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CONSUMER PARTICIPATION IN A HEALTH CARE ORGANIZATION:
THE CASE OF THE HEALTH INSURANCE PLAN
OF GREATER NEW YORK

BY

MARCIA STEINBERG

A dissertation submitted to the Graduate Faculty in Sociology
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Abstract

CONSUMER PARTICIPATION IN A HEALTH CARE ORGANIZATION:
THE CASE OF THE HEALTH INSURANCE PLAN
OF GREATER NEW YORK

by

Marcia Steinberg

Advisor: Professor Samuel W. Bloom

More and more people have become consumers in human service organizations in modern societies, but consumers have generally been excluded from membership in the decision-making systems of these organizations. Changing social conditions that include shared collective group membership, increased emphasis upon equal rights, and perceptions of service inadequacies spurred consumers in the 1960's to alter their relatively dependent status by seeking consumer participation in a wide range of service institutions.

This dissertation describes the efforts to form such a movement in health, as compared with that in other service fields. Through study by participant observation, the research shows how consumer participation affected organizational behavior in the Health Insurance Plan of Greater New York, a prepaid group practice serving 750,000 persons. Using achievements of the sociological study of social movements, bureaucratization in medical institutions, and complex

organizations, two descriptive questions are explored: how did efforts toward participation begin in the Health Plan, and what was the outcome of participation?

In answering the first question it is shown that the supportive external environment created by the movement for participation, and the organizing efforts of H.I.P. consumers themselves were not sufficient to provide consumer participation in H.I.P. Only when the Health Plan was faced with severe internal tensions did it act, through structural alteration and leadership changes, and a degree of consumer participation was achieved.

Intensive research focused on the consumer council at one H.I.P. medical group, and revealed clearly that consumers limited their activities to social organization and administration and were not interested in taking over technical medical responsibilities from professionals. The modest goals consumers in H.I.P. sought to achieve were attained in only a limited fashion, which is attributed primarily to an already weakened consumer movement in health, the cooptation process by which participation was initiated, and the constraints inherent in the H.I.P. organizational structure.

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CHAPTER I

THE PROBLEM FOR STUDY

"Consumerism" is a venerable concept in social science, but the client as consumer is relatively new. Consumer behavior, hitherto the province mainly of economic theory, has only recently become an important subject of study to sociologists, especially to those who specialize in questions of the distribution of power, the structure of complex social organization, and urbanization. Thorstein Veblen, to be sure, presented a sophisticated sociological analysis of consumption behavior, but his point of departure was capitalism, and his consumers, though influenced by factors like status-striving, were still essentially units of economic analysis (Krugman, 1968). However, as the service functions of modern society have grown, such as education, social welfare, and health, a new meaning for consumer behavior has emerged.

One of the consequences of the industrialization process has been to shift the central locus of services from the home and the immediate community to other institutions, such as schools and hospitals, creating new occupations and new institutional structures for the delivery of services. In noting this shift from a society mainly characterized by *Gemeinschaft* relationships to one mainly characterized by *Gessellschaft* relationships it is not our purpose to deplore these changes, as so many commentators do, but to identify the significance of this phenomenon for consumer behavior. Where goods and

services are provided by family members for each other, few people are consumers for there is little to buy and few services.

The consumer is usually conceptualized as one who purchases tangible objects through a financial transaction with a producer or seller (Beem, 1973). The growth of services, which are intangible, in advanced industrial nations has altered the meaning of the term consumer. As the United States develops into a "service economy," in which more than half of the workers are employed in the production of services rather than in the production of tangible objects, more and more people become consumers of these services, which include such diverse activities as health care, beauty care, household maintenance, and banking (Fuchs, 1968). The meaning of the term consumer has broadened to encompass those who utilize a service, and that is the meaning adopted here.

The subject of this dissertation is that type of consumer who is a client in a human service organization. These organizations process individuals, rather than inanimate objects, in order to change them in some predetermined manner, operating under a social mandate to maintain and improve the general well-being and functioning of the people (Hasenfeld and English, 1974: 1). Examples of such organizations are hospitals, schools, day care centers and drug rehabilitation homes.

More precisely, our focus in this research will be on the consumers of health services, and their role in the making of policy in the organizations which serve them. In the wake of intensified public attention to civil rights, poverty, and discrimination against minority

groups, clients as consumers in schools, universities, welfare systems, and health services institutions lobbied for the rights of participation in those bodies of the service organizations which make decisions about policy. We will study the process of achieving such rights in an organization that delivers health services.

The general question is descriptive: how do efforts toward increased consumer participation begin? How are the efforts of the consumers mobilized and conducted? Who emerge as the most active members of this process? What are the factors which facilitate and obstruct such a development? These are the questions which are needed to provide the data base for the interpretive issues of social theory, and these questions have not been answered in great measure up to this point in the existing literature.

The theoretical perspectives which guide this inquiry are derived from research on social movements (Smelser, 1963), bureaucratization in medical institutions (Freidson, 1973; Mechanic, 1967), and complex organizations (Etzioni, 1974; Georgopoulos, 1972). They have been selected not only for their relevance to basic questions about the "consumer movement" in health services, but also for their applicability in the study of the structure of the institutions which are responsible for the delivery of services to consumers. These choices are dictated, we believe, by the fact that to achieve objectives of participation in policy-making, movements necessarily emerge from organizational contexts. Consumer movements were able to grow outside of shared collective group membership but only for purposes of protection

against those who produced or sold the goods or services involved.

In this way such organizations as consumer cooperatives, the National Consumers' League and the Consumer Advisory Board were formed (Beem, 1973). Their goals have been to improve the buying position of purchasers relative to that of sellers, but they have not sought to become an integral part of the entrepreneurial organizations offering goods for sale. In order to participate at the source of production (in this case, of health services), there must be a common organizational framework within which both consumer and provider act. This is the goal sought today by those who are consumers in human service organizations, for they seek direct involvement in policy determination through membership in decision-making units of provider organizations.

In this research, consumer participation is studied within the context of a prepaid group practice, a form of health care organization that has gained national attention as an alternative to the present dominant patterns of care (MacLeod and Prussin, 1973) and as a potential model for a national health care system. Prepaid group practice is a form of organizing, financing, and delivering services to a defined population. It has a demonstrated record as an effective means of achieving comprehensive, quality care at a cost that appears to be lower than other systems (MacColl, 1968; Roemer, 1967). Basic features of this form of organization have recently been incorporated into Health Maintenance Organizations (HMO's), and in 1973 Congress approved legislation to fund HMO's on a demonstration basis (PL 93-222). In 1975 one hundred and fifty-six organizations received federal funds to finance HMO's (Group Health and Welfare News, August 1975). Included

in the legislation is the requirement that one-third of the members of a federally funded HMO governing board must be from its consumers. These are clear signs that national health policy may well include both prepaid group practice and consumer participation, and that the legislative decisions will come soon. It is urgent, therefore, that we understand as much as possible about their implications.

RESEARCH METHODS

The research is designed as a case study of the development of consumer participation from its inception to formal implementation in one of the oldest and largest of the prepaid group practices, the Health Insurance Plan of Greater New York, (H.I.P.). H.I.P. has been in existence for almost 30 years and presently serves about 750,000 persons in the New York metropolitan area through a network of 28 medical groups. It recently changed its rules to provide for a newly active consumer role. We obtained agreement from the Plan and its consumers to study this phenomenon, particularly within one of the medical groups.

From within the organization one consumer council was selected for intensive study, the Yorkville/Circle Manhattan Consumer Council, serving both the Yorkville Medical Group and the Circle Manhattan Medical Group. (This research was specifically concerned with the Yorkville Medical Group. The consumer council formed for that Group merged with the Circle Manhattan Medical Group so both medical groups

1. The Health Insurance Plan of Greater New York will be identified as "the Plan" or "the Health Plan" or "H.I.P." Material quoted from the Plan's written documents may refer to "HIP".

have been identified in our research design). Of the twenty-eight medical groups in H.I.P. the Yorkville Medical Group was among the first in which a consumer council was formed. Thus, the setting chosen for this research allowed study of emerging patterns of consumer participation in their developmental stage.

The choice of H.I.P. and of the Yorkville Consumer Council also resulted from the relationship between the Yorkville Medical Group and the Mt. Sinai School of Medicine of the City University of New York. For several years the Yorkville Medical Group had been participating with the Department of Community Medicine of the Mt. Sinai School of Medicine in an educational program for medical students. The advisor for this dissertation had participated in the program as a faculty member of Mt. Sinai. When a consumer council was forming in Yorkville in 1971 the medical director and the administrator of the Group indicated their interest in a study of this new organizational unit. At about this time I was meeting with my advisor to select a dissertation topic related to consumer participation in health. A study of the Yorkville council seemed to fit the needs of all parties. Consumer council leaders agreed to participate in such a study. Contact was established with the Department of Consumer Affairs of H.I.P. and the research was formally begun in late spring, 1972.

The basic method for obtaining data has been participant observation of consumer council meetings. This technique has been utilized in other studies of consumer participation in health (Bellin, et.al., 1972; Partridge, 1973) and is well suited to the case study approach. Observation is particularly appropriate when studying interaction in

settings of social change (Denzin, 1970), and consumer participation in H.I.P. was introduced early in a period of significant change for that organization, as will be documented below.

In addition to the intensive observations of the consumer council of the Yorkville Medical Group, data collection included interviews with a wide variety of individuals who were involved in the process under study at the Yorkville Medical Group: the medical director and administrator; at the central H.I.P. headquarters: the head of the Department of Consumer Affairs, and members of the Board of Directors; and the leaders of the Yorkville/Circle Manhattan Consumer Council. Additional data were drawn from statistical records, prior studies of H.I.P., and public reports.

After being in the field two months, it became clear that the history and actions of the Yorkville council could not be separated from the nature of the parent organization. In interviews, respondents consistently referred to the development and operations of councils in H.I.P. as a whole, to actions and views of persons in varying organizational positions in the Health Plan, and to consumer goals for broad organizational change beyond that at the medical group level. The activities of the council involved interaction with persons and organizational units throughout the H.I.P. system. The organizational structure of the Health Plan, in particular the existing allocation of decision-making authority, appeared to affect intrinsically the types of decision-making activities by the consumers. As a result the existing system, and especially the articulation between the Yorkville/Circle Manhattan Consumer Council and other decision-making bodies in the Health Plan

were examined, and the scope of the research activities as originally anticipated was broadened.

Observations of meetings took place for about one year, from May, 1972 through June, 1973. Nineteen meetings were attended, including both the Yorkville/Circle Manhattan Consumer Council and the Joint Consumer Council sessions. A total of 42 persons were interviewed, occupying at least 50 organizational positions. In addition to interviews, the many conversation encounters, brief interviews over the telephone, and other forms of communication between the author and various persons in H.I.P. provided a continuous flow of information regarding the history and nature of consumer councils in H.I.P. and the articulation between the councils and other organizational units.

THE BACKGROUND OF RELATED KNOWLEDGE

Consumer participation in H.I.P. did not arise spontaneously, as an isolated incident on the American scene. It emerged as part of a broad social movement toward the activation of consumer involvement. Developments in other service fields, such as higher education, were transplanted to the field of health. Middle and lower class populations were increasingly displeased with the manner in which health care was being provided, and became less and less willing to tolerate what they defined as unacceptable conditions for care. The increasing bureaucratization of health institutions brought new forms of therapy to some persons, but to others it brought depersonalized care more oriented to efficiency than to concern for individual patients. Another important consequence of such bureaucratization was the creation of the client membership group essential as a condition for being mobilized

into a social movement. Yet, in H.I.P. as in the movement in health generally, there never was achieved the force, momentum, or broad scope of similar movements in other service fields. The attempt to document and explain this significant difference between consumerism in health and similar movements elsewhere in the society is a key objective of this report.

The dissertation will begin, therefore, with a thorough review of the background of related knowledge in the field, in particular the literature on social movements (Chapter 2).

External forces, alone, however, could not bring consumer participation to H.I.P. It was the confluence of internal and external factors that brought the H.I.P. consumer councils into being. Underpinning this thesis is a conception of organizations as evolving institutions engaging in interchange and negotiations with the environment in the procurement of resources, the establishment of organizational task, and the absorption of product or service output. Organizations are perceived as a set of inter-related units existing in a state of relative equilibrium and forming a whole that is, in turn, interdependent with the larger environment. Component structures emerge from the resolution of internal tensions and adaptation to external change.¹

1. This view of organizations is characterized as the "natural system model" by Gouldner (1959) and has been expounded by Selznick (1949) and Georgopoulos (1972). It can be contrasted to the "closed system

Accordingly, Chapters 3, 4, and 5 of this report identify key elements of the internal structure of H.I.P.: the fragmented authority structure, relative autonomy of the medical groups, governance by coalition, reliance upon part-time physicians, lack of adequate mechanisms for quality control and for direct consumer input into decision-making. Also highlighted are key external relationships: primary reliance upon a single source of clientele and funding, and in increasing isolation of the Plan from the academic community during the life-span of the Plan. These chapters describe the variables that we believe explain how, and why, H.I.P. moved to incorporate consumers into the decision-making system, and what happened in the organization as a result of that innovation.

Chapters 5 through 9, based mainly on participant observation data, describe the crucial consumer meetings: what they discussed, and the interaction process. The analysis evaluates the achievements in terms of their own consumer goals, the relative emphasis upon such issues as organizational procedures as compared with the technical aspects of patient care. The accomplishments of the council are identified and studied against the background of the changing external social movement and the constraints inherent to H.I.P. itself.

model" associated with Weber and summarized by Gouldner. In the closed system organizations are conceptualized as rationally conceived means to achieve expressly stated goals. A determinate system is assumed as well as resource procurement and the absorption of product output by the larger society. The emphasis is upon the presumed efficiency of the bureaucratic form as a consequence of its basic characteristics: hierarchical structure, division of labor, formal rules, impersonal orientation, employment career.

SOME DEFINITIONS

The models for the case study approach used here include works in community analysis (Gans, 1962; Hollingshead, 1949), mental health (Goffman, 1961), and complex organizations (Dalton, 1959; Perror, 1962; Selznick, 1949). The method is particularly applicable where the research framework is essentially "evolutionary," that is, where the intent is to show how and why certain parts of an organization emerge out of prior conditions and how new elements become integrated into the existing order (Sjoberg and Nett, 1969). It is precisely these types of issues with which this research is concerned.

The limitations of the case study method noted by several authors (Becker, 1970; Sjoberg and Nett, 1968) refer particularly to the difficulties in generalizing from the data to units beyond the single organization being studied. However, techniques for enhancing generalizability have been identified. These include comparisons with other related case studies (Becker, 1970), comparing elements of structure in the organization under review to elements in other organizations, and comparing processes of interaction to those identified in other locales. Such comparisons allow the researcher to identify the respects in which data are either unique or relatively common and thus to place the study within an identifiable perspective. These techniques are utilized in this report as comparisons are drawn between consumer participation in H.I.P. and in other health care organizations.

The term consumer is defined here to include any individual entitled to receive the services of the Health Plan; the term is used

specifically and is a separate category from designations such as community, non-physician, layman, and health professional.

Elsewhere one finds that the phrases "community participation" and "consumer participation" are often used interchangeably, as occurred, for example, at a 1970 meeting of the New York Academy of Medicine convened to discuss community participation in health. Actually, the terms refer to different bases for participation. Where there is "community participation" it is assumed that services are to be provided to a geographical, political, or racial entity that can be termed a community. In that case, participation in decision-making is not restricted to those entitled to receive services, but includes representatives of the community to be served. For example, residents of a geographical area elect a school board, whose members may or may not have children in the school system. As school board members, they represent the community as a whole. Where "consumer participation" prevails, those persons entitled to receive services are the participants, regardless of where they reside.

