choice, relies on the realities of public policy in which there is no defined, step-by-step process (Kingdon, 1984). Rather, as the name implies, it is a converging of forces that often brings a particular agenda item to the table. The Kingdon model will, in his own words, "allow us to see why the [HHC] agenda changed, and why ambitious reform became possible. The three streams all came together at that time, which made this sort of action quite likely. Second, the theory alerts us to the "couplings that can take place" (1995, 217). Kingdon's model will be reinforced using the expansion model of his theory of "focusing events" by Thomas Birkland, who places great emphasis on agenda setting and policy making on disasters as focusing events (1997).

Finally, an evaluation of the process and how the ultimate goals of privatization were or were not met will be interwoven throughout. A discussion of the success of achieving institutional change in a public setting will be evaluated and discussed in the context of the Kingdon model. This chapter will also evaluate whether or not privatization was in fact an "idea whose time had come," and the role that various changes in national beliefs about governing as well as local politics had in bringing the privatization "idea" to fruition. On balance, it is the opinion of this author that it was, and remains "an idea whose time had come." The fact that the Coney Island Hospital privatization proceeded to penultimate realization as an agenda item, as far along as it did, particularly since the opening salvo of the former Dinkins HHC Chairman was that there "would be riots in the streets if privatization were attempted," speaks volumes.

HHC privatization today awaits only a final, and one would hope, less tendentious court opinion. The fact of penultimate realization itself argues that the time was right for radical change in the City's municipal hospital system. But as Chapter Five clearly demonstrated, the institutional keepers of the status quo were hard at work, and as history instructs us they are too often successful at inhibiting change. The strength of the privatization initiative and how it was sustained over three years on the policy making track is enough to, at minimum, take issue with Sayre and Kaufman (1960) and other institutionalists who view change as nearly impossible in a bureaucratic institution. But let us look more closely at the events described in the previous chapters to draw that final conclusion.

Kingdon focuses on two sets of factors that affect policy making and agenda--setting the participants and the process itself; in other words, the players in the game as well as the

game itself (1995). While Kingdon focuses on the federal government, the analysis here is obviously of the New York City government. The participants are those players both inside and outside of government. Inside players include members of the administration as well as other relevant legislators. Those outside of the government include the media, interest groups, and the general public. The process of agenda setting includes three distinct but simultaneous policy “streams”. They are the problem stream, the policy formulation stream and the political stream. Kingdon theorizes that when these streams are joined together, or a “coupling” of the stream takes place, a successful policy agenda has born fruit (1984, 37).

The Process of Agenda Setting--the Game

As Kingdon describes, the three policy streams are distinct but clearly overlapping. Accordingly, the three streams may overlap in this discussion. One point made abundantly clear by Kingdon is that an idea, or any new policy, does not occur spontaneously. It typically has a long history. As was the case with Medicare, for example, the idea came from years of agitation about the lack of access to health care in general, but, in particular, the lack of access to affordable health services for the elderly. The history of problems at this level of policy making is typically a complex and long one involving an array of factors. Furthermore, for a condition to finally become an acknowledged problem, it must be publicly *perceived* as a problem.

The Problem Stream

The factors and conditions cited by Kingdon with regard to “ideas” reaching the policy agenda phase are certainly true in the area of the HHC privatization initiative. The historical problems of HHC, as clearly outlined in Chapters Two and Three, were not brought to public attention by Rudy Giuliani for the first time. There was a strong and clear thirty-year history of the worst kind of quality and financial problems at HHC. Why did it take such a long time

and such a drastic scenario to truly focus the public's attention on the problem? What were the action producing events of the problem stream? Or, as Birkland (1997) would question, were there "disasters" that "focused events" on the HHC problem in a way that would otherwise not have happened?

When Rudy Giuliani campaigned for Mayor, the problems at HHC of both quality and finances were well publicized. As discussed in earlier chapters, a key focusing event using the Birkland typology was the very public case of Yankel Rosenbaum and the alleged responsibility of King's County Hospital for, at minimum, contributing to his death. This event was an extraordinary one in highlighting HHC's problems because it entwined the entire New York City political apparatus with HHC. Because of the very political nature of the event, it directly related the Mayor of the City of New York with the alleged poor quality of care at Kings County Hospital, which would become a proxy for all of HHC in the eyes of the public.

Thus, because of this disastrous "focusing event" a very different level of attention was paid to the "problem stream" of HHC than otherwise would have been, as both Birkland and Kingdon suggest. That attention came from the general public as well as the policy entrepreneurs. The Mayor himself was now being held accountable for the quality problems at HHC. Consonant with Birkland's thesis, both the general public and political officials found out about the "disaster" of Rosenbaum's death at the same time, so there was swift reaction and serious attention paid to the problems of HHC. As Birkland points out in relation to elected officials, they do not "randomly focus on problems, but rather, [they] focus on the more serious problems when their seriousness has been revealed by focusing events and when the seriousness of the event is widely agreed upon" (1997, 150).

Furthermore, this incident led to the creation of the Barrondess Commission that was made up of a broad spectrum of well-known and widely respected health policy experts and professionals who closely examined HHC for close to one year. As discussed in Chapter Two, their report, which was highly critical of HHC was broadly circulated and thus received much public attention. Equally importantly, however, the Barrondess Commission and its findings were well circulated among the "policy elites," as Kingdon refers to them. This created at least some degree of agitation among a largely non-conservative health care community that was fairly invested in HHC. Why then, was it initially so shocking for Giuliani to be talking about privatization? And ironically why were so many quiescent early on despite their shock or dismay over this radical solution?

Kingdon's research is instructive then in understanding why something so shocking as privatization was a much more acceptable "idea" than it would have been at any time in the past. In addition to the real problems of HHC and Kings County first, Kingdon affirms that budget crises are often at the root of bringing a policy item to prominence. The early '90's in New York City, as discussed in Chapter Three, were certainly a time of severe fiscal constraint. The New York City budget deficit in January of 1994, when Giuliani took office, was \$2,135 billion, a full 10% of the City's overall revenue. If things continued on that course the gap would have nearly doubled by 1997, accounting for 19% of the City's revenue. Within one month of Giuliani's taking office, the budget gap had already increased to \$2,261 billion, 11% of revenue (NYC OMB 1998 Financial Plan 36). The budget problems and the related service delivery problems gave Rudy Giuliani a platform to promote inconceivable changes not only Citywide, but at HHC which, one could argue, was home to one of the most entrenched bureaucracies in the City.

It has also been pointed out here that HHC had its own acute budget shortfall (\$166 million) at the outset of the Giuliani Administration, and it grew within only months of the new administration. The new Mayor had a chance to highlight this problem along with the well-publicized problems of the Kings County reconstruction project and the myriad stories of HHC's hospitals losing their accreditation--the national symbol of quality, an example of using the media to help bring policy to the forefront. Kingdon also posits that the less a particular policy or political area affects the general public, the more a crisis is necessary to bring the issue to the top of an agenda. In the case of HHC, that was the phenomenon.

HHC has the dubious history of attracting a great deal of press attention and often proves politically embarrassing for any Mayor at the time of that media attention. It is not, however, for all of its publicity, an agency that directly affects the public at large. It is an institution that cares primarily for the poor and uninsured, therefore it is presumably more difficult to achieve widespread sympathy or outrage for its problems without a crisis to receive the kind of public attention that is action precipitating. Such attention, however, if received in the case of HHC, can then create the perception that the executive is not managing well. While HHC in this instance may not have directly effected particular individuals with regard to their own health care, the fact that the chief executive of the City would allow such mismanagement (as related by the media about HHC) would ultimately affect those areas of government that such individuals may care more about. Thus, despite HHC's long history of well-documented problems, it took a combination of crises to get to the point of public attention. Those crises which all occurred within the several years directly prior to Giuliani taking office included:

- a fiscal problem (nearly a \$200 million deficit) that became threatening to the entire City, because of the fact that the City's own fiscal state was so perilous;

- ❑ overwhelming problems of quality, the likes of which had not been seen since the earliest days of the department of hospitals (five of its eleven hospitals had been subject to loss of national accreditation the objective measure used to judge the quality of hospitals around the country) which also had financial implications;
- ❑ severe and well documented mismanagement (for example, HHC president Carillo's widely publicized poor management);
- ❑ a seeming disregard for tax-payer dollars through the Kings County debacle; and
- ❑ the implications and widely held negative view of how all of this would affect HHC's ability to compete in a managed care, or, a nationally reformed health care delivery system.

"For a condition to become a problem, people must be convinced that something must be done to change it" (Kingdon 1984, 119). There is no question that the combination of HHC's beleaguered history and the culmination and subsequent problems of the severe mismanagement at the time directly prior to Giuliani's taking office, allowed him to pursue a policy agenda he strongly believed in and one that would have been inconceivable only a few short years before—privatization.

Another important factor in getting HHC privatization to the top of the agenda is a rather obvious one. Kingdon's research identifies the chief executive as the single most important actor in the policy making process. Rudy Giuliani was an exceedingly strong executive with a solution to a problem that he had helped identify for both the public and the policy elites. By the time Giuliani was in office only several months, there was not an elected official or health policy analyst in the City of New York who wasn't of the belief that HHC was in desperate need of fixing. But as the literature describes, there are great stakes in how the messages are formed. How well did the Giuliani Administration package the HHC

privatization message? Was it effective? How might the message have been improved upon?

Many are of the opinion that Rudy Giuliani deserves a great deal of credit for shaking up the resistance to change mentality that existed in the City of New York and at HHC in particular. It would not be until Giuliani ran for his second term for Mayor and handily beat his opponent Ruth Messinger, a New York City, upper Westside liberal icon, that the fall of the traditionalists would truly be realized. Was Giuliani responsible for that downfall? Clearly not, rather it was, in Kingdon's words, part of the "national mood". There was a decided shift to the right nationally. It is important in evaluating the success of the Giuliani administration in bringing privatization to the top of the policymaking agenda, that it was more than just the current national "mood" that was responsible for an acceptance of change. In fact, it was far more complex than a national political pendulum swing back to the conservative right.

The national ideal of government's role had been shifting for nearly two decades. As Hirsch and others have pointed out, the early 1980s witnessed a major dissatisfaction with government and a desire to shift the responsibilities from government to the private sector (1991). As Smith and Lipsky describe it, "this is the era of the contracting regime...When public officials seek to address a new social concern, they tend first to look for a private agency with which they can contract" (1993, 43). Thus, privatization in general had become more popular as a result of overall disappointment with activist government as well as a renewed "cultural enthusiasm" for private enterprise and a reduction in government spending because of the public's outrage over the ballooning federal deficit. "After World War II governments all over the world assumed increasing responsibility for the welfare of their populations, thereby affecting lives more and more. In the process--government may

have overreached and after more than forty years of activist government—a reaction was to be expected, contributing to the popularity of privatization in the 1980s and early 1990s” (Hirsch 1991, 9). While New York City is hardly reflective of the rest of the nation, these trends had a decided effect on New York City politics and ultimately the success of Rudy Giuliani's push for privatization.

Rudy Giuliani sought to educate New Yorkers about the decay of their City. He offered new ideas that people were looking for, as discussed in Chapter Three, at a time when the general public was in the “mood” for a change because things had so deteriorated (New York Times 1994). Again, as discussed in earlier chapters, and documented repeatedly in the press, New Yorkers were now ready for much of the change Giuliani was espousing both as a result of the national trends mentioned above, as well as the deterioration of New York City. Privatizing hospitals, however, was not high on the City's public agenda. As noted earlier, the business community was beginning to pay attention to the problem of HHC but as soon as Mayor Giuliani seemed to seriously address the problem, their interest receded. So, although the “mood” in New York City may have swung towards a greater acceptance of the privatization message, there were clearly many in the City who were not yet ready for that particular agenda.

Privatization, as discussed in the literature review in Chapter One, is a “term” that had come to be identified with the administration of Ronald Reagan. Reagan may have been one of the most popular presidents in recent American history, but neither he nor his legacies were very popular in New York City. The privatization message might have been more popular initially if Giuliani and his advisors had more clearly articulated the distinction between the Reagan notion of “privatization”, and the Osborne notion of “reinventing government”. As noted in Chapter One, Kettl draws a distinction between the two. In the Reagan notion of

privatization both function and responsibility are transferred to the private sector. Under the reinventing government dynamic, the private sector is mobilized to serve the public in a cost effective way, while some funding for public services would come from the public sector, and there would be accountability by the privatized entity to government concerns (1993). The distinction between privatizing simply to unburden the government from a particular responsibility vs. trying improve a public service and saving public dollars is significant. It is clear that despite repeated speeches and written documents by Mayor Giuliani and his aides that the HHC privatization effort would continue to assure care for the uninsured, the various "interested advocates" would never trust that message. In fact, the closer a privatization deal came to reality, the less trust in the message existed. Ironically, the Coney Island Hospital contract guaranteed far more resources for both the uninsured and the hospital in general, than either the city or HHC would commit. This result of the privatization process supports the conclusion of Salamon who determined that:

As a framework for structuring the debate...privatization has serious limitations. For one thing, it remains preoccupied with the distinction between public and private action, thus downplaying or ignoring the many other dimensions in terms of which different instruments of public action can be categorized and assessed....finally, privatization can be a highly loaded term that signals not a search for ways to improve the operation of the public sector, but a way to limit its operations instead (1989, 256).

It is likely that the speeches and general talk of "reinventing government" during the mayoral campaign did not make this distinction. Thus, the public had only the "Reagan" like privatization in mind. Moreover, it is well established that too often privatization is, in fact, too often driven by ideology, and that ideology is most often identified with a conservative agenda (Hirsch 1991). With respect to HHC privatization specifically, many in the informed public, including those at HHC hospitals and key members of the health policy community, depended on the Eimicke-Reisinger article about privatization, discussed earlier, that appeared in the City Journal during the mayoral campaign for their understanding of the

mayoral candidate's position. That article also drew little distinction between the various types of privatization that may have contributed to the confusion.

Perhaps that initial misconception was partially responsible for the fact that ultimately, the Coney Island Hospital privatization was perceived by many to be the most severe type of "Reagan"—privatization, an asset sale. The fact was it was not an asset sale. It was actually closer to "contracting out" where the government monitors the contract outputs and retains the ability to sanction the contractor for violation of the agreement. The HHC privatization met what Hirsch calls the test of "social efficiency" whereby those responsible for privatizing evaluate the need to privatize on three criteria: 1) cost efficiency 2) accountability—to the governing body and to the people served) and 3) equity—the distribution of goods and services may be effected by who provides the service (1991). Despite the efforts by those in charge of the HHC privatization to articulate these goals, there is no question, the real message was not widely understood. It is hard to know if there were many that were simply opposed to privatization ideologically that the realities were not of interest to them. That certainly seemed to be the case at the time. The fact remains that there were repeated speeches, television and press interviews and meetings with newspaper editorial boards continually keeping the reality of the effort before the public.

The problem of assuring that the public understands the message, then, is a crucial one for any privatization initiative. To the degree that very specific goals are not clearly articulated at the outset of the initiative, the more room exists, not only for confusion, but also for intentional distortion. In the case of New York City privatization, Rudy Giuliani, as candidate, was focused on reinventing government in New York City overall. The entire government, from his perspective, was out of control, and too many people were dependent

on it. In retrospect, that made it difficult to lay out a clear goal for the specific privatization of HHC.

The Policy Formulation Stream

Much of the history of HHC as well as the Mayor's attention to those problems fall under the category of "softening up". The public, the policy elites, and the media all need time to be prepared for the eventual policy agenda item. Obviously there was the negative history of HHC, but that was not enough. The Barrondess Commission Report and the loss of HHC hospital accreditation all provided Rudy Giuliani a platform to talk tough on HHC and its problems. Moreover, his willingness to discuss issues such as the widely held belief that HHC was a jobs program for many local politicians, and finally the notion of privatizing the system itself all served to prepare the system for significant change. Without that tough stance, it is indisputable that HHC would have addressed the myriad of problems it was confronting in the new and changing delivery system by its long-standing dependence on City Hall to bail it out. The initial HHC budget problem under the Giuliani administration where Dr. Jones and the HHC Board expected that a "bail out" confirms as much (discussed in Chapter Two).

While it may have been a bold stance for the Mayor or candidate Giuliani to talk about privatization of HHC, it was an exceedingly complex and difficult process to determine the appropriate strategy for determining exactly the "type" of privatization to move forward with. This necessitates a discussion of many of Kingdon's "participants". As discussed in Chapter Four, there was some degree of jockeying for power in the early days of the Giuliani Administration, which, added to the complexity of the decision-making process. Kingdon refers to the fact that one of the strengths of a policy initiative emanating from the chief executive is that he/she gets to appoint those who are in support of his/her policies. That

doesn't account for the fact that while the team may all support the Mayor (in this case they did), they don't necessarily all support one another. This is true in all executive government situations where power and control are paramount. And it is certainly true in a new administration. One need only read the recent accounts of the Clinton White House where the focus shifted from an obsession with who is in or out of a particular meeting (as in vying for power) has changed by staying away because of the fear of being subpoenaed in the Paula Jones case against the President, and related issues raised by Independent Counsel Kenneth Starr. And there are certainly many accounts of other administrations, that of the FDR administration is fraught with stories about the power struggles.

In the case of the HHC privatization there were direct mayoral aides as well as the agency heads all looking for solutions to the problem, as well as seeking to control the implementation of the solution. While on the one hand the internal power plays made the decision making more complicated and frustrating for the participants, it had, in retrospect, the value of injecting competition into the selection process and improving on ideas. Ironically, this is similar to the benefits of privatization itself. It became apparent that if there was an option that was acceptable to all of the related parties internal to City government, who were not all of like "political" minds, it was likely to be more acceptable to the general public. It cannot be overstated that the new Administration of Rudy Giuliani, in 1994, was indeed a fusion government, and the initial political appointees were of diverse political beliefs. It was further the case that at least, initially, those around the Mayor all, ultimately, agreed with his political approach. As time went on it was clear that both the president and chairman of HHC would not be in agreement with the Mayor, but that was for reasons well beyond privatization. Moreover, a year and a half into the administration, those officials would be gone for varying reasons, but by that time a strategy had been chosen. The

strategy, then, was ultimately chosen through much research, consultation and endless internal debate.