"Non-physician" refers to any person who is not a physician, among whom are laymen and health professionals. "Laymen" are defined as persons without training in the health field.¹ Labor union leaders,

1. In general, the term "layman" is used in the literature in the sense of the non-physician public. For example, Freidson states: ". . . it is essential that in order to protect the public interest the lay public dominate the formation of policy decisions guiding the planning of services." He writes that lay representatives in organizations "should represent the perspective of the public" (1970: 374). We seek to be

school teachers, brick-layers, mathematicians could all be considered laymen, in relation to physicians. Laymen may or may not be consumers in any particular organization. A layman who participates in decision-making in a prepaid group practice may be doing so as a consumer, as a representative of the larger community, or as a personal philanthropic act. "Health professionals" are those persons with specialized training in the health field, and include such persons as professors of administrative medicine, medical sociologists, hospital administrators, and nutritionists. The health professional may be a consumer in any particular organization, but he is not a layman.

Laymen and health professionals have been active in the governance of prepaid group practice plans for fifty years in this country, but how adequately have they represented consumers during this time? Who should represent consumers in health care organizations? Why has the issue emerged at the present time in the nation? These are among the questions to be explored in the following pages.

more exact, distinguishing between types of laymen and types of health professionals, nor do we presume that any layman is necessarily a spokesman for the public-at-large.

CHAPTER II

BACKGROUND OF THE PROBLEM: CONSUMER PARTICIPATION AS A SOCIAL MOVEMENT

The great bulk of research on consumer behavior, until recently, has been concerned with the consumption of products and not services. As a result, theories of consumption have been primarily economic, and secondly economic-psychological (Katona, 1951). Especially with the movement of large segments of the population into relative affluence, new opportunities for differentiated consumer behavior introduced a search for life-style rather than for security (Krugman, 1968). It was this kind of economic freedom and its effects upon ideologies based on conflicts between economic classes that first attracted sociological attention. It was presumed by some that antagonisms heretofore existing between social classes would diminish as economic rewards were more equitably distributed in complex industrial societies (Bell, 1959).

The relative affluence experienced by many in the post World War II era lulled the nation as a whole into the belief that all segments of the society were benefitting from economic progress. It was generally assumed that economic growth would continue, automatically bringing about a reduction in inequality and a resolution of social problems through the diffusion of wealth (Marris and Rein, 1969). Difficulties experienced by any particular groups in society would be met through the social welfare programs already enacted by the government and through

the social service network of the private sector (Sherrard, 1968). Counter voices that presented a critical view of American life, such as those of C. Wright Mills (1956) and Lewis Coser (1956) failed to stir the national complacency.

Then the civil rights movement broke into public consciousness, stirring activity in many fields. The myth of near universal affluence was shattered. The presumption that human needs were adequately considered and fulfilled in the established service network was challenged.

In health the breakthrough occurred relatively late, retarded by the tradition that health professionals are technical experts, bound by cultural factors to act on behalf of their clients. The gap of knowledge (or asymmetry) between physicians and patients was used to justify privileges of dominance and autonomy for the professionals, and, in return, clients expected their doctors to be obligated to give service in the interest of the community (Parsons, 1951). Clients of services generally, and health in particular, were the recipients of aid; they did not take part in the decision-making system of organizations providing aid. In America in the 1960's more and more clients objected to such a dependent and relatively powerless status. In a number of institutions consumers demanded to be able to represent their own interests. A social movement emerged, directed toward bringing consumers into the decision-making bodies of the organizations serving them.

How did such a social movement arise? Why were existing patterns of authority in organizations challenged? To answer these questions we follow a perspective that seeks to "establish the conditions under which

events become significant determinants" of a social movement (Smelser, 1963: 277). Smelser identifies seven factors: social conduciveness, social strain, generalized beliefs, precipitating factors, mobilization of participants, and response of agents of social control. These may or may not appear in a time sequence. It is the continuation of all factors that must be present, regardless of the order in which they appear in society.

The particular aspects of each factor that contribute to the development of a social movement vary with the type of movement. The drive for consumer participation may be considered to be a norm-oriented movement seeking change in accepted patterns of service bureaucracy governance with the support of, and within the context of, the broader value system of the nation.¹ The American emphasis upon equality and democracy fostered heightened expectations about the provision of health care. These expectations produced social strain because they could not be adequately met by the prevailing institutional structure. Consumer participation arose out of disharmony between expectations and reality, between the care that Americans grew to believe the health organizations and workers should provide and the care that actually was provided.

1. Smelser distinguishes norm-oriented movements from the following types of collective episodes: the panic, the craze, the hostile outburst, and the value-oriented movement. A norm-oriented movement is defined as "an attempt to restore, protect, modify, or create norms in the name of a generalized belief" (1963: 270).

A fundamental condition of a social movement, Smelser maintains, is social conduciveness, which permits a given type of collective behavior without pre-determining the form it might assume, nor whether it will occur. Social conduciveness exists when: (1) there are structures through which people can express their interests, such as political parties, ethnic groups, and social class groups; (2) there are structures capable of responding to these interests, such as legislatures; (3) there are mechanisms available for affecting the normative order, such as elections; and (4) people are able to communicate with each other directly or indirectly by means of newspapers, television or organized groups.

It seems clear that the health sector of the United States in the mid-1960's presented all these elements and therefore capable of producing a normative social movement. It was in the next category of elements, social strain, that the nature of American society can be seen as a seed-bed from which the thrust for consumer participation could grow.

SOCIAL STRAIN

Smelser defines social strain as "impairment of relationships among and consequently inadequate functioning of the components of action" (1963: 47). These "components of action" are identified as values, norms, mobilization and situational factors. Essentially, strain is perceived as disharmony between normative expectations and social conditions. This may be either the result of deprivation, in which rewards such as health care, which were previously enjoyed are no longer available, or it may be the result of newly aroused expectations which are not met, such as the desire for better education or

housing. The existence of social strain was a key factor in the emergence of consumer participation as a social movement.

By the mid-1960's Americans' expectations concerning health care were raised as a result of higher levels of education in the population, greater affluence, and a record of major federal actions, beginning with passage of the Hill-Burton Act, that promised improved health care for the nation (Geiger and Cohen, 1971; Somers, 1971). The quickened growth of scientific medicine in the years following World War II brought into being whole new areas of knowledge which were publicized as having the potential to improve health conditions (Bloom, 1971; Richardson and Scutchfield, 1973). Expectations were reinforced by greater financial access to health services as a result of health insurance coverage. By 1972 insurance paid 82 per cent of consumer expenditures for hospital care; in 1950 insurance paid only 37 per cent of these expenditures (Saward, 1973). Of total non-government health expenditures, insurance accounted for 19 per cent in 1969, but only 9 per cent in 1950 (Anderson, 1972).

The above picture of rising expectations applied mainly to the middle and upper class populations. The poor and minorities expected little of the health care field for they had little positive experience with it. Deuschle (1969) identified the difficulties urban ghetto populations experienced utilizing voluntary hospitals: lack of continuity of care, long waits for appointments, and over-worked staffs. Strauss (1967) noted that poverty families average fewer visits per year to a physician than do others, that 60 per cent of the poor have two or more disabling conditions as compared to less than 25 per cent

of other population groups, and that members of minority groups experience explicit racial bias in their encounters with medical institutions. Speaking at the National Health Forum, Julian Bond (1970) noted that many counties in the rural South do not have any physicians, so that medical help for the poor cannot be obtained. Statistics from the National Health Survey conducted by HEW, as reported by the Citizen's Board of Inquiry (1972), show that non-white infants die at a rate double that of white infants, and that non-white mothers die in childbirth at a rate four times that of white mothers. While these events are the result of a number of factors other than available health care it is nonetheless the case that "the poor are sicker than the non-poor and utilize fewer services" (Richardson, 1969). Whatever the origins of their medical and health problems, these problems are less likely to receive attention than are the problems of the more affluent.

With the rise of the civil rights movement in the sixties these health conditions became the focus of anger and resentment. Blacks were no longer willing to tolerate second-class status in the health system (Hollister, Kramer, and Bellin, 1974), and both black and white Americans began to perceive health care as a right (Knowles, 1973). All segments of the population had heightened expectations: the middle and upper classes expected more and higher quality of services, while the poor expressed dissatisfaction with conditions they had previously accepted.

Yet, expectations about health were rooted even more deeply than any of these factors. There is an implied contract between society and the professional community premised upon the greater knowledge of

the professional - in return for autonomy practitioners will operate from concern for individual patients and for the general welfare rather than for personal gain. This is the exact opposite of the premise upon which goods are offered to the customer for purchase in the commercial marketplace, where the relationship between provider and consumer is summarized by that ancient phrase, "Let the buyer beware." In the service arena it is the professional's obligation to be aware on behalf of the consumer (Parsons, 1960; Blau and Scott, 1962). It is the consumer's perception that this has not occurred that is at the root of the consumer movement in health. After all, from the viewpoint of the consumer, if care were offered for his benefit it would be accessible, priced so he could afford it, and capable of producing the promised improvements that technology is supposed to bring. Expectations were raised by the very nature of health care as a service provided by a profession given a social mandate to function for the collective good. The sense that the collective good had not been met contributed to the consumer movement in health. More than this, there was a growing conviction that physicians should not act on behalf of consumers, even if they were able to do so in an equitable manner. This belief was crucial to the consumer movement in health, as detailed in a later section of this chapter. The proposed remedy for the profession's failure to act was not reform of the profession, as Freidson has suggested (1970), but reform of the institutions that provide care. The consumer movement grows out of, and in turn recognizes the importance of, the bureaucratic structures through which health care is provided.

Bureaucratization is a major feature of the present health care network, consisting of two distinct, but related processes: the provision of increasing amounts of care in organizational settings, and the progressive differentiation of the internal structures of these organizations. As an example of the first phenomenon, we note the movement toward cooperative practice among physicians (Freidson, 1973), the continuing growth of medical centers (Bloom, 1971), and the generally acknowledged centrality of the hospital in the health care network. For example, recent figures show that, of the total expenditures in the health field, the hospital sector accounts for slightly more than one-third, while only one-fifth is for physician services (U.S. Social Security Administration, 1974).

The bureaucratization of medical care is likely to continue, for it grows out of basic aspects of contemporary American society. Mechanic identifies two basic factors: the efficiency of bureaucracy as a form for providing care that utilizes the new technological advances; and pressures from large purchasers of care, such as government and labor unions, for the greater quality control and efficiency believed to derive from the organizational provision of care. As Mechanic states:

As the needs for greater efficiency and productivity in the provision of medical care grow, and as increasing developments in medical technology demand greater organization and coordination, the arguments toward bureaucratization of medicine are compelling. Many technical-scientific aspects of medicine can be efficiently organized within bureaucratic forms, thus making it possible to reach more people and to facilitate a more adequate pattern of distribution of medical

services. Moreover, bureaucratic contexts facilitate the imposition of quality controls (for example, routine auditing of medical care) and enhance the possibilities for continuing education in a situation of rapid social and technological change. The trend toward greater bureaucratization of medical practice is not only a certainty because of the forces within medical practice, but it is also being encouraged through growing involvement in medical affairs of other organizational forces: government agencies, labor unions, and other major purchasers of medical care are increasingly conscious of the value received for their investments and concerned that their constituencies enjoy a standard of medical care at least equal to that of the individual consumer who purchases his own services (1967: 711).

All social classes are affected by the continuing bureaucratization of medical care. The neighborhood solo-practice physician is now likely to be situated near a regional center and practicing in a group; the physician formerly located in an urban ghetto is likely to have left the area, with patient care being provided by municipal institutions, hospital emergency rooms, and out-patient clinics of voluntary hospitals; patients needing diagnostic services may be referred to such institutions as the Mayo Clinic; the concentration of specialists in medical centers requires that patients travel to these institutions in order to receive care.

However, bureaucratic systems for care contain inherent delivery problems. They tend to provide services in an impersonal manner. Further, requirements for bureaucratic behavior among employees tend to militate against concern for the individual client (Merton, 1949). In order to satisfy the convenience of the organization, clients may be "managed" as they are being "served."

Bureaucratic organizations tend to develop a rhythm of existence that leads to an emphasis upon survival and maintenance, even if goals of that organization are compromised or altered as a result (Etzioni, 1974). In assessing survival needs, organizations look towards their standing in the larger community and consider the availability of funds, clients, and personnel (Levine, White, and Paul, 1963). While the tendency toward survival may be to the advantage of clients, as in the case of the National Polio Foundation (Sills, 1957), it often operates as a limitation upon services available and upon the manner in which they are provided.

Thus, bureaucracies tend to take into account and give primacy to factors other than the clients' perceived needs, the clients' cultural preferences and the clients' welfare. In such settings it becomes difficult to meet the expectations about care raised by affluence, education, technology, and the emphasis upon social equality.

Given the fact that expectations do not match realities, how does a social movement that seeks to reduce this disjuncture come into being? A facilitating factor is the existence of a group that perceives the discrepancy and is capable of acting upon that perception. By its nature, bureaucracy creates such group in its clientele. The provision of increasing amounts of care in organized settings results in greater numbers of persons, and new categories of persons, becoming clients of bureaucracies. Further, the centralization of resources accompanying bureaucratization depends upon, and even creates, a centralized clientele. Health plans enroll groups of persons employed at the same location, child health stations serve families in narrowly

defined geographical areas, and particular municipal hospitals tend to be utilized by residents of particular neighborhoods. Contact, communication, and organization of clients becomes increasingly feasible under these conditions of proximity and pre-existing client contact.

The increasing number of clients experience similar conditions in their status as clients since service bureaucracies tend to function in a uniform manner. Reeder (1972) comments: "The bureaucratic features of the profession of medicine plus the increasing bureaucratization of delivery of personal health services combine to create institutionalized, more or less standardized, environments." Claims that might be raised by one client group are able to be appreciated by others who have encountered similar situations. The base for a social movement of consumers is laid by the creation of so many consumers able to be in contact with each other to share grievances and develop solutions.

Nonetheless, it must be remembered that bureaucratization has not eliminated solo, fee-for-service practice in the medical field. Even though the bureaucratization of health has moved forward with great rapidity in recent years, the degree of bureaucratization in health is less than that of other service fields, such as education and welfare. Thus, the potential pool of consumers from which to draw members for the movement is more limited in health.

In other institutional areas practitioners function almost exclusively in organizational settings and receive a salary for their labor. They are not directly dependent upon client patronage for an income. A teacher works in a school, a social worker provides case-therapy in a

welfare agency. However, this is not the case in medicine. The majority of Americans still do not receive routine, ambulatory care in bureaucratized settings. Group practices, hospital clinics, and government programs have not displaced solo, fee-for-service practice. For example, even though outpatient visits to hospitals increased by 177 per cent from 1954 to 1970, the number of such visits still constituted only 20 per cent of the total number of physician visits in 1970 (Piore, Lewis, and Seelinger, 1971: 52). The number of active physicians practicing in group settings continues to rise, but still accounts for only 18 per cent of the total number of physicians (The American Medical Association, 1970: 4, 75-78) and, ofcourse, only a portion of these function in prepaid practices.

The solo practice, fee-for-service setting offers the patient a form of power not generally possible in organizational settings. In solo practice the patient deals directly with the practitioner. The two parties themselves set the terms of their relationship in a process of encounter bargaining set within the broader framework of the role expectations in the society. It is, in part, a recognition of that phenomenon that is at the heart of the distinction by Freidson between a lay-controlled and a colleague-controlled practice (1961). If the patient in solo, fee-for-service practice is dissatisfied with the care he receives, he may turn to another physician. In this way he can seek improvement in the services rendered. It is not necessary to join with others in a social movement to accomplish this change. By changing physicians, the patient may be able to alter the character of the health services he receives.

In terms of the discussion of this report, this means that the discrepancy between expectations and reality that constitutes structural strain, as experienced by solo practice clients, may be altered by individuals without use of collective action. In terms of the Smelser formulation, the structure of the health care field permits behavior in other than a norm-oriented social movement. There is an outlet for change other than through collective action. Bureaucratization presents the opportunity for a social movement, but the existence of solo practice appears to limit the movement's potential, as compared with other service fields. Structural conduciveness to a social movement thus appears to be weaker in health than in other service fields.

It should also be pointed out that individual action provides a false sense of consumer power because it does not alter mechanisms for service distribution and accessibility nor the organizational contexts within which solo practice functions, such as hospitals. The availability of types of physicians, the provision of a range of services, and the location of services remain within the domain of the profession without any systematic input from consumers. The patient may shift from one physician to another in search of one that suits him best, but if the area in which he lives does not have any physicians of that type, he cannot meet his health needs. In a study of Appalachia (Richardson and Scutchfield, 1973) it was noted that community members expressed the need for additional pediatricians and obstetricians in the area, but the medical profession did not recognize this as a local need. No matter how many times residents changed physicians they could not solve this basic distribution problem without some communal action.

In an organizational setting, such as a prepaid group practice, consumers have a mechanism for voicing their needs and a means of meeting them.

THE DEVELOPMENT OF GENERALIZED BELIEFS

The specific history of consumer participation in health overlapped with other service fields, such as education and welfare, in which a process of rising expectations amid bureaucratization also occurred. Services provided did not match the level of aroused expectations. For example, the promise that public education was the means of upward mobility seemed hollow to ghetto parents. The ability of the educational system to meet the needs of a "diverse student population" was in doubt (Fantini, 1969). In the colleges, able high school students who expected to be taught by learned men in their fields received instruction from teaching assistants while professors pursued research and taught graduate students (Smelser, 1971). Urban renewal programs that began with the promise of rebuilding neighborhoods and improving housing were soon perceived by residents as destroying whatever community life existed and forcing the relocation of minority populations:

Many of the earliest redevelopment projects were completed with little or no organized opposition. Somehow, however, people have learned from the experience of others, and today, in cities which have been engaged in renewal for several years, the planners often find prospective renewal areas ready and waiting for them, organized to the teeth (Wilson, 1967: 289).

Some client groups as well as some providers became increasingly aware of the discrepancy between expectations and reality. Providers

in the field of social work became concerned in the 1960's when their efforts with poverty populations did not yield the expected results in reduced levels of juvenile delinquency, higher rates of employment for the poor, or improved community functioning. New strategies of social reform were developed, based on emerging perspectives regarding the causation of social problems (Marris and Rein, 1969). The view that problems were manifestations of individual pathologies requiring forms of psychotherapy was being replaced by the view that problems were causally related to the larger social environment and could be remedied by environmental change. By altering community and organizational systems, it was believed, the conditions breeding such problems as juvenile delinquency and poverty could be eliminated and opportunities created for "self-realization" and social mobility. The organization, rather than the client became the focus for reform. This idea opened the way for various proposals to alter organizational structure. Prevailing patterns of structure, governance, and membership were no longer sacrosanct, as new strategies were developed to eliminate poverty.

At the same time client populations, principally among blacks, were concerned with similar issues. Among these groups the goal of elimination of poverty became linked with the goal of political power. If blacks were to operate from a position of strength in a pluralistic society they must achieve group solidarity through control of the institutions serving them. Carmichael and Hamilton state that "black people must lead and run their own organizations" (1967: 46). The services provided by organizations would, then, further assist upward mobility.

The developing concepts of providers and clients merged and became progressively more defined with enactment of the Economic Opportunity Act of 1964, the "War on Poverty" legislation. Beliefs about participation helped to shape that legislation and its implementation and, in turn, its passage and execution reinforced these and similar beliefs.

Of specific relevance was the OEO community action program. This program, as formulated in Title II, Sec. 202 (a) of the Economic Opportunity Act of 1964, was defined as one which sought to mount a comprehensive attack on poverty through the formation of a public or private non-profit agency that mobilized community resources and provided services and assistance designed to eliminate poverty. It was to be developed with and conducted with "maximum feasible participation by residents of the area and members of the group served." The agency was to be the mechanism both for stimulating neighborhood organization to enable the development of such programs and it was the unit to provide these programs. That is, the law explicitly specified that clients were to be given a role in directing the organization that provided their services.

The OEO action program was geographically based, in the sense that each development agency, or CAP, was designed to serve a physically demarcated area. The goal of the program went beyond simple organizational changes. The goal was to create or stimulate change in the very nature of local communities.

The purpose of community change has been perceived differently by different persons, particularly among OEO workers. As Shostak

notes, the concept "evolved" (1968). In an early view that predates enactment of OEO, change was intended to create a neighborhood infrastructure as a basis for individual human development. Mogulof describes the concept with reference to the delinquency program as the involvement of an "affected community" so that "community residents become a potent factor in the lives of their youth" (1969). In a later form the concept of community participation merged with broad notions of political participation by categories of the disadvantaged, such as the poor and minority groups. In this view, participation might move beyond the immediate neighborhood, giving disadvantaged groups direct involvement in organizational and political decision-making previously denied to them (Arnstein, 1969). The concept of community participation also became part of the move toward black power, stressing control by blacks of the geographical sections of cities in which blacks predominated. These views are summarized by Altshuler:

When black spokesmen demand greater participation in the political and economic levels of their cities, their specific agenda of reform typically includes the following: (1) devolution of as much authority as possible to neighborhood communities; (2) direct representation of such communities on significant policy bodies; (3) black representation at all levels of the public service in far more than token numbers; and (4) the vigorous application of public resources to facilitate the development of black-controlled business (1970: 14).

As contained in OEO activities as well as other later programs, the concept of community participation included the concept of client participation. These two concepts were so intertwined as to be inseparable, but each has led, in later years, to different notions

of the basis for participation in service bureaucracies. Is participation to be premised upon residing in a geographical area served by an organization, or is it to be premised upon utilization of an organization's services regardless of where the client lives? In 1965 this question did not surface openly. This is probably because, given the nature of the program, residents were defined as clients. Nonetheless, social scientists perceived the program as serving persons both in their capacity as residents and as clients, thus articulating the view that utilization bestows rights of participation upon clients. The interweaving of these two concepts is evident, for example, in the description by Piven of the objectives of participation in the anti-poverty program of OEO:

- (1) Fostering the participation by low-income people in a variety of local associations;
- (2) Enhancing the effective influence of low-income people in the policies and practices of institutions which serve the low-income community:
- (3) Establishing the conditions for effective individual and family life by altering the social context of individual behavior (1967: 153).

The term "consumer" in this research, as indicated in the preceding chapter, refers to any person who uses, or is eligible to use, the services of a given organization, wherever he may reside.

The generalized beliefs described above were also expressed in other areas of American life. The slogan "student power" was born in Berkeley in 1966 as college students sought participatory democracy on the campus (Wallerstein and Starr, 1971). Its meaning is summarized by

Edward Schwartz, representing the National Students Association:

"Let this principle apply - he who must obey the rule should make it"

(1971: 483). Schwartz elaborates on the desired role for students in college decision-making:

Students should make the rules governing dormitory hours, boy-girl visitations, student unions, student fees, clubs, newspapers and the like . . .

Students and faculty should co-decide curricular policy.

Students, faculty and administration should co-decide admissions policy (they did it at Swarthmore), overall college policy affecting the community, even areas like university investments (1971: 483).

Achieving student power at the university level was perceived as the beginning of a broad program of reform in the society as a whole. It was not simply educational change that students sought. Achieving client control in the universities, in the form of student power, was a first step in an anticipated program of reform throughout the society. Perhaps the most publicized and influential of the student groups that formed in the 1960's was the SDS, founded to "develop a new radical movement to significantly affect American politics" (Skolnick, 1969: 89). Students were involved in civil rights demonstrations, sparked the anti-Vietnam War protests, demonstrated against the spread of nuclear bombs, and were disturbed at the failure of the nation to eliminate poverty. The Free Speech Movement born in Berkeley in 1964 "showed how the campus itself might become a front line" (Skolnick, 1969: 91) in action for social change beyond the boundaries of the universities.

Just as university control was part of a broader set of issues for college students, lay participation in school systems was part of a broader set of issues among neighborhood and community groups. These groups were stirred by a desire to achieve participation in urban political systems perceived as overcome by bureaucratization and professionalism. It was anticipated that participation would affect the distribution of political power in urban centers as well as the locus of decision-making in the schools. Participation would allow local neighborhoods to establish their own policies on racial matters. Participation was a means of achieving goals pertinent to institutional areas other than the schools. The goals of lay community groups were summarized by Gittell:

This group rejects pure administrative reform and demands a redistribution of power in the school system through decentralization and increased community control. Decentralization is defined as a delegation of decision-making power to local districts within the city . . .

Community groups connect their powerlessness to the growth of a centralized, professional bureaucracy that controls the policy process to their exclusion . . . those who seek reform of the total structure are concerned primarily with the need to redistribute power within the system, to include the very people who are most directly affected by school policy (1969: 328).

However, unlike other service fields, participation in health did not become linked with broader social issues, such as class power, racial integration, and the containment of bureaucracy. Movement beliefs in the health field were directed toward that field only.

In the following paragraphs belief content is analyzed and the consequences of a focus limited to health are explored.

The emerging pattern of beliefs regarding consumer participation in health are best summarized in the report of the Citizen's Board of Inquiry into Health Services For America, convened by the American Public Health Association in 1970. The Board consisted of physicians, consumers, academicians, and politicians who had researched and reviewed the condition of American health services and suggested reform. They concluded that the health care system was deficient in that:

(1) the nation has failed to provide adequate health services to the majority of its citizens, (2) the system lacks rational integration, (3) consumers have no real or effective role in the planning, organization, or delivery of health care, and (4) consumers have few meaningful options in health care today.

The Board presumed that if the proper reform approach were adopted adequate care could be provided since the nation had the technology and the knowledge to do so. What was needed, they maintained, was the right method of organizing care. The approach advocated by the Board emphasizes consumer control of the policy and administration of health care organization. To be effective, organizations must give consumers "the dominant role at all levels in the decision-making process of the health care system" (1972: 131). The Board detailed their proposals:

The power of the consumer to control and influence the delivery system must be exercised at every level of the health care system: facility, service system or program, and neighborhood, city, state, region, or nation. This power should include, but not be limited to,

making policy, controlling assets (including capital expenditures), facilities, equipment and services. This does not mean that consumers will usurp the doctor's responsibility for meeting his patient's needs. On all levels of decision-making, clear lines between policy (the consumer's primary business) and professional judgment regarding the individual patient (the physician's primary business) should be established (1972: 131).

The inadequacies of the health care system were perceived as deriving, in part, from the lack of accountability by health care practitioners to the public and the consumer, which left these institutions free to pursue their organizational self-interest without interference. The Report states:

Health care providers often act from the narrow base of institutional or professional interests, unrestrained by consumer influence, by the rules of the marketplace or by government regulation.

The implication is that consumer participation will aid in developing health care organizations that are better able to meet the real needs of the people although the Report acknowledges that other factors also affect that ability, notably the operation of the marketplace and the relative freedom of health care organizations from government restraints.

These general approaches were detailed in several consumer forums in 1970. At a meeting of the National Health Forum of the National Health Council, Lowell Norling, President of the National Consumers Health Committee, describes the "ideal organization of a health center" as one in which the community itself defines the area that the center serves: it is controlled "physically and mentally by the community" so that it has "the heartbeat of the community." All major policies

are set by a Board composed of low income persons, other members of the community being served, and professionals. Included among its powers is the right to veto or disapprove actions taken by the administration of the center.

At an American Hospital Association meeting of many groups from across the nation that represent the poor and minorities there was support for "programs created and controlled by the economically and medically deprived" (Gosset, 1971). Gosset identifies the goals of the consumers as presented at the conference: giving consumers the "chief say" in operating health care programs; allowing consumers participation in evaluating quality of care; developing measures to bring physicians to areas lacking practitioners; and establishing restraints on the earnings of physicians.

As an activist group, the Health Revolutionary Unitary Movement, a coalition of community groups, hospital workers, and community groups developed its program: (1) community-worker control of all health services in poverty areas; (2) the right to form organizations of patients and workers to seek improved working conditions, better patient care and new health policies; (3) full employment and career advancement for workers in health facilities as well as open admissions to all health science schools (McNamara, 1972).

Among professionals in the health field many have advocated consumer participation. Health providers have sought to respond to the real needs of population groups within the context of the growing acceptability of consumer participation in the nation. Providers

urge that institutions improve the provision of care by bringing forward new services, increasing accessibility to existing services, and raising the quality of care. Introducing consumers into the decision-making process is perceived as one means among several to bring about these changes.

Consumer participation was urged by providers as part of a larger effort to reform the health care network so that prevailing inadequacies would be corrected. While consumers emphasized participation as the primary approach to the improvement of care, providers considered participation as one means among several of bringing about such reforms. For example, Count Gibson, speaking as chairman of the Department of Community Medicine at Stanford University, called for a "collegial relationship" between university medical schools and community institutions in the establishment of medical center priorities (Gibson, 1971). The community would become a participant with the medical center, but not the dominant force in the relationship. Donald Dunn, of the Iowa Hospital Association (1972), advocated placing consumers on policy-making bodies of the American Hospital Association, commenting that "This is a time of questioning throughout American society. Institutions are challenged to be responsive to the public need. Questions are addressed to formerly revered institutions asking, 'Are you serving the public interest?'" In order to respond to public challenges Dunn recommended including consumers on an advisory board of the Hospital Association; he was not advocating the replacement of hospital officials by service recipients. Thus, consumers and

providers differed in their relative emphasis upon participation as a primary means of achieving reforms in health care delivery.

As the preceding data show the ideology developing in health focused solely upon the field of health. Participation by consumers was perceived as a means of improving health care; it was not presented as having a symbolic value beyond the health field. Reform was not assumed to be a forerunner of reform in other institutional sectors, nor as a necessary first step to change in other institutional areas. In this respect the consumer participation movement in health differed from that of other service fields where the ideology stressed social issues broader than the immediate institutional change at hand.

It may be that the symbolic quality of the movement in other fields generated a fervor, devotion, energy, and member loyalty that was not aroused in health. To be involved in the student movement or in the effort to secure community control was to be a part of "a cause" in which the self could be transcended in the midst of confronting what were perceived as the most significant issues of the day. Such movements could generate a sense of purpose, a certitude that through joint action people could bring about important changes in the society as a whole. The thrust those beliefs gave to the movement for participation in other service areas was lacking in health.

Also stilling the possibilities of activity in health may be a latent sense of prestige for the medical profession among those in the consumer movement. Perhaps there is an acceptance of the expertise of the health professional even while criticizing the policies pursued

by such individuals. This is what Davis (1969) and others suggest in their cautions against optimism regarding the outcome of consumer participation in health. Davis comments that in their encounters with physicians on policy-making bodies consumers will be overwhelmed by the combination of social prestige and expertise of the physicians. Even before such encounters occur the effects of prestige may be evident in the apparent acceptance of the legitimacy of authority in health.

Thus it would appear that the structure of the health field and the nature of the beliefs that emerged in that field limited the scope and fervor of the consumer movement in health, while other aspects of structure and belief encouraged the formation of such a movement. So, with both its weaknesses and its strengths the movement stumbled forward, gathering support from health professionals and health care organizations.

MOBILIZATION OF PARTICIPANTS

How might proposals for consumer participation be implemented? Would consumers join forces with each other so as to achieve goals of participation?

In terms of the categories developed by Smelser, a number of conditions for the emergence of a social movement were present with respect to consumer participation in health: social conduciveness, social strain, a set of generalized beliefs, and precipitating factors. Yet, these have not resulted in the mobilization of consumers to gain participation in a wide spectrum of health care institutions

(Barney, 1974; Notkin and Notkin, 1970). A few isolated instances have been reported of community pressure to secure locally desired goals, such as limiting hospital expansion into adjacent residential areas (Notkin and Notkin, 1970) or securing additional beds for the treatment of drug addicts (Shpes, 1974), but there has been no consistent, organized effort to secure consumer representation on the governing bodies of hospitals, state Blue Cross or Blue Shield units, nursing homes, prepaid group practices, or other health care institutions. Instead, efforts by consumers have generally been concentrated upon the development of Neighborhood Health Centers funded by the federal government. It would appear that government has been perceived as the instrument through which participation would be realized.