The process of formulating the strategy was further complicated by the fact that the media and other interested parties were persistently asking questions about the form that privatization was going to take. The issues of striking a balance between keeping special interests appropriately informed and of developing a responsible strategy that is well thought out before going public are important ones to consider in any privatization. The process becomes further complicated in later stages when it is critical to promote competition. This tension between the dispatching of information and the desirability of preserving negotiating room is an area where the literature offers little guidance. There are legitimately interested parties who are concerned from the perspective of how privatization is going to affect them personally or their related interests. For example, the media have a responsibility to inform, and the various policy entrepreneurs such as other elected officials deserve to know how the effort will affect them and their constituents.

During the HHC privatization, when it was perceived that information was not forthcoming, it was most often the case that there was no information to give. And, in fairness, it would be highly unusual and unexpected for any elected official, or body, to go through an intricate thought process about their policy ideas publicly. The fact was that the Health Advisor was spending a great deal of time meeting both with elected officials and other "policy elites." She was very interested in gaining their insight as to how privatization might work best and, at minimum, determining their concerns so that they could be addressed in the decision making process. The need to make every effort to co-opt other "policy entrepreneurs," as Kingdon defines them was apparent. As Gordon Chase recognized,

one of the key dimensions of a public manager's job is dealing with the other players on the scene, whose help, cooperation, and support are always important and sometimes crucial. These are the players whom the manager does not control, and who have their own independent interests and agendas (1984, 16).

In the case of New York City, these "other players" were anxious to know the specific *details* of privatization from the very beginning. The fact that early on there were no details to give them was frustrating to both sides. It was also perplexing for the administration that there was criticism for not moving ahead more quickly with a much touted campaign initiative. On the other hand, when it took nearly a year for the full proposal to be developed, some accused the administration of rushing into the privatization effort.

The reality was that there had never been a municipal privatization of such magnitude, certainly not in health care in the United States. Accordingly, there was no road map to follow. Moreover, this privatization was far more complicated than the administration's other privatization efforts, such as the sale of the public television station or the UN Hotel. Therefore, Giuliani's Health Advisor, in close partnership with the Corporation Counsel's Office as well as the Mayor's Office of Operations, spent months talking with experts in the health care field and examining various options, as well as expanded privatization with financial experts. At first, it appeared as though a management contract would be the simplest route, but after weeks of internal, interdisciplinary discussion, a management contract was deemed to fall short of meeting the true goals of privatization. A management contract would leave too much authority with HHC, the problem agency, and not enough accountability with the contractor. A management contract appeared destined to re-create the pitfalls of the HHC affiliation contracts and the related ambiguity and finger pointing that had plagued the HHC system for so many years.

A full sublease arrangement was decided upon as the best solution to absolutely create new and independent management at the chosen hospital. At the same time, under a sub-lease arrangement, HHC could hold the lessee responsible for certain outputs; and there was the added benefit of government intervention in case those outputs were not met. The goal was, as Donahue describes, a "tactical privatization"; maintaining the public purpose with fewer costs (1989, 136). At minimum the goal was to cap the future risk, given HHC's financial management history.

Evaluating the Policy Stream

The author submits that the HHC privatization experience will improve future privatization initiatives. Therefore, it is important to evaluate the administration's performance. The evaluation should be twofold; strategy and substance of the deal. Both will be discussed in the context of relevant questions. The first question to be asked, and ultimately the most important from the perspective of those directly affected by privatization—the patients served by the HHC system—was whether the type of privatization chosen was a good one and, does it, have the potential to be an effective one? The second question: was the implementation of the strategy effective, and what were some of the advantages and disadvantages of such a strategy?

It is simpler to measure the success of the chosen method of privatization. While not implemented because of the judicial interdiction, enough tangible changes emerged at HHC that were a direct result of the chosen strategy to make an evaluation. Moreover, with time and distance it is easier to objectively review the value, if any, of having chosen the long-term sublease, i.e. the tactical privatization.

In retrospect, the long-term sub-lease was by far the best option. It may not have been the most politically popular, and certainly was not the easiest solution to implement, but it forced desperately needed change in the HHC system. Privatization, and in particular the sub-lease approach, rather than a management contract, introduced competition into the HHC culture—something that had never previously existed—and most staff in the system were ill prepared to deal with. It is clear from the literature that competition, in addition to being a crucial component to successful privatization may, in and of itself, often prove to be more important than the privatization itself. Kettl goes so far as to suggest that the competitiveness of the environment is a more critical component than whether, ultimately, the deliverer of services is public or private (1993).

Rudy Giuliani was well aware of the effects of competition. He spoke about it during that mayoral campaign. Did he or his advisors believe that competition alone would produce the level of successful change that was necessary or that would ultimately occur even absent the privatization? In light of HHC's history, it was difficult to believe that anything but permanent structural reform would fundamentally change HHC. However, while the Mayor had spoken often about reinventing government, he would also talk about the notion of competition in general terms. In fact, it was one of his early role models in reinventing government, Mayor Edward Rendell, who often described the greatly improved labor contracts that the City of Philadelphia achieved because of the direct threat of privatization. It was not, however, the strategy to simply use privatization as a scare tactic. The Mayor and his aides were committed to privatize in order to achieve real structural changes that were clearly necessary.

Accordingly, two things became clear early in the process. First, the "threat" of privatization did, in fact, engender a spirit of competition into the HHC system. "Without the discipline of

competition, critics contend, governments develop lazy habits. Its workers have little incentive to innovate, control costs, or deliver services effectively...government tends to grow and grow, without regard to the available resources" (Kettl, 1993). Once there was somewhat regular and public comparison of HHC vis-a-vis the voluntary hospitals, the HHC senior management set out to prove that they could be as good as the voluntary hospitals. Secondly, management at HHC adjusted fairly quickly to the fact that the Mayor was not in the business of bailing out HHC, and by the time the J. P. Morgan report was released, it was clear he was very serious about privatization. If there was any room for doubt, the release of the Mayor's Blue Ribbon Panel Report on the Future of HHC, which recommended the devolution of HHC, convinced everyone that he indeed had every intent to privatize HHC. The report also reinforced the fact that a year in office had not made him more sympathetic to the alleged difficulties in managing the mammoth public hospital system in the new health care environment. While his motivation for privatization was improving services for patients, he had little tolerance for poor management. This "tough love" approach to HHC, and privatization was the answer for anyone who couldn't manage the system. That was not an immediate remedy for HHC's ill-conceived solution of relying on the City to close budget gaps.

During the first year of the Giuliani Administration, HHC management turned to the City Council to bail them out of their difficulties. While the HHC president did make efforts to reform the system, looking to the City was too much a part of the HHC culture to believe they could manage alone. Consequently, they shifted their expectations to the City Council. They learned *almost* as quickly that the New York City Council, despite its opposition to privatization, was not prepared, as it rarely had been in the past, to make significant restorations to the HHC budget during the Citywide budget process. In terms of Kingdon's theory, the "softening up" process was working. Even the staunchest supporters of retaining

HHC's original structure knew too well that there was plenty of room for improvement. And with the many other budget and service reductions that were necessary in the City due to the fiscal crisis, there was little sympathy for HHC. Assisting the labor unions in their fight against privatization was one thing, financially bailing out a system that was failing due in large measure to its own mismanagement, was another.

A synergy was produced by a combination of the threat of privatization and the efficacy of the new and tougher management style of the Giuliani Administration. It would have been difficult for HHC employees to believe that the tougher management style was a lasting approach if, incrementally, over the course of the administration the ante wasn't constantly being upped by privatization progress. Furthermore, many of the changes following privatization would not have occurred if another method, such as a management contract, had been the designated type. Much of HHC's progress stemmed from the fact that the labor unions knew that, under a sub-lease arrangement, there would be no requirement either to keep current employees or to recognize the existing unions. Like the managers at HHC, the unions were willing to make concessions that had never made before. Severance was barely an issue for the union despite the fact that it meant a loss of employees and even layoffs occurred without much fanfare. Losing hundreds of members paled in comparison to losing control of the system--or even parts of it. In summary, labor and management alike needed to prove that they could operate like the private sector. A management contract would have never instilled a comparable level of competition. The unions would have remained in place with the City as their bargaining agent, and there would be no threat to drive the negotiating. Again, while the privatization forces knew labor was a major factor--that was not a deliberate strategy. It is useful, however, for privatization keeps things moving forward.

The HHC Board would, moreover, become more assertive in holding the management of HHC more accountable. The Board emerged from the privatization effort as less of a “rubber stamp” on important management and financial issues than they had been in the past. For example, when one reviews the Board's role in the Kings County Reconstruction Project, it is clear that they were not acting the way a private corporation's board would act. The concerns at the board level had become far more politically self-conscious than they had ever been. Over the course of the Giuliani Administration, the Board, despite the political positioning of several malcontents about privatization, would take a much more active role in bottom line financial issues of contracting out.

There were also, over time, dramatic improvements within the HHC system itself. At the end of the third year of the Giuliani administration, despite all of the threats that Medicaid cuts and other factors were going to financially destroy HHC, the system ended the fiscal year in the black for the first time in its thirty-year history, a rather extraordinary achievement. There were many reasons for that accomplishment, including strong management and leadership, and lack of political expectations for HHC's performance. However, the threat of privatization was one that everyone from the HHC senior management to the labor unions knew too well waited in the wings. If nothing else, those opposed to privatization were not going to give the Mayor any more fuel for his privatization fire. There finally existed at HHC the belief that they had to manage effectively. It forced tough minded financial management and decision making.

Critics at the time warned that the cost cutting strategies and the fiscal prudence would have a direct negative impact on the level and quality of service. The opposite occurred. For the first time in many years, all of HHC's eleven acute care hospitals were fully accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the national

accrediting body that had threatened or withdrawn accreditation at five of HHC's hospitals during the previous administration. This is a significant fact, obviously, in demonstrating that quality of care at the hospitals improved, but also it was clear that in tough fiscal times, the resources were allocated in a way that improved patient services not maintaining a highly staffed central bureaucracy. For example, when Giuliani took office, there was a central office construction staff of over 500 people. In a year, there were fewer than 100 employees in that area. This is just one example of focusing on patients rather than empire building.

Other significant achievements were the reduction of HHC's headcount by 9,681 full time equivalent employees accomplished largely through severance and early retirement programs, though there were some layoffs. Significantly, HHC changed its practice of depending on sole source contracts with familiar vendors. It adopted a new practice, encouraged at the Board level, to routinely competitively bid out contracts as well as to shorten the average length of the contracts. In addition, HHC, for the first time, built performance standards into its contracts. In 1995, HHC began and has continued a process of negotiating affiliation contracts based on productivity standards, as opposed to the long history of paying on a cost plus basis. For the first time since HHC first adopted the medical affiliation contract model, the 1996 affiliation contracts saw an actual dollar decline in real dollar value over the life of the contract. Average length of stay declined by over 20%, and other important hospital indicators also improved dramatically. Thus, by all objective measures, HHC was in better financial and quality condition than it had been in its thirty-year history.

In summary, privatization, or the competition that the threat of privatization instilled in the public hospital system, as well as the change in management and mindset of both HHC and the City, had the result of vastly improving HHC's performance. If history is any guide,

however, HHC will be unable to sustain these positive trends without more structural change—through either privatization or other means. These change, however, clearly provide a direct challenge to the Sayre and Kaufman notion New York City as “stalemated”. It is true that the national view of the “government” role was shifting to that of “governance”, as discussed earlier, and thus made the notion of privatization more viable. However, these myriad positive changes in the HHC system demonstrate that an innovative leader can create change and shake up the “status quo” that these New York City experts define as nearly impossible (1960).

The second part of the evaluation of the strategy for the first year as well as the following two years is not as clear. The so-called “softening up” period and creating the climate to get people to focus on the problem was surely successful. There was no shortage of attention on the issue of privatization of HHC as the many press accounts, discussed in earlier chapters, indicated. During the “policy formulation stream” using Kingdon’s definition, the strategy was a success. It refers however, primarily to the earlier stages of privatization. Kingdon defines this period in the following way:

Getting the policy community receptive to a new idea takes a long period of softening up. Policy entrepreneurs—people who are willing to invest resources of various kinds in hopes of a future return in the form of policies they favor—push their ideas in many ways. They aim to soften up the general public, more specialized publics, and the policy community itself.

Only after years of effort are proposals brought to the point where they can be seriously considered (*ibid.*, 151). There is little doubt that the confluence of events, and the message of a strong executive came together and allowed HHC privatization to rise to the top of the policy agenda. And there was, early on, a fair degree of receptivity to the “idea”, if not the specifics of the idea. The established health provider community such as hospital presidents and deans of medical schools were particularly receptive. Furthermore, as

discussed above it, was impossible to find a single person who had even the most basic knowledge of HHC who wasn't of the opinion that HHC was in desperate need of reform. The "criteria for survival" (ibid. 138) gets more mixed reviews. Convincing the policy entrepreneurs that this privatization was the *right* solution to the problem does not engender an easy yes or no answer. It will be discussed below in the context of the political stream.

The Political Stream

Flowing along independently of the problems and policy streams is the political stream, composed of such things as public mood, pressure group campaigns, election results, partisan or ideological distributions in [the legislature] (ibid. 152).

Perhaps a hint as to why this aspect of the three streams is more convoluted is Kingdon's commentary that it is easy for policy makers to treat these political events as outside of the process. This author believes that is not current thinking, and the notion of policy makers today not taking the media, for example, seriously is not accurate. There is, however, something special or different from these participants and events than those in the other streams. It is probably fair to say that in many instances under the daily pressure of policy making and implementation, these players and this process is easy to lose hold of.

If one were to first look back at the public "mood" of Giuliani's first term, the idea of privatization was working for all of the reasons outlined above. The public was ready for change. The fiscal crisis had changed the national and local "mood" and finally, big government was no longer the ideal. But the receptivity to the "idea" changed in the second year of the administration. It is Kingdon's attempt at the description of this particular stream and how it is treated by policy makers that is instructive. It is far more multifarious however. An evaluation of the strategy of "survival of the idea" is complicated by the fact that it is impossible to isolate HHC privatization from the myriad policy changes Giuliani was making

simultaneously. Moreover, one must add to the stream the resulting political fallout from those changes and the effect on the public's "mood".

In retrospect, it might be fair to say that during the first year the administration was somewhat lulled into a position of feeling secure about the general acceptance of privatization. The Mayor was growing more popular with each of his early successes, it seemed as though privatization was not going to be the great political challenge that his Health Advisor believed it would be. During this time the Health Advisor's strategy was to consult with those who had a real stake in the process. While not an articulated strategy, the result was to divide the special interests into two categories: true stakeholders and observers. That process began during the campaign when Giuliani met with hospital heads and deans of medical schools. They were critical to the success of the strategy because it seemed at that time, in all likelihood, that they would be the ones to take over HHC hospitals.

The Deans of the medical schools and the presidents of the academic health centers in the city were crucial to the early stages of privatization because at the time most people involved thought they would be the only "pool" of prospective buyers or new managers of the HHC hospitals. There may have been other times in the history of the City that they would have been opposed to privatization. They had depended for years on the HHC institutions to take care of the poor and uninsured and even, at one time, the Medicaid population. In a prior era, they would not have been willing to take on the responsibility of these populations. In the climate of 1994 and managed care, however, they were competing with each other both for patients and hospital facilities to draw patients to their "hub" institutions, as discussed in Chapter Three. In addition to the very competitive climate that had been created by managed care, Medicaid had also become a "good payor source"

and HHC hospitals could serve as excellent feeders of patients to their tertiary care facilities. Suddenly, the HHC hospitals could be of great advantage to the new, large voluntary hospital networks. This was a dramatic shift in their thinking from only several years prior. The new competitive conditions in addition to the fact that the Deans of medical schools and Presidents of the academic health centers were considered the "policy elites" in this area, make it obvious that without, at least, their tacit support, or non-objection there would be no privatization.

Giuliani's Health Advisor followed this strategy and continued to meet with both the elected officials and the established healthcare provider community. She also spent time with other related, interested policy elites in the field, such as the president of the United Hospital Fund, the President of the Greater New York Hospital Association and the Citizen's Budget Commission. She had also begun the strategy of inclusion at the outset of the administration. In May of Giuliani's first term she organized a full day and a half health care summit at the New York Academy of Medicine for the new Mayor to have an opportunity to hear from a broad spectrum of health care professionals and institutions. Participants ranged from public health experts, health care financing experts and those in the field not only of hospital delivery, but primary care, women's health and school health.

The new Mayor, much to the amazement of those in the profession, spent a full day and a half listening and asking questions. In total about 400 professionals from around the city were invited. It was also followed up with another breakfast at Gracie Mansion several months later with a smaller group. It went a long way in engendering goodwill from the health care community that first year. In retrospect, it may have been even more helpful to have spent time cultivating the press and other special interests during that period. Part of the problem, however, in dealing with the interest groups related to HHC, is that many of them are professional agitators, as discussed in Chapter Five. As Kingdon says "much

interest group activity in these processes consists not of positive promotion, but rather negative blocking” (ibid. 52). In fact, The First Deputy Mayor at the time, would always ask groups who were unequivocally opposed to privatization if they had any alternative solutions to fix the problems at HHC. They never did. But he would always say that he would be happy to entertain any new ideas they might come up with. That did not happen either.

The particular interest groups that have been around HHC for a long time are literally full time agitators. It really doesn't matter who the elected officials are, their job is to agitate. And in the case of HHC privatization, they also made up most of the group that fronted for the CIR. In this respect Kingdon's earlier point, about not counting these groups as much as others, is correct. At some point even appointed officials have to decide where their energies are best spent. While the Health Advisor was always very willing to speak with them, it was not a proactive strategy. The proactive focus was on elected officials, labor and the established health care provider community. That strategy worked well during the first year.

In examining other factors that had an effect on the privatization effort going forward, “mood”, elections and political parties become critical. As Kingdon makes clear:

This mood-elections combination has particularly powerful impacts on the agenda. It can force some subjects high on the agenda, and can also make it virtually impossible for government to pay serious attention to others (ibid. 172).

The second year of the administration was filled with outside changes and events that indirectly affected the privatization effort. The first, and in retrospect probably more important than was thought at the time, was the election of a Republican, George Pataki as Governor of the State of New York. Looking back, this was clearly a Birkland-type focusing event (1997). As is well known, Rudy Giuliani, New York's first Republican Mayor in a

generation supported the incumbent Democrat, Mario Cuomo for Governor. The reasons for that decision are not germane to this discussion; Rudy Giuliani, however, paid a big political price for not endorsing the Republican candidate. Most believe that, given his subsequent popularity, the effects of that action have now dissipated; however, the following year was not an easy one politically for Giuliani. He was an outcast in his own party, and the Democrats, smelling blood in the political waters, sensed his weakened state and were not as tolerant of his bold changes. It was clearly a time for those who did not support his policies to attack. In the case of those who opposed his healthcare policies in general or privatization in particular, their offensive was made easier by another action of the Mayor.

That year, 1995, Giuliani's second term in office, the budget gap was even larger than the previous year (as noted above \$2.3 and \$2.7 billion respectively). An area that the whole country was dealing with, particularly with the new Republican controlled Congress was the rising cost of Medicaid. It was an issue for most states, but New York City, unlike other municipalities pays 25% of its cost of Medicaid, that year the City's share of Medicaid equaled \$2.3 billion, almost the exact number as the City's overall budget gap of the prior year. In an effort to get the Medicaid costs under control, Mayor Giuliani lobbied in Albany for the State to make cuts in Medicaid. That was all the fodder the opponents of privatization needed to paint Giuliani as unsympathetic to the poor, and even those in the health policy circles that had supported him before were very discouraged by this action. As described in Chapter Four, this was also the precipitating event for HHC's Board Chairperson, Luis Miranda, to resign. His resignation and the Mayor's appointment of his Health Advisor--and architect of privatization--as the new Chairperson permanently changed the dynamic around the special interests and privatization. It became clear to the Health Advisor that the "fringe" advocates had a much higher degree of support from the established health care community going forward from that time.

Evaluating the Political Stream

Perhaps the Health Advisor should have spent more time "softening up" the special interests, at least in the professional community. As Kingdon says "such consensus is better built before the window opens" (1995, 221). But these events coincided with the release of the Mayor's Blue Ribbon Panel Report recommending the devolution of HHC. Moreover, there had been an HHC chairperson and president, both of whom had also, whether publicly or privately distanced themselves from the administration. With all of the objective retrospection, it is difficult to see how the administration might have handled this time better. It is obvious that it was not a positive political time, but there are times where events take over. Administration officials tried to bring the focus back on the problems at HHC that had precipitated the privatization idea, but the public was no longer interested. The Mayor was bringing solutions to the problems, so the level of public interest in HHC declined. The strategy, then, was to push forward on the substance with the original goals in mind, payment for indigent care, full access and better quality as well as a good financial deal for the city. It was the view of the Health Advisor that if these things were accomplished, and the patients whom this battle was all about were better served, than the goal would have been achieved.

Despite the interest group agitation and negative press, the only real impediment was the City Council lawsuit. That lawsuit had little, if anything, to do with the special interests (other than labor). It was prompted both by the Council's interest in its own role, as well as their concern for labor. Within a year, Mayor Giuliani was as popular as ever, and even the City Council was not so keen on taking him on. And, two years later, he would run for reelection with the support of many key Democrats, including the Queens Borough President in whose Borough he attempted to privatize two hospitals. As a footnote to that part of the privatization story, Rudy Giuliani has pledged to move forward with privatizing Elmhurst Hospital, and he has committed to rebuilding Queens Hospital Center. The City Council

Speaker, Peter Vallone is likely going to run for Governor, and all of the other Council members are prohibited from running for reelection under the new law. They will without a doubt seek the support of labor in any new endeavors for higher office. Therefore it is unlikely that they, or new members running for City Council Office, will be unwilling to court labor's view of privatization.

The final question to ask is what could have been done, if anything, to deter the City Council from litigating this issue. The answers are different depending on what one perceives their goal in litigation to be. If one assumes that it is a control issue for the Council, it is conceivable that involving the Council more in the process might have made them content enough not to sue. It is unlikely, however, that they would have settled for anything less than veto power over the deal. No Mayor would agree to capitulate in an area he /she cares deeply about, especially when that chief executive believes it is a management decision. Kingdon supports this point generically when he attributes one of the major reasons for the success of chief executives in achieving policy initiatives to the unitary nature of decision making. Involving 51 elected officials in a process that is so politically volatile would have likely resulted in a dismal failure. Given the way the Council works, and given that they were playing much more to the special interests, the process would have likely dragged on for months, if not years, more than necessary. No private sector group (as in the group subleasing the hospital) is willing to continue expending resources fighting a public battle that is political and unreasonable for them to fight.

Finally, all of the achievements that were made at HHC, in large measure due to the very real threat of privatization, would likely *not* have occurred had a struggle between the Mayor and the City Council dragged on interminably. The HHC bureaucrats would have assumed it was just another political battle they could wait out. It is the opinion of this author that the

Mayor made the right decision on this point. If he loses, he can always revert to working with the City Council to move forward with privatization.

If one were to assume that the Council's primary motive was protecting the interest of labor, there really was no other strategy to adopt. It is clear to the general public that the Giuliani administration has a very good working relationship with DC37. Throughout the privatization process they were kept informed as appropriate, and the administration met with them continually. In the end, the administration won for them the most they could ask for in a privatization deal—recognition. In the final analyses, however, the union is in business to stay in business. With the exception of the CIR and local 420, the unions fought their battle appropriately and respectfully. One cannot ask for more in a political landmine. As for the “rump” unions and special interests, they've moved on for the moment to another cause. They are now arguing, ironically, that HHC won't care for the poor in the former City Department of Health Clinics. They are referring to the same HHC that was needed to protect the poor from the voluntary hospitals. Moreover, without the threat of privatization looming large, local 420 recently walked away from severance talks, forcing the Giuliani Administration's hand in laying off hospital workers thus forcing a politically volatile situation that had largely been unnecessary. Not to mention that once again, it was the employees that lost out over the larger concern of the union local as was discussed in Chapter's Two and Five.

Final Conclusions and Lessons Learned

In the end it is fair to say that there was a coupling of the three streams Kingdon talks about. Privatization moved farther along the process than most political analysts believed possible. A distinct success of the process is the shape of HHC today—financially stronger, nationally recognized for its quality improvements and surviving in the New York City health care industry's community at its most competitive moment. Thus, this privatization effort supports

the literature that finds competition to be a fundamental and positive element of privatization. This study also confirms the findings in the literature that public accountability is paramount to the success of privatization. While there may have been a degree of public mistrust of the privatization goals, the fact that the process was, in reality, driven by interest in the public's concerns and the goal of not diminishing the *mission* of HHC—to assure access to health care for the indigent—allowed the process to move along as far as it did. This case study also demonstrates that the Kingdon and Birkland theories that crises and focusing events help bring and maintain policy items on the agenda is accurate.

A somewhat more obscure lesson learned from this effort is the need to articulate clear goals and expected outcomes as early on in the process as possible. It was also learned that this is not always such an easy task. In the case of New York City's HHC privatization, it was impossible because the Mayor had, necessarily, made so many speeches of a more general nature about privatization and reinventing government for many months prior to taking office which would ultimately comprise this effort. Only after much research could an actual method be responsibly chosen. In the interim, a vacuum was created for the emergence of doubt and distortion about the HHC privatization. Embodied in this lesson is that privatization is too often driven by ideology and thus even when it is not it allows such a misperception to grow. When such misperception of goals exists, privatization efforts will become more difficult and politically contentious. Consistently then, privatization needs to be driven by more than the financial concerns that typify the proponent's "ideology" of privatization. Unfortunately the privatization literature and many who espouse privatization focus primarily only on the cost-benefit analyses of privatization. These multifarious issues, which are complexly intertwined throughout this privatization process, further underscore the need for an ongoing assessment of the political environment, strategy development and strategy implementation, not only in privatization but also in any process involving the

change of powerful interests. Again, the privatization literature provides little guidance in this area.

Finally, as stated by Smith and Lipsky, policy makers must continually seek the “proper balance between the efficiencies of the markets and the inventiveness of the voluntary sector—and the legitimate role of the state in raising revenues, setting standards and allocating resources” (1993, 231). In considering privatization, policymakers must be obsessive about discerning—as Abraham Lincoln said—the role of government and doing for those that cannot do for themselves—without taking on an inappropriate role for the government or conceding a role that most appropriately resides with government.

One particularly provocative question remains unanswered by this research. While it has been demonstrated that change is possible, even in the bureaucratic, status quo environment of HHC, if the court prohibits privatization, how will the necessary changes be continued in a system that has elicited repeated calls for reform throughout its entire thirty-year history? If one looks to Kingdon for guidance, it becomes clear that only an acute crisis can force necessary fundamental changes. While HHC has improved dramatically over the past several years, the history of HHC lends no confidence to the notion of sustaining those improvements, or for making the increasing enhancements called for by the ongoing changes in the health care delivery system. Moreover, it is not clear that such a crisis precipitating change doesn't hang ominously over HHC.

The ongoing changes in the national health care system discussed in Chapter Three show little sign of dissipating soon. The health care delivery system is only growing more competitive, particularly in New York City. Mandatory, citywide Medicaid managed care is to be implemented over the course of the next year, meaning that competition for the healthiest Medicaid clients is going to become even fiercer. Conversely, the costlier sicker Medicaid

patients, under a competitive system, will become even less desirable and more likely to wind up in the HHC system. The financial consequences for HHC could be staggering. The major academic health centers are consolidating their large networks and have created unparalleled delivery systems that are much larger than the HHC system. Thus, they have removed the single advantage that HHC had going into this new delivery system—size and integrated delivery systems. The entire mindset of New York City's health care community has changed dramatically to a fiercely competitive one. While it was this mindset that allowed privatization to move forward, without privatization, this competitive nature could prove crippling to HHC.

It is essential to understand the important role that the continually changing national and local health care system played not only in the current privatization initiative, but also in any future privatization efforts. Moreover, the increasingly competitive nature of the New York City health care delivery system is likely to have a dramatic affect on the future of the Health and Hospitals Corporation even without the pursuit of privatization. First, as mentioned earlier, the days when the prestigious academic health centers were content to operate their large teaching hospitals in Manhattan, and had the luxury of attracting patients from all of the New York City boroughs based on their reputations, are long gone. The competition injected into the system has forced the development of fully integrated delivery systems, price competition and very aggressive marketing for all types of paying patients. It was that necessity to attract a broad mix of new patients to their tertiary hospitals that was the driving force behind their support for privatization. Many of the HHC hospitals have a fairly good payor mix, and if they controlled those hospitals they could control the referrals to their institutions. Only a decade before, these issues were non-existent in New York City. That competition has not abated. Absent privatization, these institutions have found and are continuing to seek new ways to attract HHC's paying patients. Aggressive marketing from television commercials to local community based marketing are the norm. Moreover the

mega-mergers of the academic health centers have broadened their networks far beyond the scope of HHC's, providing them not only with a broader patient base, but the ability to be even more competitive on pricing than HHC. Health care has become a business. If HHC had the kind of management, financial and quality problems it had in a world of no competition, it is safe to predict that a new crisis period looms on HHC's horizon. It was the nature of this new competitive mindset and radical change in the thinking of these health care "elites" that helped propel privatization high on the policymaking agenda. There should have been a lesson to the opponents of privatization in such an unexpected development in the health care system (though it was not unexpected to all). To his credit, Mayor Giuliani understood the implications of the changes. To their detriment, the opponents of privatization, on the other hand, believe that the City will continue to bail HHC out of any financial problems. After all, they reason, Giuliani won't be Mayor forever. In the words of the renowned New York City experts:

There is nothing intrinsically desirable about change. But it becomes a problem of major importance to the well-being of the city if the governmental system has such a built in resistance to change, such a tendency to suppress innovation, that it cannot keep up with the problems that confront it in a constantly and rapidly changing world. A city in stasis faces the potential fate of many of the great urban centers of the past, whose glories are all in archives and museums, whose significance is solely historical (Sayre and Kaufman, 1960, 719).

Labor may well be another wildcard in the equation of HHC's future. DC37, the primary umbrella group for HHC's unions is in its own state of crisis; seven of its locals are under investigation by the District Attorney with possible implications for the entire organization. Depending on the outcome of those investigations, it could be that a weakened union is one that more likely supports a privatization initiative. Conversely, in a defensive posture the union could become more hostile to the current administration in order to play better to its members, thereby setting off another type of crisis at HHC. It is unclear how that crisis

would play out, but the combination of a financial crisis and union unrest (which has not really existed for a number of years) has all the ingredients for a crisis-precipitating event.

Legislative change is a final possibility. If the legislation that created HHC was faulty at the outset, crises such as those speculated above might allow for fundamental change in that form. The experience over the past year with the Board of Education is instructive. There is no question that, at minimum, there was a perceived crisis in the state of education in New York City. The current Chancellor, with the support of the Mayor and the Governor was able to achieve legislative changes that for two decades had appeared impossible to obtain, such as changing the role of the local school boards. If a crisis-precipitating event is severe enough, it might be possible to successfully pursue the legislative changes that were necessary from the inception of HHC.

Finally, consistent with the Kingdonian method, the “players” who champion this fundamental change should be planning their strategy now, so that when the window of opportunity opens, they’re prepared.

CHAPTER SIX

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APPENDIX 1 METHODOLOGY

The research for this case study involved several empirical methodologies on the part of the author. First, as a participant in the privatization discussions from the time of Rudy Giuliani's first successful mayoral campaign and subsequently as Health Policy Advisor to Mayor Giuliani and two years as the chairperson of HHC, I spent three and a half years closely involved with the entire privatization process. Obviously the insight gained from that experience was invaluable in learning about this privatization process as well as in gaining knowledge of other privatization efforts, particularly in health care, in the United States. It was necessary during that period to research the efforts of other municipalities in dealing with their public hospitals and any efforts to privatize them.

Savas talks about the learning that occurs during a privatization effort. This author learned not only about the efforts of privatization, but about the complex mechanics of privatizing municipal hospitals as well. That knowledge made it infinitely easier to write this case study as well as conduct and evaluate other related research. It is important to note, however, that this research contains no privileged or confidential information. On the advice of the Office of New York City's Corporation Counsel, any written or verbal communication that was regarded as confidential was not incorporated into this research. The exception would be any material that was confidential at the time, but during the privatization process was leaked to the press or by some other means ultimately found its way into the public domain. Therefore, with little exception, others would have access to the information used in this case study.

In addition to any knowledge gained during my participation in the privatization effort, I conducted multiple interviews with current and former city officials, reviewed the numerous studies of the health care delivery system in New York City over the past forty years, and examined many source documents, including publicly-available records such as relevant City Council hearing records and testimony, official speeches, press reports, legal filings and other public hearing records, and, of course, HHC Board meeting minutes.

Four years of press accounts of this particular privatization effort were reviewed, as well as press material related to the national and local "mood," or politics, in order to evaluate the various Kingdon "streams". The press accounts that were researched were primarily those of the three New York City daily newspapers. Numerous transcripts from public hearings on this topic were reviewed, as well as non-confidential papers generated by various City officials and agencies, such as the two reports to Mayor Giuliani by the Blue Ribbon Panel he had appointed to study the future of HHC and indigent care. The documents released by J. P. Morgan were also used, as well as Mayoral and mayoral staff speeches.

Historical documents such as the original Piel Commission Report, which was the impetus for the creation of HHC, memoranda circulated at that time, in addition to testimony on hearings related to that subject, provided much of the historical context of HHC. Similarly, documents from other mayoral administrations were reviewed in depth. Former Mayor Ed Koch made this part of the research easier by publishing two books during his time as Mayor.

Multiple interviews were held with current and former City and HHC officials both for the purpose of gaining new information as well as verifying existing information. The interviews were also used as a means of testing objectivity about the privatization process. Finally, a number of these officials were willing to review early drafts of sections of this dissertation of which they had particular knowledge. This was extremely useful not only in assuring factual accuracy, but it provided the benefit of the thinking by several participants in the same incidents to assure, to the degree possible, perceptual accuracy. Interviews were conducted to gain knowledge and insight not only into the issues surrounding privatization, but also the entire HHC background and history. The interviews were informal, and none were for attribution. Since attribution is not possible, the utility of these interviews lay primarily in their validating other, objectively demonstrable propositions.

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Appendix 2

This presentation was prepared exclusively for the benefit and use of The City of New York in order to indicate, on a preliminary basis, the feasibility of a possible transaction or transactions.

The information in this presentation is based upon data supplied by the Health and Hospitals Corporation and reflects prevailing conditions and our views as of this date, all of which are accordingly subject to change. In preparing this presentation, we have relied upon and assumed, without independent verification, the accuracy and completeness of all information available from public sources or which was provided to us on or on behalf of the Health and Hospitals Corporation.

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Executive Summary

J.P. Morgan was engaged by the Economic Development Corporation of New York City to advise the City regarding the feasibility of privatizing three hospitals (Coney Island Hospital, Elmhurst Hospital Center and Queens Hospital Center) which are currently part of the New York City Health and Hospitals Corporation ("HHC"). J.P. Morgan analyzed the financial and operating environment of the three facilities. The conclusions of this analysis are as follows:

1. The operating and financial performance of Coney Island, Queens and Elmhurst is inferior to that of surrounding not-for-profit hospitals.
2. The facilities are burdened by a quasi-governmental operating structure, resulting in high personnel costs and administrative expenses when compared to their not-for-profit counterparts.
3. During 1994, the three hospitals required over \$180 million of financial support from the City, of which \$95.5 million was paid in cash and the remainder represents additions to property plant and equipment, which will have to be paid in future years. Refer to Table Seven on page 24.