As new organizations established through OEO or the Public Health Service, Neighborhood Health Centers offered the maximum opportunity for consumer governance. However, by focusing attention in this single area consumers left relatively untouched the major part of America's health care system. There were never more than fifty Neighborhood Health Centers in the nation funded by OEO (Hollister, Kramer, Bellin, 1974); by contrast, for example, there are approximately 7,000 hospitals (Croog and Ver Steeg, 1972), and the latter have been essentially untouched by the consumer movement. In service fields other than health the thrust toward participation was directed toward major institutional networks in that field. It was the entire public school system that was the object of advocates of community control in New York.

Minority groups were not seeking alternative structures to the schools; they were seeking governance of the existing school network.

Similarly, health professionals have concentrated their efforts for securing consumer participation in programs operated under government auspices. The general pattern in the field of health has been the emergence of participation in those specific organizations and programs that are publicly funded. After 1964, there were new federal initiatives in the field of health and many of these required consumer participation: Comprehensive Health Planning Agencies, designed to coordinate planning for health facilities in local areas (Brown, 1972; Brieland, 1971); the Regional Medical Program, whose purpose was to coordinate activities to control the "killer diseases" of cancer and heart disease (Wells, 1970); legislation authorizing funds for Health Maintenance Organizations (PL 93-154); and, at another level of government, the Ghetto Medicine Consumer Advisory Boards in New York State (Bellin, et al., 1972).

Since the thrust for participation primarily has been contained within publicly funded programs, it is particularly pertinent to note the increasing role of the government in the health care field. In 1965, 25 per cent of all funds expended in health were derived from public sources; that figure had been relatively stable for 15 years. In 1965 Congress approved Medicare and Medicaid, and in the five years that followed, Congress approved a variety of additional health programs, as previously noted. By 1970, public funds accounted for 37 per cent of all expenditures in health and the percentage

continues to climb, although less dramatically (U. S. Social Security Administration, 1974).¹

The number, variety and funding level of public programs have introduced new patterns of financial support to established health care institutions. Medicare provided almost 27 per cent of hospital income for the years 1966-1972 (Knowles, 1973), and currently provides 68 per cent of the in-patient revenue for New York City municipal hospitals (New York Times, January 5, 1975). Public funds in construction and research support account for over half the total of such funds expended in 1972, totaling \$5.8 billion in 1972. These funds have been available to institutions at a time when many of them confront serious financial difficulties through the combined effects of inflation, rising labor costs, expenses of new technology and new service demands. For example, the Greater New York Hospital Association reported that in 1973 the city's voluntary hospitals had an

1. The details of the Medicare program have been described by Somers and Somers (1961) and the details of the Medicaid program by Stevens and Stevens (1974). In brief, Medicare provides hospital insurance for all those aged 65 or older receiving Social Security or Railroad Retirement Benefits, and provides partial payment of physician and other medical bills through a voluntary self-paying program. The Medicaid program provides a minimum of five basic services (in-patient and out-patient hospital care, physician services, nursing home and home health care, and laboratory and x-ray services) to all federal welfare recipients in states agreeing to participate in the program. Each state has the option of providing additional Medicaid services and may extend benefits to other categories of welfare recipients and other low-income groups.

operating deficit of \$75 million contrasted to an operating surplus five years earlier (New York Times, February 4, 1973).

Government initiatives in the health field are proliferating, providing funds to organizations at a time of their financial need. As a result the prohibitions, restrictions, and mandates that accompany these funds become particularly pertinent to the receiving institutions. It is they, not the consumers, who must respond to government conditions for funding. As government programs are formulated, in cooperation with segments of the health professions, it is organizations that study the nature of funding requirements and determine the steps they must take to qualify for funding. Where consumer or community participation is a requirement, the organization acts to establish the appropriate mechanisms for participation. Local community groups may apply for funds for local projects, such as a health center, but it is not from these groups that the impetus to achieve participation in already existing health care organizations has appeared.

In general, in any specific health care organization, the impetus for participation has come from the organization or its funding sources, and not from its consumers (we note that this has not been the case in other institutional areas of American life, such as education, perhaps because the acceptance of health care as a right is comparatively more recent than acceptance of other services as a right). The case of consumer participation being studied in this research is consistent with this history. As we will show in later chapters, the impetus for participation in H.I.P. derived primarily from within the organization

as members of the Board of Directors sought to achieve internal reform, secure additional federal funds and stabilize enrollment and income in the Health Plan.

CHAPTER III

H.I.P. AS A PREPAID GROUP PRACTICE

Incorporated in 1944, H.I.P. is now the second largest prepaid group practice health plan in the nation. More than 1,000 physicians in 28 medical groups throughout the New York metropolitan area provide health services to 750,000 persons. As a prepaid group practice, H.I.P. provides care through a particular type of organizational system. The basic elements of that system are described in the first part of this chapter. The founding of H.I.P. is then discussed with emphasis upon the emerging structure of the Health Plan, particularly the system of governance.

THE ELEMENTS OF PREPAID GROUP PRACTICE

The question of how to secure quality care and consumer representation was not new in the health field. In an effort to provide quality care at a reasonable cost, prepaid group practice plans were begun in the 1920's, and, in many instances, were initiated and governed by consumers.

Prepaid group practice is a system for financing, organizing and delivering health care to a specified, enrolled population; services are offered, on a contractual basis, to an enrolling group, such as a union, which agrees to pay a stated premium for those of its members who decide

1
to join. Payment of this premium entitles the subscribers, and their eligible dependents, to a wide range of services by the health plan at little or no additional cost to the enrollee. The enrollee is able to select a physician from among those participating in the health plan. In 1973 there were nearly four million persons enrolled in the five largest prepaid plans in the nation (U. S. Social Security Administration, 1975).

Prepaid group practice is an alternative to a fee-for-service system of health care in which patient bills are paid in full or in part by insurance companies. A prepaid group practice plan provides or arranges for health services while indemnity insurance companies, such as Blue Cross and Blue Shield, offer payment for medical services rendered by others:

The basic obligation of the prepaid group practice program is to arrange for and make available all the physicians (including specialists) and facilities necessary to provide comprehensive health care services to its members. Thus, the prepaid group practice actually takes complete responsibility for providing its members with medical care services 24 hours a day, seven days a week, 365 days a year.

If a prepaid group practice medical care program adds a benefit, the program must have the personnel and facilities to provide all the services necessary to implement that benefit. However, if an indemnity insurance company adds a benefit, the company merely offers to pay for the covered services if the insured

1. An enrollee is defined as anyone eligible to receive the benefits of the plan. A subscriber is the person in whose name the insurance is written (The Health Insurance Plan of Greater New York, 1971).

uses them. The indemnity insurance company has no responsibility to the insured to make the services available (1972).

In sum, the principles of operation of this system have been described by Saward (1969), in what he terms the "genetic code," as: prepayment, comprehensive services, voluntary enrollment, group practice and capitation. Group practice is defined by Roemer as "3 or more physicians of different specialties working together in 1 location and sharing income according to some prearranged plan" (1965). Group practice is in contrast to the dominant form of practice in the United States. In 1969 only 18 per cent of active physicians practiced in a group with their colleagues (The American Medical Association, 1970: 4, 75-78). However, that number has been growing steadily as the process of bureaucratization continues in the medical field. Group practice in a prepaid plan typically brings together specialists and family physicians, with specialists in unusual types of care such as neurosurgery, available to the plan when needed. Other health services may also be available, including diagnostic testing, laboratory facilities, and ancillary personnel, such as health educators. Within a single organizational body, separate components of health care are integrated, so that the enrollee does not have the full responsibility of charting and negotiating his own way through a medical system characterized by specialization and fragmentation. The health plan offers preventive, chronic, and acute care at home, in the physician's office, and in a hospital, with each plan offering its own particular set of services.

There is a difference of opinion expressed in the literature of prepaid group practice as to the need for all physician members to serve

the plan full-time. Soward specifies that full-time participation of member physicians is a requirement of an effective organization; however, there are a number of plans in which only some of the physicians serve full-time¹ and guidelines of the Group Health Association of America require only that a portion of the plan's total number of physicians be full-time (Group Health and Welfare News, November, 1973).

Payment by the health plan to the physician groups is by means of capitation, a fixed sum per year, per enrollee in the group. Capitation payments are made directly to the medical group rather than to the participating physicians, and the group determines the formula for distributing income among practitioners. Where funds are derived from capitation, there is no additional income obtained from treating ill patients, nor any decrease in income if few enrollees utilize physician services. This system removes the fee-for-service structure that prevails outside prepaid group practice. For the patient, the cost of medical care is not a barrier to seeking aid, since there is little or no fee for any visit or service. The costs are covered through the premium.

Structure

Structurally, the "ideal model" of a prepaid group practice is exemplified by the Kaiser-Permanente Plan on the West Coast, as described

1. Plans in which only some physicians serve full-time include the Harvard Community Plan (Dorsey, 1973), the United Mine Workers Welfare and Retirement Fund (Munts, 1967) and H.I.P. (Feldman, 1953).

for example, by Fleming (1971). Organized during World War II, this plan is the largest in the nation, serving 2.5 million persons in several states, including California, Washington, Oregon and Hawaii (Group Health and Welfare News, May, 1973). A central administrative body contracts with six different physician partnerships which, in turn, provide ambulatory care to enrolled members. The central administrative unit enrolls members by contracting with subscriber groups; the unit is responsible for maintaining records, collecting premium payments and arranging for the provision of health care for enrollees. Hospital care is provided in institutions operated by the Kaiser Foundation under separate contract to the Health Plan. A Board of Directors governs the plan, with members drawn from the business community, primarily from Kaiser Industries (Munts, 1967). Among existing prepaid group practices there are many variations of this structural form although all plans include an administrative unit, physician services, an enrolling population, and a system of governance.¹

Governance of Prepaid Group Practice Plans

Unlike indemnity insurance plans, such as Blue Cross or Blue Shield, and unlike most health care institutions, such as hospitals, prepaid group

1. There may be two or more centers, as in the Harvard Community Plan sponsored by the Harvard Medical School (Dorsey, 1973), or there may be a multiplicity of centers, as occurs in the United Mine Workers Welfare and Retirement Fund (Munts, 1967). Where there are multiple centers each may be operated by a separate physician partnership that has its own contract with the central administrative unit, as occurs in H.I.P. in New York (Feldman, 1953) or there may be multiple centers under the jurisdiction of separate physician partnerships, as exists at Kaiser.

practice plans have a history of consumer involvement. Consumers have been active in the formation, sponsorship, and governance of many prepaid plans. While some of the existing plans are sponsored by physician groups, employer-employee groups, and other bodies, the largest and best known are either consumer cooperatives or community-sponsored plans (Yedidia, 1965). Prominent among the twelve cooperatives in the nation (Schwartz, 1968) is the Group Health Cooperative in Puget Sound, Washington, founded in 1947 and presently enrolling approximately 109,000 persons. Founding members paid \$100 each to join the cooperative, receive health care, and secure voting privileges; about 55 per cent of the Plan's current enrollees have joined in this manner (Bloomberg, 1969). Governance, as it is situated in a Board, is solely the responsibility of enrollees elected by fellow Health Plan members.

Cooperatives demonstrate that merging enrollee governance with the prepaid group practice form is both feasible and successful. These plans can be reference points for others in prepaid group practice as they seek reform in that system.

In community plans, persons from the local area sponsor that plan and are members of the Board of Directors. Board members are usually "chosen from the responsible members of the community" (MacColl, 1966:170). The largest community-sponsored plan is Kaiser-Permanente, begun under the sponsorship of Henry Kaiser to provide medical care during World War II for thousands of workers employed in shipyards he owned. H.I.P. is the second largest community-sponsored plan, enrolling approximately 750,000 persons. Other plans have been initiated by labor unions,

such as the Cleveland Health Foundation (MacColl, 1966) and the multiple programs operated by the United Mine Workers (Munts, 1967).

The governance system of community-sponsored plans function on the premise that enrollee interests can be adequately taken into account by the public spirited citizens who act on their behalf as members of the Board of Directors. That concept seemed appropriate in an era preceding the growth of consumer participation, but, as this study will show, it is no longer acceptable to some enrollee groups.

The interests of enrollees are also presumed to receive attention during contract negotiations between subscribing groups and the health plan. Through negotiations subscribing groups are able to set some of the terms of their enrollment. For example, in 1952 labor unions participating in the Kaiser-Permanente Plan negotiated the first dual choice option in prepaid plans (Munts, 1967). (Such options are now available in most plans, and permit members to select coverage from an indemnity insurance company if they prefer that to the prepaid plan). Yet, as a form of enrollee control, how effective is the contract negotiation process?

With the dual choice option enrollees are periodically given the opportunity to review their health care status and decide whether to remain with the plan or receive health care through a different arrangement. It is presumed among advocates of prepaid group practice that this form of voluntary enrollment allows subscribers to express their evaluation of the plan (MacLeod and Prussin, 1973). Voluntary willingness to remain is perceived as a form of client participation in plan

decision-making. With the rise of the consumer participation movement enrollees were no longer willing to accept this as their only direct means of expressing their views.

The components of prepaid group practice that we have described are explored below with specific reference to the establishment of H.I.P.

FOUNDING H.I.P.

The idea of a quality, comprehensive health care program through prepayment for low and middle income workers in the City of New York was suggested by Mayor Fiorello La Guardia in 1943. He was concerned about the financial ability of municipal workers to purchase medical care. Wages were frozen. Workers had already experienced serious economic deprivation during the Depression when the city, owing to financial shortages, instituted "payless" work days and overtime without compensation (Schweppe, 1948). These limitations on personal income occurred at a time when each individual was primarily responsible for meeting his own medical expenses. Medicare and Medicaid were not to appear until 1965, and no similar program preceded them. As late as 1950, two-thirds of the total health care expenditures of the nation were met through direct payment by individuals, with no assistance from insurance companies or the government (Feldstein, 1973).

A study of New York City workers by the Municipal Credit Union had shown that medical expenses were the single largest cause of debt among city workers, and many of these expenses were incurred for the care of wives and children (Baehr, undated). La Guardia called attention

to these findings when he asked Dr. George Baehr, who had administered a prepaid group practice in a New York City housing project, to use his experience to develop a health care program for low and middle income workers in the city. Dr. Baehr recalled the request in an interview:

In 1943 Fiorello sent for me . . . He said he had made a study of municipal employees who are in debt and take graft. It was sickness. Give me a plan whereby I can cover everything - pre-existing illness and no limit on benefits. How much will it cost? I said, who knows.

The Mayor appointed a committee, headed by Dr. Baehr, to "devise a prepayment plan which would provide comprehensive medical care for city employees and for employees of private industry and their dependents" (Baehr, undated). The intent was to provide quality care at a reasonable cost. To implement the proposals of this committee, a second group was formed, the Mayor's Committee on Medical Care, whose members included physicians, city officials, businessmen, philanthropists, and union leaders. Among the city officials were the Mayor, the Commissioner of Health, and the Commissioner of Hospitals. Legal advice was provided by the city's Corporation Counsel. Other administrative officials were available for assistance. The Mayor offered the "assurance of the eventual participation of city employees" in the program (Feldman, 1953: 26), and he offered payment of half of each enrolled municipal worker's premium by the city (Baehr, undated). H.I.P. would be the only non-hospital service that employees could select for which the city would pay any part of the premium.