The estimated present value of the City's long-term obligation to operate these facilities is \$1.7 billion, assuming an operating environment similar to today's and HHC's constrained capital budget. Refer to Table Eight on page 26.

4. Operating losses at the three hospitals will be exacerbated if, as has been proposed, Medicaid rates are reduced.
5. With the exception of Elmhurst Hospital Center, the facilities are aging and require a huge capital investment in order to maintain the existing level of service.
6. The shift to managed care and the related transformation of New York City's health care environment provide a unique opportunity for the City to sell these assets. Other institutions may see value in assuming ownership of these facilities, depending upon the structure of the transfer.
7. The amount of savings from the elimination of the City's financial support for the three hospitals far outweighs any sale proceeds.

I. Scope of the Assignment

J.P. Morgan was asked to examine the possibility of privatizing the Health and Hospitals Corporation's Coney Island Hospital, Elmhurst Hospital Center and Queens Hospital Center (the "Hospitals"). The purpose of the analysis was to assess the financial ramifications to the City of privatizing these three institutions. Specifically, J.P. Morgan was requested to consider the following issues regarding the sale of the three facilities:

- Have the Hospitals under consideration imposed a significant financial cost to the City?
- Is the financial performance of these Hospitals likely to improve or deteriorate considering the numerous changes in health care?
- Would other health care organizations be interested in taking over ownership of these assets?
- Would the financial performance of the facilities be stronger if they were run by others?
- What would be the financial ramifications of a transfer for the City?

J.P. Morgan performed significant analytical work in answering these questions, including: gathering financial information from HHC Central Office relating to each facility; conducting site visits and management discussions at the individual Hospitals; researching industry developments nationwide and in the New York City market; reviewing the financial performance and strategic objectives of competing institutions and potentially interested parties; and analyzing financial information and relevant market data to determine the financial impact of various options.

II. New York City's Health Care Environment

The health care delivery system in the City of New York has been shaped by the reimbursement system, the large number of academic medical centers, and the high proportion of individuals living below the poverty line. Citizens in New York City are served by a remarkably diverse health care system. Academic medical centers, diagnostic and treatment centers, family planning clinics, home health services, hospices, hospitals, nursing homes, privately practicing physicians, public health departments, school-based health clinics, special treatment services, and many other providers contribute to a complex array of services.

The organizing force within the health care system for the last several decades has been the hospital, which in turn has centered itself around inpatient services. In 1992, there were 78 hospitals in New York City with more than 35,000 beds.¹ Table One, based on 1992 data, illustrates the fact that New York City provides a higher level of inpatient care than the rest of the nation. There are several reasons for this phenomenon, including: (1) the fact that the City of New York has lagged behind the nation in its acceptance of managed care; (2) the large number of academic medical centers; and (3) the paucity of primary care physicians, resulting in a system which relies upon the emergency room as the front line of medical care, rather than the general practitioner's office - a very inefficient means of providing services. Table One highlights the differences in occupancy rate, average lengths of stay and adjusted patient days for the City versus the nation. As a further point of comparison, we have included statistics for California, one of the most aggressive states in the control of health care costs.

New York State's health care delivery system is heavily institutionalized, and is subject to the regulatory control of State government. Under Article 28 of the Public Health Law, New York permits hospitals, a term which includes general hospitals, nursing homes and diagnostic and treatment centers, to be organized as either not-for-profit or for-profit entities, subject to the following limitations: (1) the stock of a proprietary corporation operating a hospital may not be owned by another corporation; (2) the members of a partnership must be natural persons; and (3) limited partnership may not be approved to operate hospitals. Nursing homes, home health care agencies, and HMOs are a mix of for-profit and not-for-profit entities. Very few proprietary general hospitals are in existence today within the City of New York.

¹ United Hospital Fund Health Care Annual Data on Hospitals in New York - 1994 Update, containing 1992 statistics.

TABLE ONE

Comparative Hospital Inpatient Statistics - 1992

	New York City ^[1]	California	United States ^[2]
Occupancy Rate	84.7%	62.4%	65.6%
Average Length of Stay (days)	9.9	5.9	7.1
Adjusted Patient Days per 1000 Residents	1,499	778	1,184

[1] United Hospital Fund Health Care Annual Data on Hospitals in New York - 1994 Update, containing 1992 statistics.

[2] AHA Hospital Statistics 1993/1994 Edition, containing 1992 statistics.

a. Overview of Reimbursement System

Health care financing in the City of New York revolves around a single State statute, Article 28 of the Public Health Law and the regulations promulgated thereunder, known as the New York Prospective Hospital Reimbursement Methodology ("NYPHRM"). Through this regulatory scheme, State government sets hospital inpatient reimbursement rates, facility by facility, for all third-party payors except Medicare². The current provisions of the Public Health Law will expire December 31, 1995.

Under NYPHRM, all payors are required to use a uniform, State-developed prospective reimbursement methodology for inpatient hospital services based on diagnosis-related groups ("DRGs"). Medicaid, Blue Cross/Blue Shield and HMOs all pay essentially the same rate, and the payment for all other payors is calculated at a percentage above that rate. Medicare retains its own system. In 1988, as an incentive to encourage managed care growth, HMOs were given the option of negotiating rates with individual hospitals. They remain the only third party payors, other than Medicare, able to pay for inpatient hospital costs outside the NYPHRM system.

NYPHRM was originally designed to meet several different objectives, including hospital cost containment and support of financially distressed hospitals. Perhaps the most significant public policy initiative within NYPHRM was the creation of bad debt and charity care ("BDCC") pools to compensate hospitals for care provided to the indigent.

Although New York has an intricate system in place for the reimbursement of hospital inpatient services, there is no equivalent system for ambulatory services. The State regulates Medicaid payments for outpatient services, but not for other payors. The Federal Government has implemented a payment mechanism for physician services through Medicare, and reimburses certain outpatient/ambulatory services based upon pre-determined fee schedules.

b. Academic Medical Centers

The high concentration of medical schools produce a significant number of physicians, interns and residents. In New York State there are 13 medical schools, which graduated 1,855 physicians during 1992.³ For the 1991-1992 academic year there were 13,443 residents statewide, representing 15.6 percent of all residents nationwide.³ Furthermore, the residency rate per capita was 75, the highest in the country.³ The residency programs are skewed toward specialty care, with 60 percent of all residents being specialists. The result is a system dominated by academic medical centers and specialists, thus driving up the cost of delivering care.

² New York is one of only two states that continue to set hospital inpatient rates; the other is Maryland.

³ New York State Council on Graduate Medical Education, Fifth Report, 1992/1993, containing 1991/1992 data.

III. Health and Hospitals Corporation

a. Introduction

The Health and Hospitals Corporation ("HHC" or the "Corporation") is by far the largest municipal hospital system in the United States. HHC is composed of eleven acute care facilities, five long-term care facilities, six diagnostic and treatment centers and numerous clinics. During 1994, HHC employed over 47,000 individuals and had annual operating expenses in excess of \$4 billion.⁴

HHC provides comprehensive physical, mental and substance abuse services to the ill and infirm. This vast array of services is provided by the Corporation through a substantial physical plant. The map on the following page identifies the HHC sites throughout the City. Summary statistics on the HHC facilities is provided below.

- Acute care hospitals - 8,115 beds/11 hospitals

Bronx	1,866 beds/3 hospitals
Brooklyn	2,340 beds/3 hospitals
Manhattan	2,635 beds/3 hospitals
Queens	1,274 beds/2 hospitals
- Long term care facilities - 2,826 beds/5 facilities

Manhattan	2,238 beds/3 facilities
Queens	284 beds/1 facility
Staten Island	304 beds/1 facility
- Diagnostic and treatment centers - 6 facilities

Bronx	2 facilities
Brooklyn	2 facilities
Manhattan	2 facilities

b. The City of New York's Involvement in the Health Care Business

The City of New York is in the business of health care with a public health care delivery system which is far more extensive than any other in the country. While other major metropolitan areas have been exiting or reducing their involvement in health care, leaving the delivery of care to not-for-profits and in some instances for-profit providers, the City of New York has maintained its presence in this area. Table Two highlights the City of New York's commitment to health care versus that of other major municipalities. During 1994, 23.3 percent of all acute care beds in New York City were public hospital beds, while the comparable number for Los Angeles County was 11.4 percent and 4.8 percent for Cook County (Chicago). New York City also has far more public hospital beds per 1,000 residents than other cities. New York has 1.11 beds per 1,000 as compared to 0.32 and 0.19 beds per 1,000 for Los Angeles County and Cook County, respectively.

⁴ Source: New York City Health and Hospitals Corporation and Subsidiaries June 30, 1994 audited financial statements.

Health and Hospitals Corporation Locations

- 1 North Central Bronx Hospital
- 2 Bronx Municipal Hospital Center
- 3 Highbridge Clinic
- 4 Morrisania D&TC
- 5 Polo Grounds
- 6 Drew Hamilton
- 7 Harlem Hospital
- 8 Lincoln Medical & Mental Health Center
- 9 Segundo Ruiz Belvis D&TC
- 10 Grant Houses
- 11 Sydenham Neighborhood Family Day Center
- 12 Lenox
- 13 Metropolitan Hospital Center
- 14 Community Health Project
- 15 Bellevue Hospital Center
- 16 Roberto Clemente Family Guidance Center
- 17 Judson Health Center
- 18 Gouverneur Skilled Nursing Facility
- 19 Coler Memorial Hospital
- 20 Goldwater Memorial Hospital
- 21 Elmhurst Hospital Center
- 22 Queens Hospital Center
- 23 South Queens Community Health Center
- 24 Greenpoint Health Center
- 25 Williamsburg Health Center
- 26 Woodhull Medical & Mental Health Center
- 27 Cumberland D&TC
- 28 Bedford-Stuyvesant Alcoholism Treatment Center
- 29 Bushwick Health Center
- 30 East New York Neighborhood Family Care Center
- 31 Kings County Hospital Center
- 32 Coney Island Hospital
- 33 Ida Israel Community Health Center
- 34 Neponsit Health Care Center
- 35 Sea View Hospital and Home

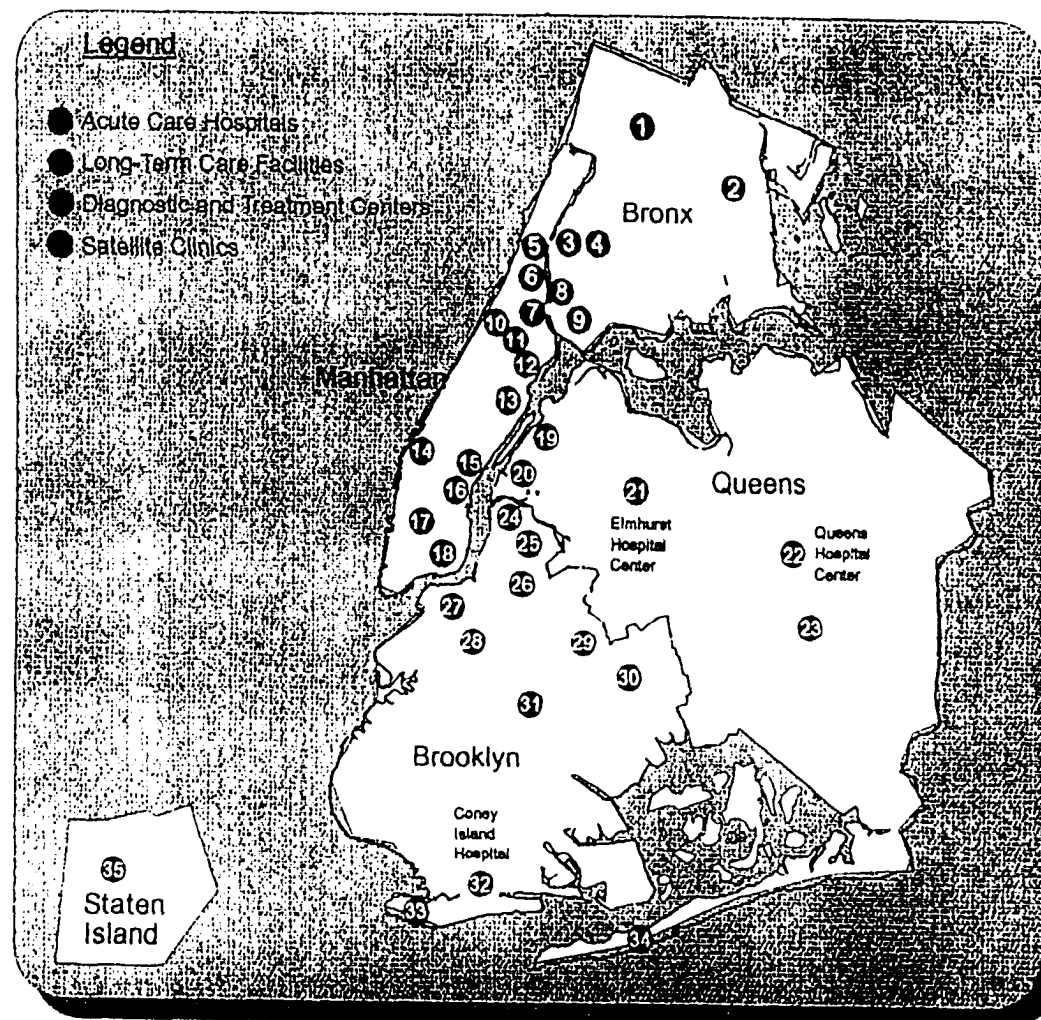


TABLE TWO

Public Hospital Beds in Major Metropolitan Areas

	<u>Population^[1]</u>	<u>Total Hospital Beds^[2]</u>	<u>Public Hospitals^[3]</u>	<u>Public Hospital Beds^[2]</u>
New York City	7,311,966	34,776	11	8,115
Los Angeles County (Los Angeles)	9,053,645	25,718	6	2,933
Dade County (Miami)	2,007,972	8,627	1	1,446
Harris County (Houston)	2,971,755	11,445	3	1,124
Cuyahoga County (Cleveland)	1,411,209	7,316	1	1,014
Cook County (Chicago)	5,139,341	20,468	2	984
Denver	483,852	3,568	3	654
Washington D.C.	585,221	5,247	1	395
Boston	551,675	6,445	1	312
Detroit	1,012,110	4,867	0	0
Philadelphia	1,552,572	9,732	0	0

[1] Source: U.S. Bureau of the Census - County and City Data Book: 1994.

[2] General, medical, and surgical only. Source: AHA 1994 Guide.

[3] State, county, city-county hospitals with general, medical, or surgical beds only. Source: AHA 1994 Guide.

Major cities have been reducing their participation as providers of health care services. For example, in the late 1970s, the City of Philadelphia closed its public hospital, Philadelphia General Hospital. Over the past ten years, D.C. General has reduced its bed count from over 1,000 to 395 beds, and is slated to decrease the number of beds even further. Cook County's (Chicago) planned replacement facility will be half the size of the existing hospital.

Over the past few years, HHC has faced increased competition from the not-for-profit hospitals, who have aggressively pursued HHC's Medicaid patient base. During 1994, over 50 percent of HHC's admissions were Medicaid patients. As Medicaid managed care continues to gain momentum, not-for-profit voluntary hospitals have an even greater incentive to pursue this patient population. This has resulted in acute care discharges at HHC facilities declining by 4.8 percent over the past five years, from approximately 247,000 during 1990 to 235,000 during 1994. In addition, acute care occupancy at HHC facilities decreased from 86 percent during the fiscal year 1990 to 78 percent during the fiscal year 1994. As this phenomenon continues to gather momentum -- New York State and New York City are accelerating plans to move the Medicaid population into managed care plans -- HHC faces significant risk as the not-for-profit hospitals continue to build networks, and develop contractual arrangements with Medicaid HMOs.

c. Overview of the Hospitals

The following paragraphs provide a brief description of the three hospitals which are the subject of this report: Coney Island Hospital, Elmhurst Hospital Center and Queens Hospital Center.

Coney Island Hospital

Coney Island Hospital, located in Brooklyn, New York is a 498-bed acute care facility. Coney Island Hospital combines general care and surgery with services in psychiatry, drug/alcohol treatment, cardiac diagnosis, rehabilitation, and oncology. Coney Island Hospital provides primary care services to south Brooklyn. The following table summarizes the major utilization statistics of Coney Island. In 1994, Coney Island opened a new 25 bed psychiatric unit, accounting for the increase in its certified beds.

Coney Island Hospital: Utilization Statistics

	<u>1992</u>	<u>1993</u>	<u>1994</u>
Certified Beds	473	473	498
Admissions	15,827	15,676	16,406
Patient Days	157,266	155,546	157,419
Occupancy	90%	90%	87%
Average Length of Stay	9.9	9.9	9.6
Clinic Visits	320,115	326,560	336,112

Source: HHC records.

Elmhurst Hospital Center

Elmhurst Hospital Center ("Elmhurst"), located in Queens County, New York, is a 646-bed acute care facility and teaching hospital. Elmhurst, which was established as a municipal hospital in 1957, is a major provider of health services in western Queens. Elmhurst provides a full range of inpatient and outpatient services. The following table summarizes the major utilization statistics of Elmhurst over the past three years. During 1994, Elmhurst experienced a decline in its average length of stay and an increase in its admissions.

Elmhurst Hospital: Utilization Statistics

	<u>1992</u>	<u>1993</u>	<u>1994</u>
Certified Beds	646	646	646
Admissions	22,200	22,482	23,667
Patient Days	201,605	205,984	196,314
Occupancy	85%	87%	83%
Average Length of Stay	9.1	9.2	8.3
Clinic Visits	355,565	373,633	397,885

Source: HHC records.

Queens Hospital Center

Queens Hospital Center ("Queens Hospital"), located in Queens County, New York, is a 556-bed acute care facility. Queens Hospital is a full service community hospital in eastern Queens offering medical, surgical, obstetrical, gynecological and pediatric inpatient services and a full range of ambulatory care services. In addition, it is the sole provider of physical medicine and rehabilitation services in the area. The following table summarizes the major utilization statistics of Queens Hospital over the past three years. As a response to declining inpatient admissions, Queens Hospital's certified beds were reduced by over seventy during 1994.

Queens Hospital: Utilization Statistics

	<u>1992</u>	<u>1993</u>	<u>1994</u>
Certified Beds	628	628	556
Admissions	17,416	17,069	16,444
Patient Days	155,265	153,149	149,886
Occupancy	69%	67%	74%
Average Length of Stay	8.9	9.0	9.1
Clinic Visits	248,273	243,969	258,808

Source: HHC records.

IV. The Changing Health Care Paradigm

While the debate rages in Albany about how to cover all the uninsured and slow the rapid rise in health care spending, provider organizations (hospitals, HMOs and physician groups) are effecting a revolution in the delivery of health care in the City of New York. They are reinventing the delivery system based on two principles: integration of services within restructured provider organizations, and constant improvement in the quality of care provided. Together, these two ideas are driving improvements in the performance of the health care system.

a. Growth of Managed Care

New York City, albeit at a slower pace than the rest of the nation, is moving toward a managed health care system in which purchasers are contracting with providers who deliver the greatest value. However, the rate of managed care enrollment in the region is beginning to accelerate. During 1993, the New York City Metropolitan Statistical Area ("MSA") added more new HMO enrollees than any other MSA in the nation - 730,271 new enrollees.

Table Three depicts the percent of total population enrolled in HMOs as of January 1, 1994. Only 14.7 percent of the population in the New York City MSA was enrolled in an HMO. This is among the lowest penetration rates for a major MSA in the nation. Note that 63 percent in Rochester's MSA was enrolled in an HMO.

As a general matter, the term "managed care" means: (1) organizing and integrating health care delivery to improve quality and enhance value to purchasers, which may mean integrating financing with delivery; (2) managing care by guiding patients to appropriate services in the most cost-effective setting; (3) developing measures of health care quality that enable purchasers to identify providers that produce the best results; (4) purchasing health care from providers that deliver the greatest value -- the best quality at a reasonable cost -- and giving consumers strong incentives to use these superior providers; and (5) promoting health by emphasizing wellness, prevention, and primary care.

The key concepts embodied in this definition of managed care are: quality, efficiency, and value. A managed care delivery system is based on the assumption that providers should be measured and judged on their ability to deliver services of high quality in an efficient manner --- to deliver value -- to purchasers. This makes the health care system subject to a clearly stated standard of performance. Health care in the future will be quality-based and performance driven, like other sectors of the private economy.

Implicit in this concept is the assumption that high quality care can be delivered cost effectively, that quality and efficiency actually go together. For too long the opposite assumption, quality costs more, has implicitly been accepted in New York City.

TABLE THREE
HMO Enrollment in Major MSAs

Metropolitan Statistical Area	Total Enrollment^[1]	% Enrolled
New York, NY	2,700,630	14.7%
Rochester, NY	638,322	63.0
San Francisco, CA	2,485,858	39.2
Minneapolis, MI	965,028	38.5
Los Angeles, CA	5,185,994	35.0
Baltimore, MD	717,419	29.7
Philadelphia, PA	1,644,373	29.4
Miami, FL	915,846	28.1
Detroit, MI	1,017,676	23.1
Cleveland, OH	461,373	21.8
Chicago, IL	1,490,207	20.5
St. Louis, MO	538,072	20.5
Washington, DC	756,456	19.0

[1] As of January 1, 1994.

Source: The InterStudy Competitive Edge - March 1995.

b. Effect on New York City Hospitals

As discussed earlier, New York City hospitals have been subject to a highly regulated environment. Quite unintentionally, these strong regulatory policies in New York have, it now appears, shielded hospitals in the State from market forces which have grown in other states and are just now coming into play in New York.

It is only in the last three years that hospital utilization rates have begun to drop. The initial reduction foreshadows the inevitable effects of managed care on hospitals. Over the past several years, there has been a steady decrease in utilization of acute inpatient services. Hospital occupancy rates in New York City have decreased from 85.4 percent in early 1990, to 73.4 percent in 1993.⁵ Still, New York City's hospitals have a higher occupancy rate than the national average of 66 percent. Hospital length of stay in the City, which has dropped to 8.2 days from 8.7 days in 1990, is 74 percent above the national average of 4.7 days⁶. With the acceleration of managed care, we expect both the average length of stay and occupancy of New York City hospitals to rapidly decline, as HMOs place more pressure on facilities to lower costs.

c. Response of New York City Hospitals

In response to changes in the marketplace, New York City hospitals are now actively developing survival strategies. Some are seeking long-term partnerships with HMOs, while others are trying to become HMOs. Still others are merging with neighboring hospitals in the hope that there will be strength in numbers. Many are establishing primary care practices and otherwise seeking to reinvent themselves as vertically-integrated systems of care. A few are establishing niches as providers of highly specialized services and preparing to subcontract with some of the large integrated systems. The following paragraphs highlight the recent initiatives undertaken by some of the major New York City not-for-profit facilities in response to the changes in the market place.

New York Hospital. New York Hospital consists of a Manhattan Division and a Westchester Division. Its 1,371 bed Manhattan facility is the primary teaching hospital for Cornell University Medical School. New York Hospital has adopted a strategy whereby it will create a full service network capable of bypassing insurers. In order to implement its plans, New York Hospital is aggressively seeking partners, both in terms of physicians and facilities. Over the last three years New York Hospital has formed the New York Hospital Care Network which currently consists of 13 institutions with over 4,100 beds. The strategy combines both affiliation and acquisition to attain its objectives. New York Hospital purchased Methodist Hospital in Brooklyn and the former Booth Memorial Hospital in Queens. Although it has had success in establishing affiliations, the institution has experienced a loss of certain long standing relationships, including

⁵ New York State Department of Health, overheads presented to the Network Development Committee, July 6, 1994.

⁶ The Sourcebook: The Comparative Performance of US Hospitals, Deloitte & Touche and Health Care Investment Analysts, Inc., 1993.

those with: Catholic Medical Center, North Shore University Hospital, Lenox Hill Hospital and Staten Island University Hospital.

Beth Israel Medical Center. Beth Israel consists of the Medical Center, which is a 940 bed facility, and the North division, a 240 bed facility. Although Beth Israel has purchased two hospitals over the last five years (Kings Highway in Brooklyn and Doctors in Manhattan), it is pursuing a strategy to develop a network of physicians, without obtaining more beds. The primary vehicle to implement the plan is affiliation. Affiliation arrangements allow partnering physicians to remain independent, while securing patient referrals and primary care access for Beth Israel. Also, Beth Israel organized HealthFirst, a hospital based HMO serving Medicaid participants, with twelve other New York City Hospitals.

Preferred Health Network ("PHN"). PHN commenced operations in 1991 and represents one of the few community based, multi-hospital systems in New York City. The network consists of six hospitals and five health centers. PHN seeks to gain economies of scale through the centralization of certain functions. PHN is pursuing affiliation and acquisition opportunities with private practice physicians and community hospitals. PHN believes the combination of being a low cost provider with significant primary care access will strengthen its negotiating position in a managed care environment.

Columbia Presbyterian Medical Center. Columbia Presbyterian Medical Center's flagship facility is the Presbyterian Hospital, which consists of the "main campus," a 1,346 bed tertiary facility, and the "community hospital," a 257 bed acute care facility built in 1988. The medical center suffered huge operating losses in the early 1990's. In spite of these operating losses, the medical center continued to generate positive cash flow. Recently, the medical center has begun to show improvement in its finances due to a cost reduction program. In order to continue to enhance its financial position, the medical center has sought to develop a referral network to insure patient flow to the medical center. Due to its location near the George Washington Bridge, Columbia has strong ties to northern New Jersey hospitals and certain New Jersey based health plans.

New York University Medical Center ("NYU"). NYU consists of the 152 bed Rusk Institute of Rehabilitation Medicine and the 726 tertiary bed Tisch University Hospital. NYU has adopted a network strategy in an effort to secure its place in the future health care system. NYU's position is to closely align with its affiliates, while maintaining autonomous governance for itself and its partners. This strategy is exemplified by its affiliation with the Brooklyn Hospital Center and the North Shore University Hospital. Both institutions ended long standing relationship with other teaching institutions in order to affiliate with NYU. The affiliations include a sharing of physician, medical students and facilities along with the development of primary care capabilities.

Mount Sinai Medical Center. Mount Sinai operates the 1,167 bed tertiary Mount Sinai Hospital. Mount Sinai's preparation for managed care has included a decrease in the number of beds while increasing the number of doctors, particularly primary care physicians. Mount Sinai is following an affiliation strategy. It recently joined forces with Staten Island University Hospital. Mount Sinai's relationship with HHC is extremely important. The affiliation contract represented \$100 million in revenues for Mount Sinai in fiscal 1993. The contract also provides a training site for residents and interns with the added benefit of patient referrals from Elmhurst and Queens.

V. Peer Group Analysis

In order to assess the financial and operating performance of the three selected hospitals, we compiled data from surrounding hospitals. We believe that this geographic peer group analysis provides useful insights into the overall efficiency of the HHC facilities. The peer group for each of the HHC facilities consists of hospitals which are within a seven-mile radius. The peer group analysis is preferable to a hospital-to-hospital comparison, because it provides average level of performance measures upon which we can gauge performance.

Academic medical centers ("AMC") were not included in the peer groups. Because the Hospitals are community based institutions, we felt that this was inappropriate due to the tertiary nature of the AMCs. For example, the case mix index at New York Hospital in 1993 was 1.60, significantly higher than the case mix indices at Coney Island, Elmhurst or Queens.

The geographic peer group for the 498 bed Coney Island Hospital consists of seven not-for-profit institutions ranging in size from 308 occupied beds (University Hospital of Brooklyn) to 906 occupied beds (Brookdale Hospital). The Coney Island peer group is listed below:

	<u>Occupied Beds</u>
Victory Memorial	366
Lutheran Medical Center	452
Maimonides Medical Center	640
Brooklyn Hospital ^[1]	587
Methodist Hospital	547
University Hospital of Brooklyn	308
Brookdale Hospital	906

[1] Consists of: Caledonian and Brooklyn campuses.

The geographic peer group for the 646 bed Elmhurst Hospital Center consists of eight not-for-profit institutions ranging in size from 213 occupied beds (Western Queens Medical Center) to 1,296 occupied beds (Catholic Medical Center). The Elmhurst Hospital peer group is listed below:

	<u>Occupied Beds</u>
Wyckoff Heights Medical Center	337
Western Queens Community Hospital	213
Catholic Medical Center ^[1]	1,296
LaGuardia Hospital	229
Jamaica Hospital	523
Parkway Hospital	217
NY Hospital Medical Center of Queens	422
Flushing Hospital ^[2]	380

[1] Consists of: Mary Immaculate Hospital, St. John's Queens Hospital, St. Joseph's Hospital and St. Mary's Hospital.

[2] Consists of: Flushing Hospital Medical Center and Flushing Hospital Medical Center - North.

The geographic peer group for 556 bed Queens Hospital Center consists of seven not-for-profit institutions ranging in size from 217 occupied beds (Parkway Hospital) to 1,296 occupied beds (Catholic Medical Center). The Queens Hospital Center peer group is listed below:

	<u>Occupied Beds</u>
Catholic Medical Center ^[1]	1,296
Jamaica Hospital	523
Parkway Hospital	217
LaGuardia Hospital	229
New York Hospital Medical Center of Queens	422
Flushing Hospital ^[2]	380
Long Island Jewish Medical Center	801

[1] Consists of: Mary Immaculate Hospital, St. John's Queens Hospital, St. Joseph's Hospital and St. Mary's Hospital.

[2] Consists of: Flushing Hospital Medical Center and Flushing Hospital Medical Center-North.

a. Summary and Conclusions

The conclusion of our analysis is that the operating and financial performance of Coney Island, Elmhurst and Queens was below that of their respective geographical peer groups, as illustrated by Table Four. The following paragraphs highlight our findings.

Full Time Equivalents ("FTEs") per Occupied Bed. On average, Coney Island, Elmhurst and Queens employ approximately two additional FTEs per occupied bed than hospitals in their respective peer groups. Patient intensity, as measured by the case mix index, is approximately the same as the peer group, and therefore does not appear to be a reason for the variation. The additional FTEs may be explained in part by the fact that the outpatient volume of the HHC facilities is significantly higher than the average for the peer group. However, a regression analysis was performed which examined FTEs as a function of both inpatient and outpatient volume of Coney Island, Queens and Elmhurst versus that of their respective peer groups. This analysis showed that, even after factoring-in higher outpatient volumes, the FTEs of the HHC facilities were still significantly higher than the average of the peer group. Since labor (employee salaries and benefits) is typically 50-60 percent of a hospital's total expenses, the fact that the HHC facilities have these extra FTEs places them at a significant disadvantage.

Earnings Before Interest, Taxes, Depreciation and Amortization ("EBITDA"). This measure provides an indication of a hospital's operating performance, before capital expenses and taxes. During 1993, the average EBITDA for hospitals across the country was 11.67 percent. Since capital expenses (interest plus depreciation) averaged 8.37 percent nationwide, the average hospital generates sufficient earnings to fund existing capital and to save money for future plant replacement. Due to the harsh operating/reimbursement environment which exists in New York State, the EBITDAs of the peer groups range from 6.44 percent to 8.27 percent, and are below the national average. However, the fact that the peer groups have positive cash flow demonstrates

7 Moody's Investors Service - Health Care and Utilization and Financial Statistics - January 1995.

TABLE FOUR

Peer Group Comparison - Fiscal 1993

	<u>Coney Island</u>	<u>Peer Group</u>	<u>Elmhurst</u>	<u>Peer Group</u>	<u>Queens</u>	<u>Peer Group</u>
FTEs per occupied bed	6.77	4.92	6.60	4.39	7.48	4.69
Case Mix Index						
Medicare	1.38	1.49	1.29	1.33	1.16	1.37
Non-Medicare	1.20	1.19	1.10	1.21	1.07	1.15
EBITDA ^[1] margin	(7.33)%	8.33%	(12.37)%	6.44%	(23.10)%	6.58%
Bad debt and charity care (\$MMs)	\$23.3	\$12.6	\$57.5	\$13.1	\$35.3	\$14.1
Net pool receipts ^[2] (\$MMs)	\$13.0	\$3.7	\$28.9	\$4.1	\$28.8	\$4.5

[1] Earnings before interest, taxes, depreciation and amortization.

[2] Represents pool receipts from Regional, Supplemental and SLIPA pools, net of New York State assessment. Net 1994 pool receipts for Coney Island, Elmhurst and Queens were \$15.3 million, \$50.4 million and \$31.5 million, respectively.

that the surrounding not-for-profits generate sufficient monies from operations to fund existing capital, with a small amount remaining for future plant replacement. Since Coney Island, Elmhurst, and Queens all have negative EBITDA, these facilities do not generate sufficient operating revenues to pay for current capital and are unable to fund future plant replacement.

The difficulty faced by the hospitals to pay for current capital and future plant replacement is a systemwide problem, as illustrated by the current method of payment of debt service. The City currently pays debt service on HHC's portion of the general obligation and New York State Housing Finance Agency ("HFA") debt throughout the year, an amount which totaled \$175 million in fiscal 1994. Twice a year, HHC reimburses the City for the debt service on the general obligation and HFA debt.

The City's direct support to HHC, a subsidy known as the "tax levy," covers a number of costs, including: reimbursement for services provided to the City's uniformed employees; settlement of malpractice insurance claims; support for indigent care; and the payment of interest on City general obligation and HFA debt used to finance HHC facilities. The appropriation from the City totaled \$343 million in fiscal 1994.

As detailed below, HHC generated **negative \$231 million** in operating cash flow in 1994, prior to the subsidy from the City. Therefore, without the City subsidy, HHC would have to take remedial actions to reduce its costs in order to continue to reimburse the City for debt service.

(\$ in thousands)	<i>June 30, 1994</i> <u>Operating Cash Flow</u> ⁸
Loss from operations	\$(145,561)
Add:	
Depreciation	154,685
Interest ⁹	102,683
Less:	
Appropriation from the City	<u>343,017</u>
Cash flow operating deficit	<u><u>\$(231,210)</u></u>

Bad Debt and Charity Care versus Net Pool Receipts. This compares the actual amount of monies received by the facilities from the bad debt and charity care pools against what is received by the peer group. It is interesting to note that Coney Island, Elmhurst and Queens are reimbursed, through the bad debt pools, a significantly higher percentage of their bad debt and charity care (approximately 50 percent as compared to the peer group average of approximately 30 percent).

⁸ Source: New York City Health and Hospitals Corporation and Subsidiaries June 30, 1994 audited financial statements.

⁹ Includes interest which is supported by the tax levy (i.e. City general obligation debt, HFA debt), along with interest paid directly by HHC, including HHC's Series 1993 debt.

VI. Measurement New York City's Obligation

Our analysis indicates that the City bears a significant financial burden in supporting Coney Island, Elmhurst and Queens. The following paragraphs outlines the four major financial costs which are borne by the City. *One*, the facilities obtain significant financial support from the bad debt and charity care pools, which are partially funded by the City. *Two*, the City funds the perennial operating losses of the facilities. *Three*, with the exception of Elmhurst Hospital Center, the facilities are aging and require a huge capital investment in order to maintain the existing level of service. *Four*, HHC has a substantial Central Office, whose overhead in 1993 was in excess of \$147 million. Another cost, which cannot be quantified, is the time which City management devotes to HHC related issues.

a. Bad Debt and Charity Care

The bad debt and charity care funding received from the State is broken down into three distinct pools, namely: Regional, Supplemental and SLIPA. In addition to its funding of the Medicaid program, the City also provides a portion of the funding for the pools. The City's financial responsibility for each pool is as follows: 0 percent for the Regional pool and 50 percent for each of the Supplemental and SLIPA pools. The City's funding for bad debt and charity care for fiscal 1994 is illustrated in Table Five.

These monies are in addition to the City's Medicaid payments and the City's appropriation to HHC. The pool monies are recorded as net patient service revenue by the facilities, thereby reducing the operating deficit. Thus, whatever funds the City spends on the pools effectively funds the operating deficit of the facilities.