In September, 1944, H.I.P. became a non-profit corporation under terms of the New York State Insurance Law. The incorporators included many persons serving on the Mayor's Committee. In 1947, H.I.P. began providing health care. By 1949, 201,000 city workers and members of their families belonged to the Plan, constituting 88 per cent of H.I.P.'s enrollment. As the employer, the city was the employees' enrolling agent. The city signed a contract with H.I.P. specifying the services to be provided to enrollees and the premium rate to be paid in return for these services. Thus, simultaneously, the city became the major source of the H.I.P. clientele and, as a consequence of premium payments, the major source of H.I.P. funds. A pattern of mutual dependence was established in 1947, in which H.I.P. depended upon continued city enrollment for its survival, and the city depended upon H.I.P. to provide health care for its employees. As a consequence, any future changes in the municipal work force could have profound effects upon H.I.P., and any internal changes that H.I.P. might wish to make in its organization could be stymied if the City of New York refused to pay the premium to support these changes.

Representatives of New York City employees did not participate in the deliberations leading to the formation of H.I.P., nor were there enrollee representatives on the first Board of Directors. The concept of consumer participation in decision-making in bureaucracies that has become so familiar to us in recent years had not yet emerged. New York City workers had no official bargaining agents at the time to explicitly represent them, since they had not yet been unionized (Schweppe, 1948).

The Mayor's initiative in the development of the Plan and his continuing participation in its initial operations, can be viewed as the activity of an employer, acting in his capacity as management, in establishing a health care program for his employees. In the 1930's and 1940's such a management initiative was not unusual (Banta and Bosch, 1974; Munts, 1967). Indeed, the creation of the Kaiser-Permanente Plan resulted from the efforts of Henry Kaiser to meet the health needs of his employees. While leaders from national unions participated in founding H.I.P., there was no indication in this research that they were perceived as, or that they participated as, representatives of the workers to be enrolled. The broad spectrum of leaders included among the Health Plan's Board of Directors were viewed as representing the community in general, rather than specific segments within it. In their capacity as community representatives they would presumably take into account the needs and aspirations of the enrollees.

Among the groups that did have representatives on the Board were foundations that gave the fledgling Health Plan loans which provided the initial necessary income before monies generated by enrollment and premium payments were received. Loans were secured from the Rockefeller, New York, and Lasker Foundations. Members of each of these foundations were among the incorporators of H.I.P., and the members of the first Board of Directors (Somers and Somers, 1961). Thus, at the very inception of the Health Plan, the Board of Directors included among its members those who controlled the external resources needed by the organization. That pattern of membership has persisted to this day.

Recruitment of physicians to serve the Plan was hindered by the

opposition of organized medicine to any limitations upon "free-choice-of physician" for subscribers and "fee-for-service" payments, as well as non-physician governance of the Plan (Munts, 1967). Physicians had to be found who were prepared to ignore the opposition of the medical societies; these would be physicians "with the courage to defy the stand-patters of their profession" (Baehr, undated). They were primarily recruited from among physicians returning from service in World War II, according to several respondents. Practitioners were needed to serve the Plan in medical centers throughout the city, yet H.I.P. had little money with which to pay these professionals. Therefore, most physicians served the Plan on a part-time basis, while simultaneously building their own private, fee-for-service practices (Baehr, 1972). At the time this decision seemed a practical organizational solution to an immediate problem (Baehr, 1972), but it has had unanticipated consequences that appear to have adversely affected the ability of H.I.P. to achieve its goals as a health care organization (Munts, 1967; Yedidia, 1962).

In sum, H.I.P. was designed as a prepaid group practice plan to offer comprehensive, quality care by part-time and full-time physicians within the structure of a complex organization. It was to be governed by community representatives; it lacked enrollee representation. The Plan's clientele was primarily derived from a single source - the City of New York acting as the enrolling agent for its employees. A state of mutual dependency emerged between the city and H.I.P., so that changes in one organization might cause changes in the other. Because the

clientele was concentrated in a single source, it reflected the homogeneity of that enrolling population, whose members included workers employed at low and middle income wages for the City of New York and members of their families. In response to the limited availability of funds, and the immediate need for staff, physicians were recruited on a part-time, rather than a full-time basis.

What would be the later consequences of initiating a Plan lacking client representation, dependent upon a single client source, operating with limited funding, and utilizing part-time professional personnel? How would future events, both within H.I.P. and external to it, react upon these already existing conditions? As we describe the organizational structure of the Plan in the following chapter, we can begin to see some of the consequences of the initial decisions and how they led to the development of consumer councils in 1971.

CHAPTER IV

THE ORGANIZATIONAL STRUCTURE OF H.I.P.

There are three basic organizational units in H.I.P. - the central administrative unit, the medical groups, and the Board of Directors. These are formed around three corresponding organizational functions - administration, the direct provision of care, and governance. In this chapter we look at the structural elements of H.I.P., specifically directing attention to the division of decision-making.

ADMINISTRATION: The Central Unit

The central unit, also known as the Health Plan, handles financial, administrative, and service matters for the Plan as a whole. It is staffed primarily by non-physicians, who, typically, are health professionals from such fields as social work, sociology, statistics, administration, and finance. Administrative officers include the President, the Executive Vice-President, three Vice-Presidents and a General Counsel, each of whom is chosen by the Board of Directors.

As in other prepaid group practice plans, the central unit negotiates a contract with enrolling groups in which the services to be provided by the Plan are specified. The Plan negotiates a contract with medical groups to offer these services. It is the responsibility of the Plan to ensure that the services it has agreed to provide to

enrollees are actually presented by the medical groups. H.I.P. lacks organizational mechanisms for interaction among the enrolling groups, their enrolling agents, the Health Plan, and the medical groups - an interaction that might permit the exercise of sanctions by the enrollees and their group representatives in situations of contract non-compliance. Specifically, in H.I.P., the city must rely upon the Plan to ensure that services are provided by the medical groups.

This responsibility of the Plan is carried out by the Medical Department, but its only powers are persuasion and influence. During Dr. Baehr's tenure as President (from 1950-1957 and 1960-1962), monitoring personnel of the Medical Department reported directly to him in his capacity as Medical Director and President. Dr. Baehr personally recruited physicians to study medical group performance through on-site, routine visits. He intervened to secure compliance when his staff encountered particularly stubborn situations. This procedure depended for its success upon his personal characteristics; the qualities of the man, rather than the powers of the office, permitted whatever success could be attained. When he retired in 1962 and a health professional became President, another physician was appointed Medical Director. Monitoring personnel reported directly to him, but not to the President. Routine on-site visits were terminated, and reliance was placed upon the review of forms prepared by the medical groups.

Using these methods, reports were prepared by the Medical Department in the early 1970's, specifying alleged contract violations. These

included failure to hold periodic clinical staff conferences among physicians, failure to appoint full-time medical directors in some groups with more than 15,000 enrollees, and failure to provide appointments for H.I.P. patients with their physicians within a reasonable time. Another document noted that more than 30 of the Plan's 700 physicians lacked a hospital affiliation, that three of the groups did not provide physical therapy by personnel having proper credentials, and that more than 150 physicians in the Plan failed to maintain minimum office hours at the medical groups (it is presumed that these are part-time physicians who provided care to H.I.P. enrollees in their private fee-for-service offices, rather than in the H.I.P. center). Most recently, the Chairman of the Health Committee of the New York City Council cited a report by the City's Department of Health, describing care in some medical groups as "substandard" (New York Times, February, 1976).

Recent efforts to obtain compliance in those instances where standards have not been followed include forwarding reports to the President and/or the Board of Directors, sending letters to medical groups judged to be in violation of standards, or discussion with medical groups to encourage self-correction. There is no requirement that the Medical Department forward such reports to organizational units with sanctioning powers, such as the Medical Control Board. The informal efforts at persuasion that could bring success under Dr. Baehr appear to have floundered under his successors who lacked the prestige to be effective within the limits of personally derived power. Enrollees are

dependent upon the Medical Department to ensure the delivery of contractually agreed upon services, but the Department's weak powers limit its ability to perform this function.

Non-physician members of the Board of Directors, including union leaders and health professionals, have consistently sought to improve levels of contract compliance. Their approach has been to encourage the formation of new organizational units with new charges of responsibility, rather than to work with already existing units. Thus, in 1968, the Joint Committee for Improved Medical Care was created to review specific complaints from enrollees regarding the performance of individual physicians. While this body can censure physicians, and, according to interview data has done so, it cannot take further disciplinary action against them; a health professional stated that the committee "can suspend or reprimand . . . the only agency that can dump a doctor would be the medical groups or the Medical Control Board." Membership on the committee is limited to physicians who are selected by the medical groups and central H.I.P.; there are no lay members.

Compliance is important to enrollees for, otherwise, they are subject to uncertain, variable, and potentially inferior care. Are there other senses in which compliance is an important issue in this organization? Is compliance only a question of service delivery? Perhaps the sanctity of the contract is also an issue, apart from any specific portions of it that may or may not be violated. So long as some violations persist that organizational mechanisms cannot eliminate, the formal authority of the Health Plan and of the Board of Directors

is eroded, and that of the medical groups enhanced. The efforts of the non-physicians to achieve contract conformity may be viewed as both an effort to raise the quality of care, and a means of containing and reducing the power of the medical groups.

In sum, a basic responsibility of the Health Plan is securing compliance with the specific contract terms agreed to by the medical groups, but the mechanisms developed at the central level to achieve this goal have no sanctioning power, and operate with changing and uncertain procedures. The question of how effective compliance might be secured remains unresolved.

The central unit also provides direct services to enrollees by means of the medical groups, including social work assistance and health education. The medical groups have the option of offering,¹ or of rejecting, these services. The exercise of the options by the medical groups has consequences for enrollees, since it results in different types of service availability at different medical groups in the system. Both the exercise of options by the medical groups, and the failures of some groups to achieve contract compliance, result

1. Where services to enrollees are provided, they are given at the medical group center, primarily by personnel attached to the central office. Complex financial arrangements exist between the Health Plan and the medical groups for payment of costs for these services. In general, additional per capita payments are made to the medical groups by H.I.P. for enrollee services, as specified in their contract. Separate agreement must be secured from each medical group for its participation in any particular program generated by the central department, unless the medical group contract already specifies such participation.

in service variability for enrollees; persons with the same H.I.P. contract actually receive different services. This lack of equality constitutes an impairment in service delivery that enrollees were no longer willing to accept by the 1970's. The organizational system of the Health Plan generated service inadequacies that, in turn, contributed to the development of a consumer movement in the Health Plan.

THE DIRECT PROVISION OF MEDICAL CARE

The Medical Groups

Health care is provided by 28 separate physician partnerships.¹ Each medical group signs its own contract with the Health Plan, but negotiations are carried out by associations which represent clusters² of medical groups. Each group agrees to provide specific health services to enrollees: general medical, surgical, specialist, and obstetrical care; laboratory procedures and diagnostic procedures; periodic health examinations and other measures for the prevention and detection of disease; physical therapy, eye refractions; visiting nurse service as prescribed by a physician; and ambulance service. Each group agrees to establish and maintain a center at its own expense,

1. The number of medical groups has changed over the years, as some merge and others leave or are added. In 1970, there were 31 medical groups. In 1973, there were 28.

2. Prior to 1973, the medical groups primarily staffed by part-time physicians belonged to either the Medical Group Council, or the Medical Group Association. The few full-time groups functioned as independents. In 1974, the Council and the Association merged.

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with the approval of H.I.P. as to its location and adequacy; and to obtain H.I.P. approval for physicians who are hired.

In the contract, the medical groups agree to follow additional standards specified by the Health Plan's Medical Control Board (this body is appointed by the Board of Directors of H.I.P., and consists solely of physicians. See p. 78). Among the matters detailed by this body are minimum medical group hours, specific family and specialty care to be provided at each center, procedures for approval of H.I.P. physicians, and appropriate physical conditions of medical group centers.

The contract terms between the medical groups and H.I.P. constitute the only formal obligations assumed by the medical groups toward the Health Plan. As one provider stated: "Whatever is in the contract is the only control over us." However, a complex set of factors have interacted over the years to limit the ability of the medical groups to adhere to contract terms and, in general, to provide as high a level of care as both the providers and H.I.P. might desire. However valid these factors may be, we note that where contract terms are not met, the minimum obligations of the groups to the enrollees are not met. Enrollees experience the consequences of variable compliance as a limitation of services.

1. Prior to the 1960's, each medical group was responsible for financing its own center. Some groups purchased a building and others leased facilities. In 1965, the central Health Plan began to finance the centers of those groups with a total complement of full-time physicians.

One basic factor affecting adherence was identified by Yedidia in a 1962 study of H.I.P. as the use of part-time rather than full-time physicians. Yedidia stated that part-time physicians have economic interests that are divided between their own private practice and the group practice of H.I.P., and this may have consequences for H.I.P. enrollees. If a physician seeks to maximize his fee-for-service income, H.I.P. patients may be "slighted in regard to appointments . . . by busy practitioners whose H.I.P. income is fixed, but whose income from private patients is variable."

In its use of part-time physicians, H.I.P. departs from the pre-paid group practice model exemplified by the Kaiser-Permanente Plan, and expounded by Seward. As described in the following chapter, efforts to bring all physicians into the Health Plan on a full-time basis were begun in 1970, but disagreement persists within H.I.P.¹ regarding the need for such reform. For purposes of our research, we can state that part-time practice places a physician in a situation of status conflict in which he must balance the needs of different

1. The full range of this debate is outside the scope of this research. The issue is pertinent insofar as the use of part-time physicians is related to the delivery of services and contract adherence. One medical director states that use of part-time physicians allows the medical group to utilize the services of outstanding physicians who would not be willing to enter H.I.P. on a full-time basis. Another states that the specific benefits of full-time service have never been fully documented. Since 1962, H.I.P., under the direction of its President, has sought to increase the number of full-time physicians, but in 1972, ten years later, only 100 have been added. As we noted in Chapter III, there are other prepaid group practice plans in which physicians serve part-time.

patient groups, as well as his own personal needs. If he chooses to devote attention to his fee-for-service patients, he may act in a manner that results in non-compliance with the H.I.P. contract. For example, a physician may extend his private office hours if his waiting room is crowded, thus arriving late for his H.I.P. patients, or he may have private office hours on Saturday and prefer not to be available to H.I.P. on that day, limiting the ability of the medical group to be open on Saturday. For the H.I.P. enrollees, the consequences of physician status conflict may be reduced availability of services.

Other factors inhibiting contract compliance are cited, particularly by providers, including difficulties in securing physicians, shortages of money, erratic variations in levels of enrollment at the medical groups, and personnel problems. Shortages of money are cited as being an endemic problem in the Health Plan; one provider states that H.I.P. has always been "under-financed" so that the medical groups have not been able to obtain the funds needed to provide the

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services stated in the contract. One administrator at central H.I.P.

1. Members of the medical groups, the Administration, and the Board of Directors express the belief that H.I.P. is not sufficiently funded. When the Plan began, there was limited money available for capital, service and personnel needs (Health Insurance Plan of Greater New York, 1972; Yedidia, 1962). Funding levels remain minimal. In part, this may stem from the attitude of the City of New York, H.I.P.'s largest single client. Studies by the City Club (October, 1972) and the Comprehensive Health Planning Agency of the City of New York (1973) have concluded that the City has not shown sufficient willingness to pay for the health services that it desires for its employees. The insufficiency of funding also stems from a basic element of organizational

identifies the general problem of obtaining physicians for the medical groups: "There is still a very conservative element in organized medicine that has yet to accept group practice, particularly, prepaid group practice," making it difficult to attract physicians to the Health Plan. According to this respondent, recruitment of physicians is "difficult to achieve where physicians have such a wide market for their services," and can find employment elsewhere, or open their own fee-for-service practices. The problems of uncertain enrollment, compounding financial difficulties, are described by one provider:

Our group has a problem. We lost 8,000 subscribers. That's 30 or 40 per cent of the subscribers we had a couple of years ago. We didn't lose them because

structure - the lack of a hospital base. In part, as a result of the lack of funds at the time of its founding, as well as restrictive state laws, H.I.P. does not operate a system of hospitals as do several other prepaid plans. H.I.P. offers members coverage for physician services; enrollees must obtain Blue Cross for hospital coverage. However, hospitalization rates for prepaid group practices have generally been shown to be lower than rates for Blue Cross and other insurance companies (Roemer, et. al., 1972). The care provided by H.I.P. may result in lower hospital rates, but it is Blue Cross rather than H.I.P. to whom the financial benefit accrues. In its study of H.I.P., the City Club recommends that "The City of New York . . . rate the three systems being used by its employees - Blue Shield, Group Health and H.I.P. - to establish their effect on hospital use . . . Manifestly, if it turns out that H.I.P. requires only 60 per cent of as much hospitalization of its patients, the City would be justified in paying higher fees for medical care to H.I.P. than it pays to the others" (1972:2). Within the Health Plan, a multiplicity of rules govern the internal disbursement of available funds. The system allows the medical groups to participate in the determination of their funding levels, with the result, one consumer leader states, that medical groups tend to determine service issues more on the basis of their own financial benefit than the need by enrollees for the service.

they were unhappy with us. The City took them away from us. They were on Medicaid. (1) This puts the group in financial difficulty.