An example of this phenomenon occurred during 1994, when Elmhurst recorded an operating gain of \$7.3 million, versus an operating deficit of \$26.7 million during 1993. This improvement in operating performance is due in large part to the fact that Elmhurst's net pool receipts increased by \$21.6 million during 1994, from \$28.9 million in 1993 to \$50.5 million in 1994. If Elmhurst pool receipts had remained constant during 1994, the facility would have experienced an operating loss of approximately \$14.3 million.

b. Operating Losses

The three facilities have consistently lost money on an operating basis. Like any business operating losses must be paid for - the books must eventually balance. In the case of Coney Island, Elmhurst and Queens, these cash flow operating losses are funded by the City, through the subsidy. Table Six highlights each facility's earnings before interest, depreciation and amortization. The amounts *excludes* any subsidy from the City, implied revenues for services to the City, and Central Office allocation. It is important to note that these cash flow losses are prior to any debt service payments. Our analysis showed that the reimbursement which the facilities receive for City services (care to uniformed services, emergency medical services, care for the prison population, and mortuary services), covers the actual cost of providing these services. City services represent a small component of overall services provided at each facility.

TABLE FIVE
Bad Debt and Charity Care Pool Funding - 1994

	(\$ in thousands)					
	Coney Island		Elmhurst		Queens	
	<u>Total</u>	<u>City Portion</u>	<u>Total</u>	<u>City Portion</u>	<u>Total</u>	<u>City Portion</u>
Regional	\$4,694	\$0	\$6,651	\$0	\$3,146	\$0
Supplemental	3,927	1,963	24,975	12,487	8,683	4,341
SLIPA	<u>8,460</u>	<u>4,230</u>	<u>21,159</u>	<u>10,579</u>	<u>21,374</u>	<u>10,687</u>
Total	<u>\$17,081</u>	<u>\$6,193</u>	<u>\$52,785</u>	<u>\$23,066</u>	<u>\$33,204</u>	<u>\$15,028</u>

Source: HHC Central Office.

Note: Represents gross receipts from Regional, Supplemental and SLIPA pools prior to New York State assessment. The New York State assessment during 1994 for Coney Island, Elmhurst and Queens was \$1.8 million, \$2.4 million and \$1.7 million, respectively. Therefore, net pool receipts in 1994 for Coney Island, Elmhurst and Queens were \$15.3 million, \$50.4 million and \$31.5 million, respectively.

TABLE SIX

Historical Earnings Before Interest, Taxes, Depreciation and Amortization

	(\$ in thousands)			
	<u>1991</u>	<u>1992</u>	<u>1993</u>	<u>1994</u>
Coney Island	\$(6,229)	\$371	\$(10,842)	\$(11,743)
Elmhurst	(14,310)	(10,485)	(26,712)	7,330
Queens	(25,079)	4,740	(38,323)	(25,812)

Source: HHC Central Office.

c. Capital Investment

Major future capital programs along with maintenance capital represent an enormous potential liability for HHC. Planned construction of a new facility at Queens is estimated to be \$435 million. Coney Island requires a major capital reconstruction project within the next five years. Even without the major renovation, its capital maintenance budget is \$87 million through 2004. The cost of a new facility at Coney Island is estimated to be approximately \$300 million. Elmhurst Hospital Center has \$67 million in additional capital requirements through 1998.

Unlike the facilities in the peer group, which have generated sufficient cash flow from operations to fund current capital and maintain a small margin to fund replacement capital, the HHC facilities do not generate sufficient operating cash flow, prior to the City subsidy, to fund operations, let alone current and future capital expenditures. Future capital investment at Coney Island, Elmhurst and Queens depends upon three factors: the general health care and reimbursement environment; the level of the City subsidy; and any steps taken by management to increase cash flow either through revenue enhancements or cost reductions.

d. HHC Central Office

The HHC Central Office represents another layer of cost in the delivery system. The operating losses noted previously did not include an allocation of HHC Central Office overhead. In 1993, the operating expenses for HHC Central Office totaled \$147 million. Costs have been reduced since 1993, but still remain high when taking into consideration the fact that each hospital also performs administrative functions. For purposes of our analysis, we assumed that the HHC Central Office overhead allocated to each facility was \$7 million per year.

e. City Management

Finally, City management commits a large amount of resources to HHC including: Department of Health, Office of Management and Budget, Corporation Counsel, and the Mayor's Office. Due to HHC's sheer size, the City is in the health care business, including the cost of litigating the various malpractice cases against HHC. The dedication of resources required to operate a health care organization of this magnitude is staggering. HHC is a massive health care organization which operates in a governmental framework.

f. Summary of 1994 Financial Support

The financial burden which Coney Island, Elmhurst and Queens have placed on the City has been and will continue to be significant. Table Seven outlines the obligation of the City of New York to the three facilities during 1994, which was in excess of \$184 million, including additions to property, plant and equipment.

TABLE SEVEN
New York City Financial Support - 1994

	(\$ in thousands)			
	<u>Coney Island</u>	<u>Elmhurst</u>	<u>Queens</u>	<u>Total</u>
Pool Contributions	\$6,193	\$23,066	\$15,028	\$44,287
Net Cash Flow Deficit	11,743	(7,330)	25,812	30,225
Estimated Central Office Allocation	<u>7,000</u>	<u>7,000</u>	<u>7,000</u>	<u>21,000</u>
Subtotal	24,936	22,736	47,840	95,512
Capital Expenditures ⁽¹⁾	<u>14,744</u>	<u>65,370</u>	<u>9,234</u>	<u>89,348</u>
Total	<u>\$39,680</u>	<u>\$88,106</u>	<u>\$57,074</u>	<u>\$184,860</u>

(1) These numbers represent the additions to property, plant and equipment at each facility during fiscal 1994. Although funds were borrowed to finance these expenditures and only interest was paid during 1994, it is our opinion that the entire capital expenditure should be displayed in this analysis. In order to understand the absolute cash flow cost to the City, the financing decision, i.e. buy/cash versus buy/borrow, must be isolated from the operations of the three facilities. Because the facilities have historically been unable to fund their operations, it is appropriate to include the current capital expenditures on this schedule.

g. Present Value of the City's Future Obligations

Estimates of the total costs to the City for the continued support of the three facilities were projected into the future, based upon historical operating data. We want to stress that this is a static analysis, which assumes no major changes in operations (e.g. reimbursement, staffing, etc.). Projections for the pool contributions and estimated HHC overhead were based upon 1994 support levels. Estimates of the net cash flow deficits were forecasted through the year 2004 from a model using historical financial and operating data as a base, and then projecting forward based upon assumptions developed using data provided by HHC Central Office and the Office of Management and Budget. The projections included incremental capital reimbursement based upon current reimbursement methodology. The projected capital expenditures were furnished by HHC Central Office, and reflect HHC's constrained capital program. The projections have been discounted at eight percent per annum to arrive at the City's total obligation expressed in today's dollars, i.e. present value. To reiterate, if the operations of the three facilities were to continue based upon the current environment, the potential cumulative cost to the City, in today's dollars, would be approximately \$1.7 billion, as detailed in Table Eight.

h. Sensitivity Analysis - Medicaid Reductions

We attempted to analyze the future operating losses of the Hospitals assuming the Medicaid reductions are enacted without a corresponding change in service. Table Nine estimates the present value of future operating losses assuming the facilities continue to operate based upon the status quo. For example, if a 20 percent cut in Medicaid is enacted, without a corresponding change in service, the present value of the future operating losses at the three facilities would be approximately \$1.2 billion.

It is important to note that this is a static financial analysis because management would most certainly alter operations in order to reduce the future operating losses. However, we cannot predict the specific managerial actions which would be taken in response to the proposed Medicaid reductions and their effect on the financial condition of the Hospitals.

i. Data Issues

Our financial projections were based upon historical financial and operational data furnished by HHC Central Office and the individual hospitals. Some information was difficult to obtain and at times we found inconsistencies in the data. Although these discrepancies existed, we do not believe the differences would alter our final conclusions. However, our projections relied upon the best information available and are subject to adjustment, contingent upon the accuracy of the data supplied.

TABLE EIGHT

Estimated Present Value of New York City's Future Obligation

	(\$ in thousands)			
	<u>Coney Island</u>	<u>Elmhurst</u>	<u>Queens</u>	<u>Total</u>
Pool Contributions	\$77,450	\$288,325	\$187,850	\$553,625
Net Cash Flow Deficit	2,601	44,665	98,549	145,815
Estimated Central Office Allocation	87,500	87,500	87,500	262,500
Capital Expenditures	<u>116,521</u>	<u>209,735</u>	<u>395,877</u>	<u>722,133</u>
Total	<u>\$284,072</u>	<u>\$630,225</u>	<u>\$769,776</u>	<u>\$1,684,073</u>

TABLE NINE

Medicaid Sensitivity - Present Value of Future Operating Losses

(\$ in millions)

Change in Medicaid Rates ^[1]	Present Value of Operating Losses		
	Coney Island	Elmhurst	Queens
1% increase ^[2]	\$(3)	\$(45)	\$(99)
10% reduction	(152)	(269)	(275)
20% reduction	(289)	(468)	(436)

[1] Represents increase/decrease in Medicaid rates for the initial year in the forecast, Medicaid rates increase one percent per annum thereafter.

[2] Assumption used in forecasting net cash flow deficit in Table Eight.

VII. Potential Buyers

As discussed earlier in the report, the City's health care environment is undergoing rapid transformation. Over the past three years, there has been a significant increase in the level of network development throughout the City. Stand alone institutions are eager to partner with other institutions in order to survive in an era of managed care and network building. As managed care plans make inroads in the City of New York, the acquisition of primary care physicians and network development are two important ingredients of a successful integrated delivery system. The critical components for most institutions are the building of market share, the adjustment of their cost structures, and the diversification of services and geographical service area.

The academic medical centers are at the forefront of network building. Because they have long been high cost, highly specialized tertiary facilities, they are in the process of reinventing themselves in order to survive. Many of the teaching institutions have spent/will spend significant dollars to replace/refurbish their physical plants. In order to cover their high fixed costs, these institutions must secure referral sources in the surrounding communities. The HHC facilities can add value during this transition period for the following reasons:

- 1. Instant market share gains*
- 2. Primary care access*
- 3. Densely populated service areas*
- 4. Source for referrals to tertiary site*
- 5. Physician staffing opportunities*
- 6. Profit potential through improvements in operating performance*

Among the institutions which are likely to be interested in Coney Island, Elmhurst and Queens are the following:

- Beth Israel Medical Center
- Catholic Medical Center
- Maimonides Medical Center
- Mount Sinai Medical Center
- New York Hospital - Cornell Medical Center
- New York University Medical Center
- Preferred Health Network
- St. Luke's Roosevelt Hospital Center
- The Presbyterian Hospital in the City of New York
- University Hospital of Brooklyn

In addition, physician groups and HMOs may have an interest in purchasing these facilities in order to vertically integrate. While uncommon in New York, there are many examples across the country of HMOs and/or physicians linking-up with hospitals to form fully integrated delivery systems. Although publicly traded companies are prohibited from owning hospitals, several large hospital management companies could be interested if the legal environment were to change, including:

- Columbia/HCA
- OrNda Health Corporation
- Quorum Health Group, Inc.
- Tenet (combination of NME/AMI)

The potential buyers would examine various opportunities to improve the operating performance at each hospital through various management initiatives. The following paragraphs provide brief summaries of the considerations a potential buyer might take into account when evaluating the facilities.

Coney Island Hospital. Coney Island is a relatively valuable asset due to its strategic location, primary care physician group, and attractive payor mix. However, its plant is old and in need of major rehabilitation. Any potential purchaser must weigh the benefits of adding this service area to its network versus the future capital requirements of the hospital.

Elmhurst Hospital Center. Elmhurst's main attraction is its newly renovated facility. Although it is a growing service area, Elmhurst has a poor payor mix and relies heavily on support from the bad debt and charity care pools. Any potential buyer must weigh the strategic fit of Elmhurst into a network and the ability to attract a more diverse patient population in the future.

Queens Hospital Center. Queens Hospital Center is the least attractive of the Hospitals, due to its enormous capital requirements. Queens Hospital Center may be enticing to a buyer, if the buyer has the option to transform the facility. If rebuilt, Queens could be rightsized to reflect diminishing admissions. Queens may also be sold in conjunction with Elmhurst. Elmhurst would provide a strong anchor in central Queens, while Queens Hospital Center would supply access to significant covered lives in eastern Queens.

VIII. Summary

The City of New York commits a tremendous amount of resources to the Health and Hospitals Corporation. Financial resources are dedicated in the form of the tax levy, bad debt and charity care pool contributions, and support of capital. The City also expends significant management time in administering HHC.

In the case of Coney Island Hospital, Elmhurst Hospital Center and Queens Hospital Center, financial support from the City for 1994 was approximately \$180 million, including capital expenditures. The present value of the City's estimated long-term obligation to operate these hospitals is \$1.7 billion. The elimination or substantial reduction of this obligation should be included in the calculus when considering the price tag of each institution. The current health care milieu provides an opportunity for the City to sell these assets. With the shift to managed care, the facilities possess attractive characteristics including: primary care capabilities, access to covered lives, and a source of referrals to tertiary institutions.

Coney Island Hospital is the most desirable asset due to its strategic position. The hospital's primary care orientation and desirable location will pique the interest of buyers. Elmhurst Hospital Center's central location in Queens, along with its newly renovated facility, provide an attractive combination for prospective buyers. Queens Hospital Center is the least desirable of the three hospitals. Queens Hospital Center will have to be creatively packaged in order to affect a sale. A likely outcome may be the combined sale of Queens with Elmhurst.

In any sale, the City should be prepared to be flexible in structuring a deal with buyers. The financial benefits to the City of New York, of course, also depend upon factors not considered in this analysis, such as conditions of sale relating to care of the indigent, provision of services to the City and the like.

Selling the city's hospitals

It's time to privatize them

By MARIA K. MITCHELL

THE SUGGESTION that New York City find an alternative to its vast system of public hospitals operated by the anachronistic Health and Hospitals Corp. has provoked much political posturing and righteous indignation.

But critics of the mayor's Advisory Panel on the Future of the Health and Hospitals Corp. deftly avoided mention of the system's gross deficiencies, in terms of accessibility and quality of care.

Because we have focused so heavily on acute care hospitals to treat the poor and indigent, they too often lack access to the most basic health services and rely instead on expensive emergency rooms.

Long waits for care

A recent state survey found that many HHC patients had trouble getting appointments with physicians for basic health needs. One woman, four months pregnant, could not secure an initial examination with an obstetrician for 78 days — until well into her second trimester. A parent with an 18-month-old infant needing immunization for measles, mumps and rubella could not get an appointment for 99 days.

On the other hand, the poor have little difficulty accessing in-patient hospital care. In fact, the system is geared to encourage them to seek expensive hospital care for the most minor ailments.

Last year, for example, nearly 100,000 emergency room visits by children and adults were for asthma. Untreated asthma can be life threatening, but medical literature suggests the need for emergency room treatment should be minimal. Moreover, 7% to 11% of those treated for asthma in HHC emergency rooms had to return within a week, meaning they were not treated properly or lacked good follow-up care.

Such treatment costs money, and — worse yet — may cost lives. No wonder the city has some of the worst U.S. health indices, such as central Harlem's infant mortality rate, 83% higher than the national rate.

Privatization's critics accuse voluntary hospitals of being inhospitable to the poor. Again, not true. In 1992 and 1994 the city Department of Health found HHC facilities the least accommodating New York hospitals in facilitating pre-natal care and Pap smear appointments — two of the most basic needs of women and children.

In addition, the city's voluntary sector has increasingly demonstrated its commitment to care for the mentally ill and substance abusers, including the homeless. There is now such intense competition

among voluntary hospitals to attract these patients that they have increased their psychiatric bed capacity by 24% over the past year and eagerly accepted additional catchment areas in Brooklyn and Queens that have large proportions of mentally ill and substance-abusing populations.

It's time the city began treating its poor and indigent as it does the well-to-do and insured. Instead of continuing to operate a \$3.3 billion-a-year public hospital system it needs to establish a single system to serve all New Yorkers regardless of ability to pay.

Preserving the city's expensive, inefficient public system of 11 acute care

A City Hall proposal starts a healthy debate over medical care



hospitals is not the answer. An emotional attachment to the system is neither practical nor sensible. Instead, we should invest in improving the delivery of primary care.

The panel's report should be a starting point for vigorous discussion about restructuring the city's health care delivery system, not just in its public hospitals. The panel will next devise a plan for protecting and enhancing health care for the poor and indigent. Instead of defending the current system, public health advocates should join our search for better ways to protect the health of the most vulnerable.

Mitchell, chairwoman of the HHC, is the mayor's health policy adviser.

But who'll care for the poor?

By DAVID R. JONES

LAST WEEK'S proposal to dismantle the city's Health and Hospitals Corp may very well be a scare tactic by the administration. The real aim is to privatize three municipal hospitals.

While the idea of dissolving HHC has sparked protests, City Hospital Center at Elmhurst, Queens Hospital Center and Coney Island Hospital already are in play. J.P. Morgan & Co. has been hired for \$3 million to find buyers. Aside from the philosophical question of whether the administration should sell capital assets, the practical

residents. Today some 40% of all in-patient care and 50% of ambulatory services for the poor are provided at HHC facilities.

Even this is not enough. Two years ago Action for Primary Care Legislation, a providers and advocates group, estimated that the city's entire medical network needs to provide for 3 million more patient visits a year. The Primary Care Development Corp., which grew out of my organization's study showing the lack of family doctors in low-income neighborhoods, was designed to fill the gap. But PCDC calculates it could only add 1 million more patient visits a year — when all its neighborhood facilities come on line in two to three years.

There are nearly 1.3 million uninsured patients in the city. What will happen to them between the time the municipal hospitals close and community clinics open?

Public health risks

There is also the wider question of what happens when city hospitals fail to contain such modern health "epidemics" as asthma, drug abuse, tuberculosis and AIDS. The entire population will be at risk.

The mayor argues that privatizing HHC is all about ending huge subsidies to the corporation. The reverse is true. HHC has given the city well over \$100 million annually in free care to inmates, police and firefighters injured in the line of duty, and to help operate the Emergency Medical Service and the morgue. Without the public hospital system, who will provide this care? Who will pay? Surely not already financially strapped voluntary hospitals.

While many things are wrong with HHC, there is plenty that is right. Bellevue's emergency room and microsurgery department are ranked among the nation's best. Elmhurst is a fully accredited regional referral center for catheterization, obstetrics and neo-natal intensive care. Lincoln Hospital, formerly a private HHC facility, trains some of the best physicians in the world. If publicly financed centers are sold, who can guarantee these hospitals will be able to provide the same quality?

No public discussion of these fundamental questions took place before the dismantling of HHC was recommended. The HHC board, of which I am a member and which is legally obligated to vote on policy, was never allowed to debate the issues. No public hearings were scheduled or testimony solicited. Instead, a private committee, handpicked by the mayor deliberated behind closed doors. Are we to have government by fiat instead of democracy?

Jones is the president of the Community Service Society.

question of care for indigent patients now served by HHC takes precedence. Shouldn't there be a plan before precious HHC facilities are off-limits to the poor?

To his credit, Mayor Giuliani has admitted that his committee's proposal fails to detail how the poor will access medical care in the post-HHC era and needs "a good deal of separate elaboration." But his statement that if there are no public hospitals "private hospitals are legally required to care for indigents" is wrong. Voluntary hospitals need only provide emergency care to anyone who shows up.

The Legislature set up HHC in 1969 to assure access to care for the city's poorest

DAILY NEWS • Friday, August 25, 1995

The Privatization of Coney Island Hospital

HHC

1997

The Health Care Market

As the dramatic changes within New York City's healthcare system continue, the Health and Hospitals Corporation (HHC) must undertake a number of innovative joint ventures to position itself to succeed in this competitive market and continue to serve its traditional patient base. HHC's priority is to provide health care to people who have fewer options: the uninsured, the underinsured and Medicaid beneficiaries. The goal of the Corporation's strategic plan is to continue to provide services to the City's neediest residents while restructuring the public health care delivery system. The privatization of Coney Island Hospital (CIH) serves as a model program for the Corporation, and a blueprint for the future.

Privatization, in the form of a public-private partnership, will allow HHC to continue to operate City-funded hospitals and clinics. The expertise, resources and investment of a new partner will make this possible. The goal is to guarantee that Coney Island Hospital provides all patients with the highest level of health care.

Coney Island Hospital

Coney Island Hospital is a 450-bed facility with 2,710 full-time employees, located in South Brooklyn, and serving an ethnically diverse patient-base. Currently, two-thirds of the patients in the Coney Island Hospital catchment area make the choice to receive care from competing providers.

Currently, CIH is:

- more than \$48 million in debt
- in need of at least \$25 million in capital investment
- saddled with FY95 operating losses of approximately \$11.5 million
- responsible for \$4 to \$5 million per year in routine maintenance

The privatization of Coney Island Hospital offers significant advantages for its patients and for HHC. By transferring operations of the hospital to Primary Health Systems-New York (PHS-NY) - a for-profit company specializing in working with inner city hospitals, patient care will be expanded and enhanced, capital improvements and on-going maintenance will be made at no cost to HHC, and debt service will be handled by the lessor. PHS-NY will assume \$48 million of Coney Island's debt, and pay for \$25 million in capital improvements and up to \$5 million per year in routine maintenance. J.P. Morgan estimates that New York City taxpayers will save \$100 million over the first five years of the contract alone.

The Lease with Primary Health Systems - NY

PHS-NY is a duly constituted, privately held company incorporated under New York State Law. It is an affiliate of Primary Health Systems, Inc. (PHS, Inc.). PHS-NY has agreed to take over the operation of Coney Island Hospital in a long-term lease. Both PHS, Inc. and PHS-NY are for-profit companies,

owned by their senior management. Neither company is a publicly traded corporation. Shareholders are the hands-on professional hospital executives who possess a reputation for meeting rigorous management standards and ensuring high quality care.

Corporate Strategy

PHS-NY's corporate strategy has been to dramatically invest and improve the facilities, equipment and clinical services of each hospital it manages. PHS is known for its expertise in reviving, improving and expanding distressed hospitals in urban-based multi-ethnic environments. By modernizing and upgrading the facilities that they operate, PHS has been able to attract a higher proportion of patients from the community. Consequently, PHS-NY's business objectives coincide with the interests of the Coney Island community, HHC and the City in maintaining and even enhancing quality care and improving the facility.

Full Access to Quality Care for Indigent Population

This transaction is a lease rather than a sale of CIH and as a result, the City will have the contractual ability to impose strict standards on PHS-NY in its operation of CIH. PHS-NY risks losing its lease if it breaches its obligations or does not comply with the extraordinarily high standards mandated by this agreement. Indeed, the standards of indigent access far exceed those imposed by the State on any of New York's voluntary hospitals.

Moreover, PHS-NY will assume the full cost of indigent care - up to 115% of the audited levels offered at CIH, adjusted for inflation, and net of all third-party reimbursements from State bad debt and charity pools. Coney Island's charity care costs in FY96 - approximately \$9.2 million - will now be assumed by PHS-NY.

PHS-NY will follow HHC's charity care policy and employ a sliding fee scale similar to the one currently in effect at CIH. PHS-NY will continue to provide the extensive level of charity care available at CIH, which is much more than that provided at many of the voluntary hospitals, such as Columbia-Presbyterian, Beth Israel, or St. Lukes-Roosevelt. As mentioned, coverage will be increased by an additional 15% above and beyond inflation, after which the hospital will seek third party reimbursement for charity care.

PHS-NY's profit will be made by improving the overall quality of care, attracting more insured patients to CIH - and thereby capturing a larger market share — and also by winning the loyalty of indigent patients, many of whom may subsequently gain jobs and/or insurance.

Furthermore, the lease has stringent terms and conditions which PHS-NY must meet or it is subject to extensive and severe penalties, which ultimately includes the City's ability to revoke the lease. This would mean that PHS-NY would forfeit millions of dollars which it plans to invest in the modernization and upgrading of CIH when it assumes control of the hospital.

Capital Improvement and Modernization of Coney Island Hospital

PHS-NY is committed to a substantial change in the appearance and operation of the hospital. First of all, operating losses of about \$11.5 million in FY95 will now become PHS-NY's responsibility. Furthermore, a minimum of \$25 million will be spent by PHS-NY over the first five years to upgrade the hospital's facilities and equipment. In addition, PHS-NY will spend another \$4 to 5 million per year on routine maintenance. The physical plant of CIH will be more modern and attractive to its patients. PHS-NY plans to relieve congestion in the emergency room by redesigning the department, vastly

expand community-based outpatient services, upgrade diagnostic and laboratory equipment and modernize the hospital turning wards that now hold six patients into true semi-private rooms with their own bathrooms. It also plans to increase the number of its community-based physicians, expand ambulatory services and enhance primary care clinics.

This is a clear example of how public policy and corporate policy mesh to produce improved quality of care for the community. A further benefit to HHC and the City is PHS-NY's responsibility for full liability costs currently totaling \$6 million a year. Unless PHS-NY can successfully compete against other providers for patient and physician loyalty - and this can only be achieved by improving the quality of care for patients so that they choose to use Coney Island Hospital - PHS-NY will lose money. Patients return to a hospital when they feel confident about their care.

How the City and HHC Will Monitor and Enforce the Terms of the Lease with PHS

The State and Federal government routinely monitor quality and levels of charity care and this will continue under PHS-NY's management of Coney Island Hospital. Furthermore, the hospital will also undergo strict monitoring from HHC. Community monitoring will be required as well and will include the public release of periodic report cards by PHS-NY. In addition, a Community Advisory Board will be obligated to monitor grievances. HHC is the City's center of expertise in hospital administration and care of the poor and uninsured, and will administer the auditing process mandated by the sublease. Audits will be performed by HHC, with enforcement of provisions of the contract and remedies to include penalties and corrective actions and, if necessary, injunctive relief. These are part of an extensive process, including:

- Notice and cure periods
- Arbitration
- Imposition of a monitor
- Corrective action plans
- Seeking of specific performance of service obligations through the court, and
- Seeking of specific performance, damages, and termination of the lease in the case of indigent care obligations

PHS's Record of Improved Care

The company operates hospitals in Cleveland, Ohio including Mt. Sinai Medical Center that is similar in size and capacity to Coney Island Hospital, Saint Alexis Hospital Medical Center, and Deaconess Hospital. In just two years, PHS has invested almost \$11 million in capital upgrades to the three facilities. The following outlines the commitment PHS has made on behalf of its Cleveland facilities.

Mount Sinai Medical Center:

PHS acquired the 450-bed Mount Sinai Medical Center in April, 1996 and has planned upgrades which include:

- renovation of obstetrical unit
- renovation of outpatient treatment and examination areas
- purchase of MRI
- expansion of surgi-center
- expansion of home health, renal dialysis, women's health programs
- development of an oncology program

Deaconess Hospital:

PHS acquired the 316-bed Deaconess Hospital in December, 1994 and has completed the following capital upgrades.

- new laboratory information system
- new ultrasound equipment for vascular studies
- expansion of dialysis unit
- renovation of Emergency Department
- new anesthesia monitors

Deaconess also has expanded programs to meet community demands which include:

- women's institute
- peritoneal and renal dialysis
- psychiatric "partial" hospital
- parish nurse program

Saint Alexis Hospital Medical Center:

PHS acquired the 220-bed Saint Alexis Hospital Medical Center in September, 1994 and has completed the following capital upgrades:

- new urology suite
- new endoscopy suite
- new post-anesthesia recovery unit
- upgraded ICU monitors
- new anesthesia and telemetry monitors

PHS initiated a number of innovative programs to increase care to the indigent, including:

- At the University Settlement House, PHS offers free care to expectant mothers, free immunizations and child care, as well as free programs for seniors PHS is developing a traveling physician program for elementary schools within the hospital's catchment area
- PHS offers low- and no-cost home visits to indigent seniors
- Free community health screenings (breast, prostate, skin and colon cancer; eye exams; blood pressure; and cholesterol) are held at Saint Alexis each month
- Saint Alexis has developed affiliations with public assistance agencies to enroll indigent clients

PHS also expanded the hospital's community advisory board to improve representation from the many communities served by the hospital.

Saint Alexis underwent its first survey under PHS ownership by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) in August 1996. The hospital increased its score by 3 points under PHS ownership. The 1996 score - 93 - was the highest in the hospital's history.

The PHS-NY agreement will immediately result in aggregate savings for the City and HHC of more than \$100 million, with additional savings thereafter of approximately \$30 million a year. HHC will be able to reinvest those savings to improve its other facilities.

**RESPONSES TO ISSUES RAISED AT THE JOINT PUBLIC HEARING
HOSTED BY THE DEPARTMENT OF HEALTH
AND THE HEALTH AND HOSPITALS CORPORATION
OCTOBER 8, 1996**

How will care of the indigent be provided and financed under the agreement?

Some speakers asked whether PHS-NY will continue to provide care for people who are uninsured and unable to afford to pay for care. Others asked what amount of indigent care would be required, and how the dollar value of that care would be quantified.

Under the agreement, Coney Island Hospital will provide full access for the indigent, even if the dollar amount of services rises as much as 15% (the "trigger point"). The Hospital may apply for available charity care pool support--as other public and voluntary hospitals do--but any such amount will not apply toward the City's obligation above the trigger point.

The dollar value of care provided to the indigent will be booked at cost, thus protecting HHC against any increase in charges. Moreover, the dollar amount of care Coney Island Hospital is expected to provide to the indigent will be adjusted upward each year to reflect inflation and other natural increases.

What commitments have PHS-NY made for the investment of capital in CIH? Will the agreement bring savings to the City or HHC?

The agreement with PHS-NY stands to save taxpayers considerable sums, while still ensuring that equivalent health services are available in the community, including for the indigent. Indeed, it is more than likely that the transaction will allow the Hospital to provide a wider array of better quality services to the community.

With this initiative, the people of Coney Island communities stand to benefit from an investment of over \$70 million in the infrastructure and delivery of health services--at a time when dollars are diminishing in the health system as a whole. In addition J.P. Morgan estimates that the City will save approximately \$100 million in the first five years, funds that would have been spent operating the Hospital. This includes:

- savings from projected loss from operations for the hospital of approximately \$25 million;
- savings from pool payments for indigent care amounting to \$37.5 million; and
- savings from principal payment on the existing hospital debt, estimated at \$12.2 million.

PHS-NY has committed to remediate the outstanding debt of CIH (approximately \$50 million). Of that amount, \$42 million will be paid by PHS-NY upon closing, and the remaining \$6 million will be paid through lease payments to HHC. In addition, PHS has committed to investing another \$25 million in capital improvements at CIH.

Who is Primary Health Systems and Primary Health Systems-New York?

Primary Health Systems (PHS) has a proven track record of operating hospitals in urban-based, multi-ethnic environments. As our comprehensive due diligence process has revealed, the company has justifiably earned a reputation for preserving the community-based focus and traditions of each hospital in their system. The company operates health care facilities in urban markets in Cleveland, Ohio, including Mt. Sinai Medical Center, which is similar in size and capacity to CIH.

PHS was formed in 1994, but the senior management team has over 20 years of experience acquiring and managing hospitals nationally. As head of American Healthcare Management, Inc., PHS president Steven Volla rescued the company from bankruptcy by centering its mission on providing high quality health care in diverse urban environments. He is a nationally known proponent of health care reform that ensures access for the low income and uninsured, he was frequently called upon by the Clinton Administration during development of the President's health care reform act.

Primary Health Systems-New York (PHS-NY) is a duly constituted, privately held company incorporated under New York State Law. It is an affiliate of PHS, Inc., wholly owned by individual, noncorporate shareholders. Under the terms of the sublease, PHS-NY would be the lessee of CIH, and will contract with PHS, Inc., to serve as the manager of CIH.

Is it appropriate for a for-profit company to run a hospital in New York City?

Speakers asked how it could be legal for a for-profit company to operate a hospital in New York. Others noted that the Offering Memorandum prohibited for-profit companies from submitting proposals. There was also concern that a for-profit company might neglect patient care or cut corners on quality in order to improve the bottom line.

For-profit companies are permitted to own hospitals in New York State, and in fact there are several such hospitals currently operating. As the law requires, PHS-NY is incorporated in New York State as a business corporation with individual, non-corporate shareholders.

The Offering Memorandum did not prohibit for-profit entities from submitting a proposal. The Offering Memorandum stated that any proposal must preserve the tax-exempt status

of the underlying bonds associated with CIH's outstanding debt. The PHS-NY proposal and the subsequent sublease agreement meet the requirements of the Offering Memorandum.

PHS-NY is able to preserve the tax-exempt status of the bonds by retiring them. PHS-NY will pay to the City and HHC the value of HHC Series A bonds and City GO bonds, and the City will then remediate the outstanding bonds. The remaining \$6 million of indebtedness will be paid by PHS-NY to the landlord in the form of lease payments for the plant, property, and equipment for CIH.

While any for-profit company will be concerned about the bottom line, the ability to turn a profit depends entirely on whether the hospital does a good job and satisfies its patients. The hospital's ability to attract patients and earn a reputation in the community is not a peripheral consideration to a for-profit facility, but in fact the governing principle. Indeed, unlike many voluntary or public facilities which depend on external factors like membership, fundraising, and/or the influence of politicians, a profitmaking corporation has few competing interests to distract it from its central mission to provide the most competitive, highest quality health care.

PHS-NY plans to earn profits by appealing to more potential patients than the hospital appeals to now. Currently, only about one-third of the people living in the Hospital's catchment area use the facility. By modernizing and upgrading the facility, PHS-NY aims to attract more of the community to use the Hospital.

How will the City monitor and enforce the terms of the sublease?

In addition to routine monitoring by the State and federal government of quality and levels of charity care, the hospital will undergo strict monitoring from the City and HHC as well as community monitoring by requiring the public release of report cards and obligating a Community Advisory Board to monitor grievances. Audits will be performed by the City, with enforcement of provisions of the contract to include penalties and corrective actions.

The City is relying--in part--on HHC's ability to administer the auditing process mandated by the sublease. HHC is clearly the City's main locus of expertise in hospital administration and care of the poor and uninsured. It is important to note that HHC does not currently monitor the performance of their own facilities at all, so this process will be a more stringent one than the Hospital goes through now.

What services would the new CIH provide?

PHS-NY has committed to, and the sub-lease agreement requires PHS-NY to maintain, core services currently available at CIH. PHS-NY must seek prior approval from the City in order to alter, substantially reduce, or eliminate a core service in the event the method of delivery or need for a particular service changes in the future. The sub-lease provides for a set of remedies relating to the service obligations to ensure that CIH continues to offer a full range of appropriate services to the community served by the Hospital.

What will be the role of the community in the operation of the Hospital?

The community will remain integral to the operations of the hospital, with an increased and expanded role for the Community Advisory Board (CAB). The CAB will now have the responsibility of measuring certain indicators of quality and access, administering a grievance procedure relating to PHS-NY's contractual performance requirements; and preparing a public report card to assist HHC in monitoring PHS-NY operations at the new CIH--particularly with respect to the indigent care obligations.

The appointment of CAB members will be done by the Mayor (2), HHC (2), the Borough President and local Community Board together (2), and PHS-NY (6). These appointments must be of Coney Island community members and/or users of the hospital.

What arrangements have been made to ensure continuity of care between patients and current doctors at CIH?

Patients will be ensured the continuity of care by PHS' desire to retain substantially the same physician staffing--and indeed the likely expansion of physician services available in the community. PHS-NY likely will continue to employ UGMA doctors pursuant to an affiliation agreement currently being discussed between PHS-NY and UGMA. PHS-NY also plans to recruit more community providers while extending to them admitting privileges at the new CIH.