Neither the central unit, nor the Board of Directors, nor the Medical Control Board has developed a stable, clear, persistent policy with regard to contract adherence by the medical groups. A member of the Administration admitted at a meeting of the Board of Directors in the early 1970's that the medical groups did not meet all the terms of the contract they had signed, but, he stated, "some flexibility is . . . required in special circumstances." At the same time, the Administration began a new program for contract monitoring, coupled with informal efforts to secure medical group compliance. At times, non-compliance appears to be accepted, and, at other times, contract enforcement is stressed. A Board of Directors member describes the history of contract enforcement as "a series of ups and downs." Efforts to secure greater contract adherence have been pursued sporadically.

The description presented in this chapter details a system of medical group autonomy such that the medical groups constitute an identifiable and separate sphere of decision-making authority within the Health Plan. One non-physician member of the Board of Directors has called H.I.P. a "franchising agency" for the medical groups, implying the existence of separate lines of organizational authority.

1. H.I.P. reached an agreement with the Department of Social Service of the City of New York to allow enrollment of Medicaid recipients. As eligibility rules for Medicaid recipients change, the number of persons eligible for Medicaid changes, eliminating some persons from H.I.P. enrollment.

Our evidence indicates that the medical groups are perceived by members of H.I.P., including providers in the medical groups, as autonomous bodies. Some of the comments presented to us are given below:

A provider: These are independent medical groups.

A lay member of the Board of Directors: The medical groups have veto power - structurally and financially.

A consumer speaks of the powers of the groups: It's like the times when the states were more powerful than the federal government.

A provider: My physicians are touchy as far as their own autonomy goes.

Researchers who have studied H.I.P. have come to the same conclusion. The City Club describes the medical groups as "independent partnerships of physicians (City Club Comments, September, 1972). In his review of labor's participation in prepaid group practice, Muntz refers to H.I.P., noting that "there is great variation in quality between the centers. While low rated centers have taken steps to improve themselves, the central H.I.P. organization does not have all the autonomy necessary to assure this." (1967:198).

The Hospitals

Another unit providing direct medical care is the La Guardia Hospital in the borough of Queens, New York City. At the present time, it is the only hospital owned by H.I.P. It was acquired in 1968, and serves more than 100,000 H.I.P. enrollees, as well as others in the community. There appears to be general agreement within the organization to secure a larger hospital base, either through operating

hospitals directly, or by developing various types of affiliations with hospitals. The dominant view in H.I.P. is summarized in the 1971 Annual Report:

In philosophy and practice, a hospital based pre-paid group practice, represents the most desirable organizational form for in-patient and out-patient health care services from the point of view of integrated and continuous patient care (1971:36).

In 1974, one medical group in Brooklyn changed the site of its care to a center within the Brookdale Hospital. Similar arrangements are being explored by other medical groups. La Guardia Hospital is presently completing an expansion program.

GOVERNANCE

The Board of Directors

The H.I.P. Board of Directors is the policy-making body of the Health Plan. In its structure and function, it generally conforms¹ to the prepaid group practice model. Its charge of responsibility is broadly stated in the by-laws: "The affairs, property, and business of the Corporation shall be managed by the Board of Directors." The President of the Health Plan and the major officers of the Plan report directly to the Board. Among the Board's most important duties, we believe, is ratification of the contracts between the Health Plan

1. The functions of a Board of Directors in a prepaid group practice have been described by MacColl. For a newly developing Plan, the primary obligations are "to establish the nature of the Plan, the objectives it hopes to reach, and the manner in which it will function" (1966:172). The Board develops the organization's capital structure, formulates a service contract, and establishes basic management policies regarding such matters as operating procedures and personnel policies.

and the enrolling groups, and between the Health Plan and the medical groups.

The Board consists of a maximum of 24 members; prior to 1973, the number was 30. At least one-third of these must be licensed physicians. The Health Plan began in 1947, without explicit representation of the enrollees on the Board. As a community-sponsored Plan, the Board was presumed to represent the interests of all subscribers. Membership on the Board included persons from groups that had helped to organize the Plan, and which were the source of resources vital to it - clients, funds, and personnel. Since 1947, there have been changes in membership, but the underlying theme of maintaining representation for those groups commanding resources needed by the Plan has remained.

In 1947, the eight physicians on the Board were drawn from the faculties of local medical schools. By 1973, this was no longer the case; six of the eight physicians represented, and served as physicians in, medical groups in H.I.P. When the Health Plan was formed, the medical groups were weak bases of power in the organization. Within a few years, they had formed associations and through these, the medical groups dealt with the central unit of the Health Plan. By the late 1960's, ten medical groups were threatening to leave the Plan unless contracts were signed with them on terms they considered

1
appropriate. Membership on the Board of Directors has tended to parallel the rise in power of the medical groups, and that itself increases their power.

1. In 1960, the "exclusivity clause" was incorporated into the contract with the medical groups, restraining the medical groups from providing services to organizations other than H.I.P., unless approved by H.I.P. The clause reads, in part, " . . . either as a Group or through any of its partners on behalf of the Group, no agreements or contracts shall be made to provide medical services for any individual or groups of individuals, either by individual prepaid insurance or group prepaid insurance, unless such contracts or prepayment plans is approved by HIP as not competing with the sale of HIP contracts, not interfering with service to HIP insured persons, and not resulting in damaging competition among affiliated Medical Groups with agreements with HIP. If approval of a contract is sought by the Group, such approval shall not be unreasonably withheld by HIP."

In 1972, ten medical groups challenged this provision in court, threatening to leave the Plan unless it was removed. After many months of litigation, an out-of-court settlement was reached. The agreement allows medical groups to enter into contracts with other insurers under specified conditions. A five-man arbitration panel settles disputes that might arise from the provision. Its Chairman, as of May, 1973, is a union leader who is a member of the Board of Directors of H.I.P.

TABLE 1

MEMBERS OF THE H.I.P. BOARD OF DIRECTORS
By Interest Group
Selected Years, 1947-1973

Interest Groups	Year						
	1947	1950	1955	1960	1965	1970	1973
<u>Health Professionals</u>	(20)	(23)	(23)	(17)	(18)	(18)	(8)
Physician Administrators	8	8	9	7	8	5	2
Public Officials	2	2	2	2	4	4	-
Business and Welfare	7	9	8	6	4	6	5
Community Leaders							
Academicians	-	1	1	1	1	2	1
H.I.P. Staff	3	3	3	1	1	1	-
<u>Unions</u>	(4)	(3)	(4)	(5)	(6)	(7)	(7)
Local	2	2	3	5	6	7	7
National	2	1	1	-	-	-	-
<u>H.I.P. Medical Groups</u>	-	-	-	(2)	(3)	(3)	(6)
<u>H.I.P. Consumers</u>	-	-	-	-	-	-	(2)
<u>Unknown</u>	-	-	-	(1)	(1)	-	-
Total	(24)	(26)	(27)	(25)	(28)	(28)	(23)

These physicians are either members of medical school faculties or administrators of health care organizations. None are representatives of H.I.P. Medical Groups.

- Local unions refers to both municipal unions and trade unions with locals enrolled in H.I.P.

Source: H.I.P.

Representation from the business and welfare community has continued, but the number of such representatives has declined. Loans presented to H.I.P. at the time of its inception have long since been paid. These segments of the community no longer control significant amounts of needed resources.

Also of interest are changes in union membership on the Board. At the time of its founding in 1944, there were two representatives of local New York City unions on the Board, but no representatives of the municipal workers who constituted 88 per cent of the H.I.P. enrollees. In 1950, Michael Quill, head of the Transport Workers Union of the City of New York, became a Board member, representing one of the municipal unions. By 1973, the total number of union representatives had risen to seven, out of a total of 24 members, giving the unions a higher percentage of Board members than they had previously enjoyed. All of the union representatives in 1973 were from local unions that offered the H.I.P. benefit to their members; five were representatives of city employee unions, and two were from trade unions.

The table also indicates two other significant trends in Board membership. Until 1973, there had always been at least one member of the H.I.P. staff, or one officer of the Plan on the Board. The President of the Plan had always been a member of the Board. By 1960, only the President was a member; in 1973, the holder of that office no longer was a Board member. The staff and administration of the Plan no longer had any voting rights on the Board.

The changes that we have identified in membership on the Board of Directors constitute a movement away from inclusion of non-H.I.P. members in the decision-making bodies of the organization. Outsiders are less likely to be part of these bodies than ever before in the history of the organization. The inclusion of consumers on the Board is part of this trend. Extending representation to subscribers is a form of internal democratization, but one of its consequences is to draw members of the Board only from among those who are already part of the organization.

This trend has accentuated the role of the Board of Directors as the body in which the interest groups of the organization meet. As numerous respondents in this research have stated, there are four interest groups in H.I.P. These are generally referred to as the medical groups, or "the doctors," the labor unions, or "the contracting groups,"¹ a third group whose identifying name varies, but is usually termed "the health professionals," and the "consumers." These groups are described, for example, in the minutes of the Board of Directors as "physicians from the participating groups," "large contractor groups whose members are enrolled in H.I.P.," "public members," and "consumer representatives."

Persons throughout the organization are identified in terms of the interest group to which they belong. For example, those serving

1. This term is not a correct description as applied to municipal unions since the city is the contracting agent for municipal workers, but city unions are nonetheless referred to in this category.

as medical group administrators are included within the "medical groups." Persons employed at central H.I.P., including health educators and social researchers, describe themselves, and are described by others, as "health professionals." The term by which a person is identified is less a description of occupational activity than of interest group affiliation. Our research has been limited to those serving in decision-making capacities in several units of the organization so we cannot be certain how widespread this practice may be. It does indicate that persons are placed within interest group categories and that these interest groups are identifiable throughout the organization, emphasizing the importance of the Board of Directors as the only decision-making body in which all interest groups are members.

In terms of decision-making patterns on the Board of Directors, there are various references in our data to divisions within three of the interest groups - the doctors, the health professionals and the consumers - but not among the labor leaders. That interest group is not described as containing factions, and it has exhibited consensus on key organizational issues. Its members form a relatively homogeneous group, with five leaders drawn from among the heads of the city's unions, the sixth politically allied with the municipal unions and the seventh assuming a relatively inactive role in H.I.P. owing to age and ill health.

The medical groups, health professionals and consumers all are relatively heterogeneous groups. The medical groups include representatives from the Medical Group Council and the Medical Group

Association (these groups merged in 1973 to form a single representative body for H.I.P. medical groups), as well as the full-time and part-time medical groups. The full-time and part-time groups do differ on some issues, particularly on their support for reorganization and the formation of consumer councils. The health professional group includes physicians from outside H.I.P., businessmen, government officials and professors of administrative medicine at local medical schools. A consistent term has not developed within H.I.P. to identify this group. One member of the group defines this category as "interested health professionals," another calls the group "public and health professionals," and one respondent, a consumer, seeming to give up at the effort of defining categories, describes this group as "the non-medical, non-union people." In general, the members of this group are identified as either "public members" or "health professionals," with distinctions between the sub-categories somewhat blurred. Professors of administrative medicine are always considered to be health professionals; city officials are always considered "public members." Various members of this interest group have differed on some organizational issues, including the formation of consumer councils. In this report we refer to this entire interest group as health professionals, identifying specific sub-categories where pertinent. Consumers were added to the interest group structure in 1971 when consumer councils began to form in the medical groups. The members of this group are the elected representatives of the consumer councils, who may be of varying racial and economic backgrounds. They are not presumed to be the only

persons who speak for the consumers, as we describe in later chapters, but they are the formally acknowledged spokesmen for their councils.

The Medical Control Board

The Medical Control Board is described by one medical director as "the conscience of HIP." It "promulgates standards, rules and regulations relating to professional and technical standards," as described in an information booklet for H.I.P. physicians. As one health professional says, "It elaborates generalizations contained in the contract." The Medical Control Board must approve all physicians added to any medical group. It has the power to sanction individual physicians and medical groups that fail to adhere to stated requirements by means of suspension or removal from the Health Plan.¹

At the time of the founding of H.I.P., local medical societies nominated and selected eight of the sixteen members of the Medical Control Board (Feldman, 1953).² In recent years, nominations for membership on the Medical Board have been submitted by a sub-committee

1. The Medical Department, as we have already indicated, monitors adherence to standards, but has no formal powers of sanction.

A physician or a medical group removed from H.I.P. by the Medical Control Board has the right to appeal the decision to the Board of Directors. One such case occurred in recent years, as reported to us by one respondent and noted in the minutes of the Board of Directors. The physician members of the Board of Directors recommended that the decision of the Medical Control Board stand, and the remaining members of the Board of Directors concurred.

2. It is suggested by Munts (1967) that creation of the Medical Control Board was one means of placating the medical societies when they insisted on physician governance of the Health Plan at the time of its founding. We have not found other references to such a view.

of physicians of the Board of Directors, acting, in part, upon recommendations from the H.I.P. medical groups. Members are elected by majority vote of the entire Board of Directors, which provides the non-physician members of the Board with a very limited form of input into the review process.

The Joint Board

The Joint Board was established in 1965. It is basically an advisory group to the Board of Directors and the President, with some limited decision-making powers.¹ It is composed of twelve representatives of the H.I.P. administration. It is a forum for the interchange of ideas concerning "current matters of interest between the Medical Group and H.I.P.," according to an informational booklet for H.I.P. physicians. It serves as an arena in which views on issues can be presented and resolved prior to their formal presentation to the Board of Directors, as stated by one respondent.: It provides the medical groups with a direct input into the setting of Plan-wide policy.

The Consumer Councils

Consumer councils at each medical group were mandated in the medical group contract signed in 1972, although some councils had begun to form in 1971. Consumer councils presently exist at each medical group, and are the main form of consumer participation in

1. The Joint Board can challenge the medical group reporting system established by the Medical Control Board. If central H.I.P. disagrees with the Joint Board challenge, the issue can be placed in arbitration. Joint Board approval must be secured for release to medical journals or the medical profession of information concerning the quality of care or the extent of group practice in H.I.P.

H.I.P. Membership is open to any enrollee in the Health Plan.

According to the 1972 contract, the councils are "to provide a forum for meaningful discussion of the operation of H.I.P. and the (medical) group and to make recommendations for program improvements." The formally ascribed powers of the consumer councils and the history of their formation are detailed in following chapters.

The Joint Consumer Council (JCC) was established by representatives of the consumer councils in the spring of 1972. It is composed of two delegates from each of the consumer councils. It has not been formally recognized as a part of the H.I.P. system. It is not mentioned in the Plan's by-laws, or in contracts with the medical groups or contracting groups, but it has been given the right by the Board of Directors to nominate consumer council representatives to the Board. As provided in 1972 by-laws, the JCC is authorized by the H.I.P. consumer councils to act as spokesman for the councils and to represent the councils to the Board of Directors in suggesting plans affecting consumers.