How does the City know for sure that PHS-NY is really qualified to run Coney Island Hospital?

The City has conducted a thorough due diligence process of PHS, its management, and its operating policies at other hospital facilities. HHC has dispatched a team of senior and executive level health and finance professionals to evaluate PHS' hospital operations in both Cleveland and Philadelphia. Those site visits have resulted in fair, reliable, and generally positive evaluation of PHS-NY's capacity to inherit operation and management functions at CIH. Independent confirmation of PHS' Cleveland operation have been verified by outside counsel through a separate due diligence process, and the State will conduct still another due diligence evaluation once CIH is in a position to apply for an operating license.

Do PHS-owned hospitals provide high quality care?

Some speakers referred to a study done in Cleveland called Cleveland Health Quality Choice. The study seemed to indicate that hospitals owned by PHS in Cleveland performed lower than expected in a few categories of performance. There was concern that PHS may have cut corners in quality.

The City has thoroughly investigated the quality of care provided by hospitals owned by PHS in Cleveland, and find the quality of care to be fully satisfactory and often exemplary. One of the hospitals, Deaconness, has undergone accreditation by the Joint Commission (JCAHO), the federally deemed accrediting body for hospitals, in the time since PHS acquired it. Despite having perched on the edge of bankruptcy only recently, under the leadership of PHS Deaconness earned excellent marks from JCAHO accreditation including an extraordinary score of "93".

Unlike the Joint Commission review, which is the standard bearer in the health care system, the Cleveland Health Quality Choice study is an experimental process for measuring the outcome of care provided in selected hospitals and publishing report cards. Cleveland is the first City to conduct such a study, which has many good ideas but remains untested and controversial in many of its applications. The Cleveland Clinic, one of the nation's most highly regarded health facilities and one that has consistently scored well in the Cleveland Study, has been sharply critical of some of the study's methodology and recommends major changes.

Hospitals owned by PHS performed as expected or better than expected on almost every category measured by the most recent Cleveland study, although they performed lower than expected in a few categories. In every category investigated by the study—including categories where the hospitals performed lower than expected--the hospitals owned by PHS were rated as "good" on a national scale as measured by the federal government's Apache III national norms.

In the areas where PHS hospitals showed lower than predicted performance, the difference amounted to no more than a 1.3% change, which the researchers themselves caution could be statistically insignificant. The City observed that PHS initiated its own internal process to monitor and improve quality in the areas identified by the study.

Does PHS have a good track record providing care to the indigent?

Comptroller Alan Hevesi testified that according to his research Deaconess Hospital reported a decline of 92% in charity care expense since PHS acquired the facility. The Comptroller also noted that St. Alexis provided less care to uninsured people with incomes above the poverty line but more care to people with lower incomes.

As City investigators found and reported to the Comptroller, those figures are likely inaccurate. Reviewing data over time, PHS provides a level of charity care that is consistent--and in many instances superior--to the level provided by prior owners. One unaudited number justified the Comptroller's analysis of a dramatic decline in patient care; in fact the number was an outlier, not reflective of the hospital's performance in any prior year, and almost certainly an accounting error. Ohio officials told the City and the Comptroller's staff that they believe the figure is a mistake.

The City also investigated the differences in reported patient income levels and found that prior owners did not have a computer system capable of accurately tracking patient income, nor did prior owners provide sufficient financial counseling to help qualified patients enroll in public assistance programs such as Medicaid.

Overall, the City's investigation, including site visits and detailed research into the hospitals' performance, revealed that indigent care provided by PHS-owned facilities was at least equal to and in some cases exceeding the level of charity care provided by prior owners.

Why isn't the process of negotiating the agreement made public?

In fact, community input was a strong part of the process of choosing a successful proposal and negotiating the sublease. In addition to myriad meetings with every elected official affected by the sublease agreement, representatives attended nearly every monthly meeting of the Coney Island Community Advisory Board, where concerns raised by members were duly noted and included in the process. Focus groups conducted in the Coney Island community elicited suggestions on mechanisms for monitoring the sublease agreement and creating a workable grievance process. Many of the most critical points in the sublease dealing with indigent care obligation were first suggested by members of the community and elected officials.

The negotiation deal points were not made public until they were concluded, in order to preserve the City's competitive advantage and negotiate the best agreement. As soon as key issues were agreed to, they were immediately made public and public input was carefully considered.

What role did the City play in partnering PHS-NY with New York University Medical Center and Brooklyn Hospital Center?

Neither the City nor HHC played a role in that process. PHS-NY is planning to negotiate independent, third party agreements with NYU Medical Center and Brooklyn Hospital to serve as the tertiary care and the community hospital affiliate to the new CIH. The network services expand, not replace, the services already available to people in the community.

Legislative Issues – Status

(covers only formal meetings scheduled on privatization issues)

ENTITIES BRIEFED**DATES/TIMES**

(unless indicated date is 1995)

I. City Council**A. Republican Caucus**

Meeting held on 9/7/95

B. Individual Briefings

o Enoch Williams, Health Committee

Meeting held on 9/25, 2 pm

o Herb Berman, Finance Chair

Meeting held on 10/3, 11:30 a.m.
(Amy Klein, Chief of Staff)

o Archie Spigner, Deputy Majority Leader

Attended Queens delegation meeting,
he was offered individual
briefing.

o Victor Robles, Majority Whip

Meeting held on 10/2 -
11 a.m. (with Bruce Bender)

o Una Clarke

Meeting held w/o 11/20

o C. Virginia Fields

Meeting held on 11/27

o Priscilla Wooten

[Re-scheduled?]

C. Group Meetings (all meetings in Green Rm)o Human Services and Finance Staff
Members (on behalf of Vallone)

Meeting held - 9/27, 12 p.m.

Staff level meeting held with JPM
[Date & Time]

o Queens Delegation

Meeting held - 11/17

o Brooklyn Delegation

Meeting held - 11/28

o Manhattan Delegation

Meeting held - 11/13

o Bronx Delegation

Meeting held - 11/1

Draft of: 3/14/96

o Staten Island

Jay O'Donovan was invited to attend any of the other delegation meetings. The other S.I. council members were part of the Republican caucus briefing.

II. State Agencies*

A. Department of Health
Commissioner DuBuono

Meeting held - 2/5/96

B. Office of Health Systems Management
Acting Director -- Dennis Whalen

Meeting held - 2/5/96

* There have been on-going discussions other than these formal meetings in Albany.

III. State Legislators

A. Individual Briefings

o Richard Gottfried
(Assembly Health Committee Chair)

Meeting held - 9/7/95

o Barbara Clark (Queens Assemblywoman)

Meeting held - 9/21/95

o Kemp Hannon, Senate Health Chair

Was offered a briefing.

o Roberto Ramirez, Bronx Assemblyman

Meeting held - 11/14

o Sheldon Silver, Assembly Speaker

Meeting held - 10/16 9 a.m. (with Fred Jacobs, Counsel to the Speaker)

o Joseph Bruno, Senate Majority Leader

Not scheduled. Informal discussions had with staff.

o Jules Polonetsky

Meeting held - 12/7 (with community group and Carl Kruger)

Draft of: 3/14/96

B. Group Meetings

o Queens Delegation -- Assembly/Senate

Meeting held - 10/25 ..
3:30 p.m. (Queens Borough
Hall)

Meeting held - 3/8/96
9:45 a.m. (Queens Borough
Hall)

o Brooklyn -- Affected Legislators (Jules Polonetsky and Carl Kruger)

Invited to attend first Queens
Delegation meeting and meeting
held on 12/7 with community
representatives at 52 Chambers.

o Brooklyn -- Senate/Assembly

Not scheduled.

IV. Governor's Office

Met with Jim Natoli (Director of State
Operations) and Barbara
Howard in Albany -- 2/5/96

V. Federal Legislators Individual Briefings

- o Nita Lowey (Queens and Elmhurst)
- o Nydia Velazquez (Elmhurst)
- o Tom Manton (Democratic leader Queens)
- o Charles Schumer (Coney Island)
- o Charles Rangel

No formal meetings held
and no requests
have been made yet.

VI. Borough Presidents/Comptroller Claire Schulman

Individual meetings offered. Attended
both Albany Queens
Delegation Meetings and sent
representative to community
focus groups for Elmhurst and
Queens hospitals.

Draft of: 3/14/96

Howard Golden

Meeting held -- 11/95
Attended privatization meeting
in Bklyn Boro Hall - 11/95

Alan Hevesi

Meeting held -- 10/23, 9 a.m.
He attended advisory panel
indigent care hearing 12/95

Other Borough Presidents

No meetings held (Ruth Messinger's
representative attended
advisory panel indigent care
hearing 12/95)

VII. Community Groups

o Hospital Community Advisory Boards

Luis Marcos & Karen Shaw formally
briefed groups (with updates
provided at later meetings by
HHC and hospital reps)

Queens Hospital Center
Coney Island Hospital
Elmhurst Hospital Center

Meeting held on 9/27, 6:30pm
Meeting held on 10/5, 6:30pm
Meeting scheduled -- 10/11
6 p.m.

o Queens Coalition to Save the Public Hospitals

Meeting held on 8/9/95.
Members attended Queens CAB
meeting on 9/27 and meeting
with Jules Polonetsky on 12/7.

o Forum/CI Hospital - Community Board 13 and Brighton Beach Neighborhood Association (CAU)

Held at P.S. 122 -- 3/5/96

o Queens Hospital Center -- Focus Groups

Meetings held 3/6/96 and
3/14/96 (6-8 p.m.)

o Elmhurst Hospital Center -- Focus Groups

Meetings held 2/29/96 and
[3/19/96] (6-8 p.m.)

o Coney Island Hospital -- Focus Groups

Meetings held 3/12/96 and
3/13/96 (6-8 p.m.)

\ Draft of: 3/14/96

VII. Unions

o Stanley Hill Meeting

Meeting held – 10/17
8:00 a.m.

o MLC – Group

Meeting held – 10/17
9:30 a.m.

o DC37 (Dennis Sullivan)

Meeting held – 2/22

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Distribution List for J.P.Morgan Offering Memoranda

DISTRIBUTION

Appendix 6B

Distribution List for J.P.Morgan Offering Memoranda

DISTRIBUTION**City Council**

Peter Vallone (MKM -- 10/26)
 Enoch Williams (MKM -- 10/26)
 Archie Spigner (MKM -- 10/26)
 Victor Robles (MKM -- 10/26)
 Herb Berman (MKM -- 10/26)

Council Staff (DD -- 10/27)
 Stanley Michels (Manhattan Del) (DD -- 10/27)
 June Eisland (Bronx Del) (DD -- 10/27)
 Jay O'Donovan (S.I. Del) (DD -- 10/27)
 Thomas Ognibene (DD -- 10/27)
 Charles Millard (DD -- 10/27)
 Andrew Eristoff (DD -- 10/27)
 Michael Abel (DD -- 10/27)
 Al Stabile (DD -- 10/27)
 John Fusco (DD -- 10/27)
 Vito Fossella (DD -- 10/27)

Health Committee

Morton Povman (DD -- 10/27)
 Priscilla Wooten (DD -- 10/27)
 C. Virginia Fields (DD -- 10/27)
 Jose Rivera (DD -- 10/27)
 Una Clarke (DD -- 10/27)
 Julia Harrison (DD -- 10/27)

Other Members (DD-11/3-11/8)

Micahel Abel (11/3)
 Sal Albanese (11/3)
 Lucy Cruz (11/6)
 Noach Dear (11/3)
 Michael DeMarco (11/3)
 Stephen DiBrenza (11/6)
 Martin Malave-Dilan (11/6)
 Thomas Duane (11/3)
 Ronnie Eldridge (11/6)
 Andrew Eristoff (11/3)
 Kenneth Fisher (11/6)
 Kathryn Freed (11/6)
 Vito Fossella (11/3)

Lloyd Henry (11/3)
Howard Lasher (11/6)
Sheldon Leffler (11/3)
Guillermo Linares (11/6)
Helen Marshall (11/3)
Joan McCabe (11/6)
Walter McCaffrey (11/6)
Charles Millard (11/8)
Karen Koslowitz (11/6)
Antonio Pagan (11/8)
Mary Pinkett (11/8)
Adam Clayton Powell (11/3)
Annette Robinson (11/8)
David Rosado (11/8)
Israel Ruiz (11/8)
John Sabini (11/6)
Al Stabile (11/8)
Lawrence Warden (11/8)
Juanita Watkins (11/6)
Anthony Weiner (11/6)
Thomas White (11/8)

Copies of the offering memoranda have been sent to the following people:

State Agencies (by federal express on 10/26)

Barbara DuBuono, DOH
 Jim Natoli, Governors Office
 Dennis Whelan, Health Systems Management

State Legislators (by federal express on 10/26)

Barbara Clark
 Sheldon Silver
 Kemp Hannon
 Roberto Ramirez

By priority mail on 10/30

Richard Gottfried
 Joseph Bruno

By regular mail on 10/30:

Queens--Assembly

Jeffrion Aubry
 Vivian Cook
 Joseph Crowley
 Melinda Katz
 Ivan Lafayette
 Gregory Meeks
 Nettie Mayersohn
 Brian McLaughlin
 Catherine Nolan
 Audrey Pheffer
 Douglas Prescott
 William Scarborough
 Anthony Seminerio
 Mark Weprin

Queens--Senate

Emanuel Gold
 Serphin Maltese
 George Onorato
 Frank Padavan
 Ada Smith
 Leonard Stavisky
 Alton Walden (with copy of advisory panel report)

Brooklyn-- Assembly - Jules Polonetsky

Senate - Carl Kruger

Requested and Sent

Martin Connor (MKM -- 11/8)

State Comptroller

Carl McCall (MKM -- 10/26)

Borough Presidents

Claire Shulman (MKM -- 10/26)

Howard Golden (MKM -- 10/26)

City Comptroller

Alan Hevesi (MKM -- 10/26)

Patrice Mitchell (3 copies/PS --10/27)

Richard Halverston (3 copies/PS --10/27)

HHC Board Members

JPM (10/26 -- 7 a.m.)

Unions

Stanley Hill (MKM -- 10/26)

Hospital Associations

Ken Raske (MKM -- 10/26)

Jim Tallon (MKM -- 10/26)

Community Advisory Boards

Queens: Rory Lancman (LM -- 10/27)

Elmhurst: Al Ramos (LM -- 10/27)

CIH: Martin Bromberger (LM -- 10/27)

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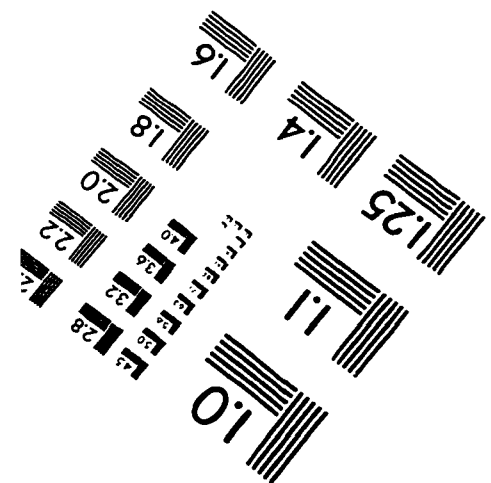
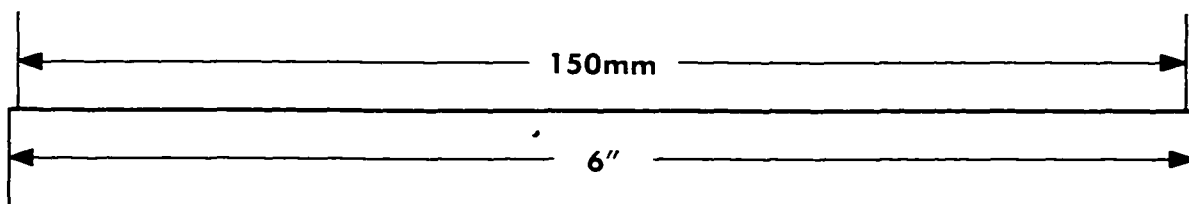
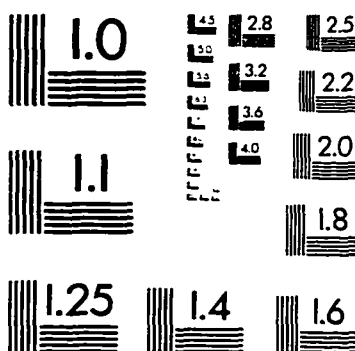
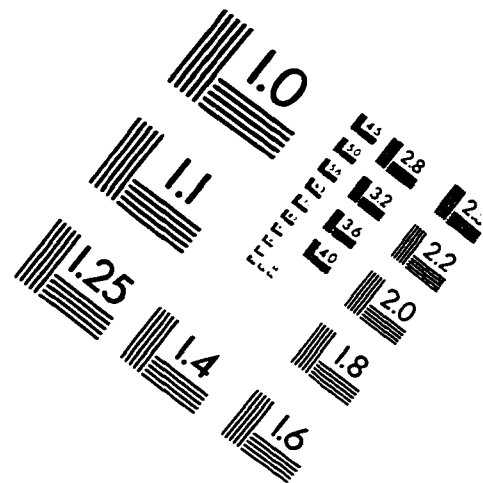
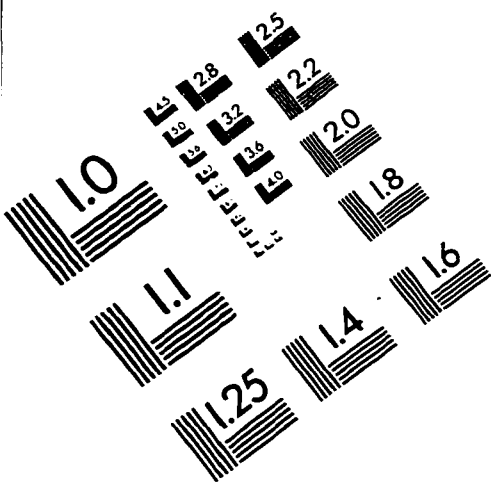
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APPLIED IMAGE, Inc
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989

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