SUMMARY

The organizational system of H.I.P. can be described as one of dispersed authority in which physicians and non-physicians share aspects of decision-making responsibility. The change in the decision-making system that is described in this research occurs when consumers join other non-physicians, including labor leaders and health professionals, as members of the Plan's decision-making system. What is the organizational context that consumers enter? How does that context limit or enhance

the possibilities for consumers to affect organizational decisions? How does the context encourage or discourage the initial establishment of consumer participation units?

Physicians in the medical groups have jurisdiction over a wide range of their own affairs, including internal governance and finances. Policy for the system as a whole is established by the Board of Directors, in which non-physicians have a numerical majority. Approval by the Board of Directors of contracts with the medical groups and the enrolling groups constitutes an important element of their policy-making powers. The central unit of H.I.P., dominated by health professionals, handles administrative matters and executes policy, but does not appear to constitute a center of hierarchical managerial authority for the Health Plan. We do not imply that it should; we are describing the form developed in this organization. A former administrative official states the matter with regard to the Presidency: "The President has all the responsibility, but none of the right," referring to the lack of authority inherent in the office of the President.

According to the Weberian model of bureaucracy, organizations have a hierarchical order, ranking positions in descending scale from top to bottom, placing each person under the formal authority of the position immediately above him while each occupant of a status in the hierarchy has formal authority over the person below (Gerth and Mills, 1946). In such a system, social control is primarily a managerial function. Other models of bureaucratic structure have

been identified, particularly taking into account methods for integrating authority and expertise in different organizational settings. For example, Goss (1963) points to the existence of a dual authority system within a single hierarchy in which persons occupying formal roles of authority are sufficiently competent in their profession to qualify as technical experts to those fellow professionals whose work they supervise. Blau and Scott (1962) identify similarities between professional principles and bureaucratic principles (with respect to application of universalistic standards, specificity of expertise, affective neutrality and achieved status), but stress that these principles diverge with respect to the degree of approval for self-interested behavior and type of hierarchical control. Specifically, where professional principles prevail social control is typically lodged with colleague groups. Where bureaucratic principles prevail social control is typically lodged with administrators. The H.I.P. structure is consistent with the professional model with respect to the administrator-professional relationship. The contractual relationship between the medical groups and the Health Plan heightens and formalizes these patterns, placing professional control in explicit, designated organizational units such as the Medical Control Board and the Joint Committee for Improved Medical Care.

Formal statements that define obligatory behavior for the medical groups are distributed in different organizational instruments, notably the contract between the medical groups and H.I.P., and the standards of the Medical Control Board. Similarly, responsibility for ensuring

delivery of care consistent with these defined standards is scattered among several organizational units, including the Joint Committee for Improved Medical Care, the Medical Control Board, the Medical Department of the central unit and, in earlier years, the office of the President. Heightening fragmentation is the apparent lack of coordinated, integrated efforts among these units to achieve contract compliance.

The dispersion of authority in this organization is such that no single group or organizational unit is able to establish or execute policy on its own and each is able to limit the ability of other units to implement decisions. If consumers are to affect decisions reached, and to ensure that desired decisions are executed, it will become necessary for them to secure informal agreement from other interest groups in the Plan and to secure agreement from formally authorized decision-making units of the Plan, such as the Medical Control Board or the Board of Directors.

The dispersed pattern of authority that characterizes H.I.P. is similar to the multiple leadership system described by Perrow, in which "two or more groups divide up the organization into segments where each has control" (1963:132):

With multiple leadership, there are a small number - perhaps two or three - of recognized centers of power. It is different from a contest for power, for the groups do not seek - at least over the short run - to vanquish each other, but recognize each other's sphere of interests. Nor is it the same as decentralized authority, where specialized units have autonomy. In such a case units are free to operate as they choose only up

to a point, when it becomes quite clear that there is a centralized authority. In multiple leadership, there is no single ultimate authority in fact, even though there is in the official construction.

Multiple leadership, as a stable system of goal determination and policy setting, is most likely to be found in organizations where there are multiple goals and where these goals lack precise criteria of achievement and allow considerable tolerance with regard to achievement. Organizations with a single goal of a clear hierarchy of goals provide little basis for multiple leadership. Multiple leadership arises because important group interests diverge and each group has the power to protect its interest (1963:132).

The result of such a distribution of authority can be organizational immobilization as each group pursues its goals and is able to check the actions of others. In general, in H.I.P., there is no single body whose agreement must be secured, nor whose agreement ensures that decisions will be implemented, so that achieving agreement would appear to require continual discussion, negotiation, and compromise. It can be anticipated that decision-making in which consumers seek to achieve their goals will occur as a process over time, rather than in the form of specific, single, notable events.

Perrow identifies three forms that policy-making may assume in multiple leadership structures: "the fortituous convergence of interests, segregated decision-making and the piecemeal accumulation of small victories" (1963:133). The different groups are not likely to alter their goals, but they do reach agreements with other interest groups that allow each to pursue their own goals within the context of overall policy decisions. That is the pattern we will trace in our

discussion of the emergence of consumer councils in H.I.P. Each interest group perceived different benefits to be derived from the formation of the councils, resulting in a convergence of interests among them.

In terms of service, the organizational structure of the Plan unintentionally contributes to service impairment. The use of part-time physicians appears to interfere with the ability of medical groups to provide the services which they have a contractual obligation to offer. Dispersion of authority allows the medical groups to exercise discretion in the provision of optional services and to determine their own patterns of internal governance. The only definition enrollees have of the services to which they are entitled is contained in their contract with the Health Plan, but neither the enrollees themselves, nor their negotiating representatives - the City of New York - can ensure that the terms of the contract will be met. The central unit of the Health Plan has that responsibility, but has been unable to adequately carry it out in the dispersed system of authority that characterizes a professional bureaucracy such as H.I.P. In sum, the organizational system itself generates inadequacies which the system is unable to correct, leaving enrollees without sufficient protection against service impairment.

By the mid-1960's, there was general agreement among the interest groups in the Plan that services varied from center to center and that contracts were not being followed by all the medical groups. By the Plan's own standards, the care being provided was not adequate. Union leaders, health professionals, and public members of the Board of

Directors grew increasingly impatient as they felt frustrated in their efforts to remedy this condition. By the 1970's, the enrollees themselves, awakened by the spirit of activism in the nation, also became frustrated and angry. The care provided did not match their expectations. To rephrase the issue in terms presented in this report, there was a disjuncture between expectations and reality, between services desired and those being provided. The elements of social strain were present in H.I.P. How could strain be reduced? One approach would be to improve the level of care provided. Such an effort was begun in the late 1960's, and the formation of consumer councils is part of that effort. In the following chapter we direct attention to the reorganization of H.I.P.

CHAPTER V

THE STRUCTURAL REORGANIZATION OF H.I.P. AND THE LEADERSHIP

CRISIS OF 1970

The origin of reorganization can be dated to 1962 when a private consultant recommended changes in H.I.P. (Yedidia, 1962) to bring the Health Plan into the pattern of the Seward model for prepaid group practice (1969). Piecemeal efforts to accomplish the goal since that time had not succeeded. By 1970, various members of the Health Plan concluded that the need to achieve reform was vital and immediate. They also believed the opportunity to achieve reform was at hand.

PLANNING A REVISED ORGANIZATIONAL STRUCTURE

Background Conditions

As 1970 dawned, the stability of H.I.P. appeared to be threatened. In the previous year, the Health Plan had experienced its first notable enrollment decline in 23 years (there was a small decline of less than one per cent in 1965). From 1968 to 1970, 21,000 trade union members and their dependents, and 17,000 city workers and their dependents left H.I.P., according to statistics compiled by the H.I.P. Research Department. For the first time, the Health Plan was slipping in acceptability to its own clients, as indicated by enrollment. Current enrollees were leaving, and new enrollees were not taking their place; a member of the Department of Consumer Affairs said, simply, "The workers don't join."

Falling enrollment particularly disturbed the medical groups, whose representatives urged efforts aimed at "fostering H.I.P. growth," and the labor unions, which wanted the Health Plan to achieve "enrollment growth."

At the very time H.I.P. was losing members, prepaid group practice gained a greater degree of favorable national attention than ever before. The federal government was increasingly interested in fostering the growth of prepaid group practice health plans as alternative systems of health care, primarily because of the apparent

TABLE 2

YEAR TO YEAR PER CENT CHANGES

IN HIP ENROLLMENT

1947-1973

Year	Year-End Enrollment	Per Cent Changes
1947	76,106	-
1950	255,494	11.5
1955	470,870	13.4
1960	590,550	5.3
1965	699,206	-0.7
1966	727,193	4.0
1967	749,504	3.1
1968	779,227	4.0
1969	752,578	-3.4
1970	749,559	-0.4
1971	739,979	-1.3
1972	740,242	0.0
1973	758,275	2.4

Source: H.I.P.

ability of such plans to provide quality care at a lower cost than other delivery systems (MacLeod and Prussin, 1973). Recognition by H.I.P. of the growing government interest was manifest in the Plan's 1972 rate request:

The decade of the 1970's will be a period of profound change in the delivery of medical services to the American people. The challenge of leadership for restructuring America's health delivery system has been clearly directed to prepaid group practice plans by the Federal Administration, and here in New York State, through action taken by the State Administration and Legislature in 1971 (1972:1).

However, unless H.I.P. altered its structure to conform to the prepaid group practice model, its position as a leader among such plans would be jeopardized. The President of H.I.P. presented his views, portions of which were quoted in the H.I.P. Almanac:

After nearly twenty-five years of struggle, facing the most powerful organized opposition and lack of recognition, prepaid group practice has become recognized as the wave of the future. Now the future is here.

Many want to get into our act. However, despite the praise, H.I.P. has defects and weaknesses that have to be overcome if H.I.P. is to capitalize on its basic sound structure and its growth potential. Some of our defects and weaknesses were inescapable in our early development because of the powerful opposition we faced from the medical establishment and the need for H.I.P. to get underway. Today we know what we must do to strengthen H.I.P., but we must move fast. If we don't act fast, others may overtake us and pass us by.

We're far ahead of the competition who are ready to go into the prepaid group practice field, but we must break with the past. We must break with comfortable, accustomed patterns. We must recognize the future. We can't roll over and play dead if we expect to keep our hard-won superiority (1972:1).

The President of H.I.P. was a health professional. Before coming to New York, he had been head of a prepaid plan operated by one of the nation's largest labor unions, and had previously working in the Department of Welfare of a large eastern state. He considered prepaid group practice along the lines of the Seward model to be the most desirable organizational form for H.I.P. Other health professionals on the Board of Directors and in the central unit shared his point of view. One health professional on the Board described his own goals for H.I.P.:

I wanted this to be more like the Kaiser Plan, to merge the weaker groups into stronger groups, to regionalize, just like Kaiser has, like Southern California and Northern California, so you can have an efficient center for specialists but local centers for primary care.

The opportunity for health professionals to pursue the reorganization of H.I.P. was present by 1970. Efforts at contract conformity in the organization that the health professionals and the unions supported had not achieved the desired results. The Joint Review Committee for Improved Medical Care, created in 1968, censured at least forty physicians, according to our interview data, yet contract violations persisted. New contract monitoring procedures were introduced, but these seemed less effective than earlier efforts. With the national emphasis upon prepaid group practice in 1970, the time to actively seek reform appeared to be at hand. As a health professional stated, "The rest of the country had caught up with us. The decision could not be put off."

The Proposed New Organizational Structure

The President of H.I.P., and other members of the administration, developed a reorganization plan that was submitted to the medical groups in the form of contract proposals for 1971. The major provisions included: (1) physician membership in H.I.P. on a full-time basis only, except for a few specialists, with guaranteed minimum income for physicians; (2) administrative merger of smaller medical groups with larger medical groups (for example, the fourteen groups in Queens, Staten Island, Manhattan and Long Island would be combined into six groups); (3) ownership by H.I.P. of the medical center facilities of the regionalized groups; (4) strengthened enforcement of standards through review of quality of care and additional penalties for violations of standards; (5) acquisition of hospitals so that all medical groups could be associated with a hospital.

Moving Ahead on Reform

Prior to submitting reorganization proposals to the medical groups, the Board of Directors took initial steps toward reform. In 1970, they approved expenditures of approximately one million dollars to begin recruiting full-time physicians and securing medical centers for two medical groups, one on Long Island and one in the Bronx. In 1971, an additional \$800,000 was allocated to the full-time group in Queens. Decisions by the Board of Directors on these matters were unanimous. Indeed, the Board of Directors was reported by several respondents as being "united" in its intention to secure reorganization in H.I.P. At this time, the unions favored reorganization. One labor leader was reported to have told the President of the Health Plan to "fix this

thing faster or it's going down the drain." The administrator of one medical group reported in an interview that at the time the "Board said we must get regionalization for everyone in two years."

As we have noted, H.I.P. had always operated with limited financial resources; therefore, the expenditures of approximately two million dollars represented a substantial financial risk. Even before approval of these funds, H.I.P. experienced specific financial difficulties. In 1969, the need for funds led to a request to the State Insurance Commission to spend monies on operating expenses that had originally been allocated for hospital acquisition. The expenditures approved by the Board of Directors in 1970 for the full-time groups could not be met at current income levels. As allowed under recently altered state insurance laws, the administration of H.I.P. paid these costs out of the standing reserves of the Health Plan, which would have to be replenished through a rate increase. Only by an increase, to be paid by the contracting groups, was it possible to carry this program forward. Approval for such an increase was required first from the state Insurance Commission, and then from the contracting groups of H.I.P. As we have indicated, the City of New York is the largest single contracting group, so its acceptance of the increase would be crucial to the Health Plan (the City enrolls its employees and Medicaid recipients, who constitute more than 55 per cent of the total H.I.P. enrollment). However, the administration of H.I.P. began to distribute the funds authorized by the Board of Directors, prior to receiving approval from either the State Insurance Commission, or the City of New York. It

was assumed by H.I.P. officials that the increase would be approved. The administrators believed they had received assurances from the labor unions to exercise their influence on the City to secure approval; the City had not previously refused a rate request; the medical groups appeared to accept reorganization, as indicated by approval of the expenditures for the full-time groups; and the moment to institute reform appeared to be at hand, given the initiatives from the national government. Nonetheless, until the rate increase was approved, the Health Plan was in a precarious financial position, a situation exacerbated by the effects of inflation. The sufficiency of one resource - money - was in doubt in early 1970 and 1971.

The continued availability of another key resource - medical personnel - also became uncertain. Medical group representatives on the Board of Directors approved the allocation of funds to the full-time medical groups, but their constituents, the medical group physicians, may not have agreed with these actions. When contracts were drawn for all the medical groups that would involve elements of reorganization, particularly the full-time commitment by physicians and the merger of smaller groups, opposition became apparent among nearly all the groups in the Health Plan. Negotiations with the medical groups were begun six months after the first authorized expenditures to the full-time groups, and they required one year to complete. The difficult character of these negotiations was described in the 1972 rate request:

At the outset of the negotiations most of the medical groups found the program which had been presented to them to be unacceptable. The program called for a completely new kind of commitment

to the Plan in the form of a transition to full-time group practice by the physicians. The sweeping nature of the restructuring proposal gave rise to intense and protracted negotiations (1972:3).

In interviews, a medical group administrator bluntly described the attitude of the medical groups: "It was obnoxious to the groups." A member of the health professional's interest group on the Board of Directors characterized the attitude of the majority of the medical groups as, "Just leave us alone," and a health professional summarized: "Most didn't want change."

Through negotiation, joint agreement was reached between H.I.P. and the medical groups, but the contract was modified to permit the shift to full-time service to take place over a period of a few years, rather than one, and allow more time for medical group mergers to take place. The negotiation process was summarized in the rate request:

On August 1, 1971, five of the thirty-one medical groups eventually negotiated and ratified the terms of the new contract. A sixth group joined them on September 1, 1971, bringing the total enrollment covered by the groups under contract to approximately 215,000 or 29% of the total enrollment. It was not until November 1971 that the remainder of the groups (except one) agreed to the ratification of the new contract with certain modifications. One medical group has refused to sign the new contract and, it is anticipated, will shortly be leaving the Plan (1972:3).

While the rate request was pending, and after the contract had been signed by the medical groups, ten of the groups challenged the exclusivity clause in the contract, limiting their right to offer services to organized groups other than H.I.P. enrollees. These ten groups seemed prepared to leave the Health Plan unless the clause

was altered (see p. 72 for a description of this clause). While the lawsuit on the matter was pending, the financial situation of the Health Plan worsened, resulting in a halt of payments to the full-time groups. Some members of these groups also threatened to leave the Plan. They demanded that the contract requiring reorganization be approved, and that promised funds be provided. A member of the Board of Directors reported to the Joint Consumer Council:

Those groups with the best service and the lowest rate of dissatisfaction are the hardest hit. Physicians of these groups have been calling the Board - unless costs in regionalization are forthcoming the group may disband. Physicians, in expectation of payment over a period of years, have homes that are mortgaged. This is very real. They're just like us. You buy a house or car expecting a raise.

The leader of the consumer council of one of these medical groups reported to the Joint Consumer Council that his group "might seek affiliation outside H.I.P. and may do so rapidly."

The lawsuit instituted by the medical groups, the continuing opposition of the majority of the groups to proposed reform and the threat of full-time groups to leave the Plan meant that continued membership of some of the groups could not be taken for granted.

The enrollment declines of 1969-1970 masked some of the changes that were taking place in the overall enrollment base of H.I.P. When the Plan began providing service in 1947, 88 per cent of the enrollees were city workers or their dependents. Over the years, the Plan broadened its enrollment base to include additional trade unions, federal employees, and welfare recipients involved in demonstration projects.

TABLE 3

SOURCE OF ENROLLMENT OF PERSONS INSURED BY HIP

1949 - 1973

Sources	1949	1955	1959	1965	1968	1970	1973
City of New York	87.8	69.2	54.7	60.9	55.6	55.8	55.0
Trade Unions	6.1	17.2	19.9	15.8	14.1	11.9	12.6
Other Groups	4.5	7.9	7.1	10.2	10.5	11.5	13.8
Non-Group	1.6	8.3	8.3	9.2	9.2	9.6	9.9
(MEDICARE)	-	-	-	-	(2.9)	(3.4)	(4.1)
Medicaid	-	-	-	-	10.6	11.2	8.7
Total	100%	100%	100%	100_	100%	100%	100%
ENROLLMENT	(229,208)	(470,870)	(559,669)	(699,206)	(783,829)	(749,559)	(758,275)

Source: H.I.P.

TABLE 4

HIP AGE DISTRIBUTION BY MEDICAID ENROLLMENT

1970

Age	% of Total Enrollment	% of Non- Medicaid Enrollment	% of Medicaid Enrollment
1 - 4	6 %	6 %	9 %
5 - 14	22	20	31
15 - 24	14	14	16
25 - 44	23	24	15
45 - 64	25	27	9
65 -	10	9	20
Total	100 %	100 %	100 %
	(74,476)	(65,992)	(8,484)

Source: H.I.P.

Based on a 10% sample of enrollees.

In 1968, H.I.P. began to enroll persons eligible for Medicare and Medicaid. By 1970, more than 100,000 of these individuals had been enrolled in the Health Plan, 80,000 of them being Medicaid eligibles. At the same time, enrollment from trade unions and city workers fell by approximately 38,000.

The population brought into H.I.P. through Medicare and Medicaid, and particularly through Medicaid, was different in several key respects from the population that had traditionally enrolled in the Health Plan. Unlike unionized workers, Medicaid and Medicare enrollees were not part of a group structure with elected officers. They had no designated representatives participating in decision-making bodies of H.I.P. One member of the Joint Consumer Council described these two populations as the "area in-between" because they, unlike enrolling groups, were "without representation" on the Board of Directors. The new enrollees lacked the franchise in an organization in which representation for different interest groups had become an accepted principle. Lack of representation for this new population, particularly for those receiving Medicaid, was one of the earliest issues brought forward by the H.I.P. consumer movement, as we describe in the following chapter.

Workers, particularly unionized workers, had always belonged to H.I.P.; now a population that contained unemployed persons was brought into the Health Plan. As workers, the enrollees of H.I.P. were members of the middle or lower-middle classes, while Medicaid enrollees were drawn from a poverty population. While figures on enrollment by ethnicity were not available, it was generally believed that the Medicaid population in H.I.P. contained a higher percentage of blacks and Puerto

Ricans than was found in other enrolling groups in the Health Plan (enrollment statistics maintained by H.I.P. did indicate that Medicaid enrollment was greatest in those medical groups located in minority areas of the City, such as East Harlem, Bedford-Williamsburgh and the South Bronx). Medicaid and Medicare enrollment altered the age mix of the H.I.P. population, as Table 4 shows, bringing in a population with a higher percentage of children and of the elderly. The Health Plan had a new constituency, and several authors note that this type of organizational shift can lead to membership in decision-making bodies for representatives of the new groups (Selznick, 1949).

In sum, in the early 1970's, H.I.P. faced uncertainties with regard to the basic resources for organizational survival - clients, personnel, and income. New organizational policies produced unanticipated consequences in regard to each of these resources. Together, those uncertainties posed a basic threat to the continuing stability of the Health Plan. In general, under such circumstances, crisis management is needed rather than routine management, and leadership changes are likely to take place (Selznick, 1957). What is required are leaders who can adequately define the organization's goals and secure support for these goals, particularly in the external environment (Selznick, 1957).

These were precisely the functions that H.I.P. required its leadership to perform in the early 1970's if survival was to be secured.¹

1. We are referring to survival of the organization in the form in which it then existed.

H.I.P. needed assurances that the flow of resources to it would continue. Those able to control this flow of resources would be in a better position to exercise power within the Health Plan than would other persons. In the case of H.I.P., one significant resource in the early 1970's was money, since the Health Plan would be in an unstable financial position until the rate increase was approved. As we have indicated, approval from the City would be needed in order to obtain the rate increase. Those able to obtain approval, or to influence the City decision with reference to approval, would have control over the availability of a needed resource to H.I.P. A second resource was personnel. Some agreement would have to be reached with the medical groups to ensure their continued participation, unless the organization was willing to function without a number of the medical groups. A third element was clients. Stability of enrollment, and even increases in enrollment, would be needed to avoid stagnation or decline in this respect. Acknowledging the relationship between power and resource control, the administrator of one of the H.I.P. medical groups commented: "It's not the consumers (enrollees) who are paying the premium, it's the labor unions. Whoever holds the welfare funds, holds the pursestrings. The consumer who holds the pursestrings is the effective one."

Two of the interest groups in H.I.P. provided control over needed resources - the labor unions and the medical groups. Yet, neither of these groups had originated the effort to redesign organization goals and alter the existing organization structure. The interest group most desiring change - the health professionals - was the least able

to command resources needed to carry out the changes. The health professionals needed the other two interest groups. The medical groups had already registered their opposition. What would the unions do?

ACHIEVING LIMITED ORGANIZATIONAL REFORM

The Union Role

The prerogative of offering H.I.P. as a health care benefit to municipal workers was a "management decision," stated a former member of the City's Office of Labor Relations in an interview; the benefit was provided "unilaterally" by the City without consultation with its employees, stated a consumer leader. Unions representing city employees enrolled in H.I.P. did not have authority to participate in the determination of such matters, but they did have influence. By the early 1970's, the municipal unions demonstrated more influence over city decisions with regard to H.I.P. than did other members of the Board of Directors.

In the late 1960's New York's municipal unions gained a higher degree of participation in New York City political affairs than they previously enjoyed. In 1970, there were approximately 222,000 unionized employees, an increase of approximately 42,000 over the number in 1967¹ (New York City, 1970). Unions representing New York City employees

1. Throughout the nation, membership in public employee unions rose markedly during the decade of 1960-1970, as state laws prohibiting the unionization of public employees were removed and the number of such employees increased. It is estimated that membership in public employee unions doubled from 1956 to 1966 (Wellington and Winter, 1971). In the City of New York, unionization proceeded slowly until the passage of the Taylor Law by the state legislature in 1965, but proceeded rapidly thereafter.

reached the highest levels of membership they had ever achieved. Negotiations with the City for periodic contracts produced major pay increases, as well as increased fringe benefits. The unions were able to deal with the City on a relatively equal basis, as partners in the collective bargaining process.

At the same time that their membership grew, unions developed an interest in the health field that they had not previously shown. Municipal unions in the City of New York had primarily been interested in wages, pensions and job security (Schweppe, 1948; New York Times, August 8, 1967), but by 1968, perhaps spurred by the large health and welfare funds they were acquiring through collective bargaining agreements, the unions formed committees with city representatives to discuss health matters relating to municipal employees. Deliberations between city workers and the city government included discussions on a number of health matters affecting city employees. For example, in 1968, the Health Benefits Policy Committee was formed, consisting of administrators from city agencies, union leaders representing municipal employees, and a representative from the City's Office of Labor Relations. In 1972, the committee engaged in a study "determining total costs, unit costs and evaluation of administrative machinery efficiency" of different types of health insurance coverage for New York City workers, including plans in competition with H.I.P. (Comprehensive Health Planning Agency, 1973). The unions lacked the authority to decide which health plans would be available to their members, but they had influence over city decisions in these areas, and they had frequent contact with city officials responsible for such decisions.

Union leaders attended meetings with the head of the Department of Personnel of the City, who also represented the City in negotiations with H.I.P. on premium rates and contract provisions. A Board member commented that "municipal unions are a potent force in these negotiations" between H.I.P. and the City. No other members of the Board of Directors had this type of contact with the City. The President of H.I.P., responsible for negotiating the contract and the premium rate for the Health Plan, did not have such contacts, and may not have fully understood the negotiating process as carried out by the City of New York. One member of the Board of Directors commented that the President made "mistakes" in dealing with the City's Director of Personnel: "I think he saw him as a civil servant rather than as a policy-maker, which he was. He was the city position." Another member of the Board of Directors noted the existence of personal friction between the H.I.P. President and the Director of Personnel.

In 1972, H.I.P. sought approval from the City and the State Insurance Commission for a rate increase of 36 per cent, a figure which reflected the needs of the broad changes that were part of reorganization. The management of H.I.P., and the President in particular, were sure that the increase would be accepted by the City and approved by the Commission, and therefore had already begun spending the anticipated new revenues. However, at hearings held by the Commission the City objected, claiming that H.I.P. did not need an increase. Previous union support was replaced by resistance. Instead of urging the City to approve the increase, the unions encouraged the City to reject it. At the time discussions with the City were taking place, union leaders attended a meeting with H.I.P.

administrators and city negotiators, and, reported a medical group administrator, "instead of backing them, the (union leaders) pulled the rug out from under them; they said, 'you managed the Plan badly'".

There was a great deal of discussion of this change in union position both within H.I.P., and in the local newspapers. Union leaders stated that the full cost of reorganization was never presented to them; those in favor of reorganization stated that costs were detailed. We cannot ascertain the truth or falsity of these claims. We can, however, speculate about the behavior of the unions, using the perspective of sociological conception of organizational behavior. We can identify factors that were pertinent to the union decision, even though we cannot establish the precise sequence of events culminating in that decision.

The union leaders in H.I.P. may be described as being in a position of status conflict, similar to that of an individual who is exposed to cross-pressures from status partners. On the one hand, the majority of medical groups opposed the goals of reorganization, had rejected moves in that direction, and wished to keep the existing H.I.P. structure. On the other hand, health professionals were firm in their view that the Plan should evolve in the direction of the prepaid group practice model. From their point of view, contract conformity had been shown to be an ineffective means of obtaining improved care. Only through major structural change could care be improved; it was time to move the organization in the direction which health professionals had long believed appropriate.

Unlike the medical groups and the health professionals, the unions did not have a set of structural goals for H.I.P., nor a sense of the direction in which the Health Plan should move. The unions wanted a health plan that provided maximum care at a minimum cost, in which the medical groups followed prescribed standards of care, and subscribers had few complaints about the system. One union leader on the Board stated: "The union interest in this is to have a functioning organization that will leave them free of complaints." Labor leaders did not share the conviction of the health professionals that major structural reform was the only way to achieve improved services. If pressure could be exerted upon the medical groups in the form of "policing," as one labor leader phrased it, then there could be greater conformity, resulting in improved care and higher subscriber satisfaction. While the unions were disturbed with the failure of contract conformity activities in the past, they were not willing to give up that approach; they did not accept the argument that reorganization was the only effective route to an improved Health Plan.

In their quest for maximum care at minimum cost the unions confronted a dilemma. Should they seek higher wages for their members, or greater health benefits? In his study of union involvement in health care, Muntz (1967) describes this as an ever present question for all unions and, in many instances, unions have chosen to seek higher wages (New York City municipal unions do not pay the premiums to H.I.P.; these are paid by the City of New York. However, if the City increased its payments to H.I.P., there might be less money available for wage benefits to employees). The problem, as it confronted municipal unions in H.I.P., was described by a union member on the Board of Directors:

They (union leaders) must face the problem of discontented members. And there is still the problem of - give me the \$5.00 [salary instead of health care benefits]. The whole question of group care is given lip service and little else.

Question: "Would that apply to union leaders?"

The union leaders who go into it are people with ideals, who see H.I.P. as a social, as well as a medical, answer. They try to keep H.I.P. as not fee-for-service.

A member of the health professional interest group commented:

There are times when they are more concerned with H.I.P. and times when they are less concerned. They are less concerned if they are in the middle of a major wage struggle. They are less concerned with fringe benefits. If they are less concerned with wages and want to get goodies, they would do fringe benefits - that's a goody.

The dilemma of the unions was compounded by economic difficulties experienced by the City of New York in 1970, as a result of national inflation and a mild recession. The government's efforts to reduce costs were focused on expenses related to city employees. Nearly 500 city workers were laid-off, the first time this had occurred since the Depression of the 1930's (New York Times, November 19, 1973). The atmosphere for increasing employee benefits, both in terms of wages and health benefits, did not seem promising.

Union leaders on the H.I.P. Board of Directors turned to their peers in the city labor movement for support of reorganization and the accompanying premium increase. They sought the approval and assistance of the Municipal Labor Committee, a group representing most of the unionized city workers, but they did not win the Committee's support. Instead, as the minutes of the H.I.P. Board of Directors stated, the

Municipal Labor Committee "tended to sympathize with the City's financial plight and to act merely as an intermediary in the negotiations with the City instead of giving all-out support." Labor leaders on the H.I.P. Board were separated from their **peers** on this issue.

Underlying these factors, was a growing interest among the labor leaders on the Board of Directors in securing a stronger leadership position for themselves in H.I.P. The President of the Plan had effectively controlled the establishment of policy by taking the initiative in developing the reorganization plan. He had done more than administer the Plan; he had expanded the influence of his office by setting organizational goals the Board initially accepted. But who should establish policy in a service organization - an appointed President or a Board of Directors? It is, of course, common for policy control to lie with administrators, for they have both the expert knowledge and the full-time organizational involvement that permits recognition of significant organizational issues and the development of proposals for meeting these. In contrast, Board members appear periodically at meetings; they are concerned with the issues pertinent to the organization in which they earn a living. As a consequence, administrators are able to define the framework within which policy issues are discussed by boards of directors, as well as develop the specific alternatives for meeting these issues. Administrators may be able to limit the matters brought before a board, thus turning policy decisions into administrative decisions. This pattern of leadership appears to have characterized H.I.P. One Board member provided the following account:

You go to a Board meeting one time a month. You have other things you're doing. You cannot give it your full attention, so you cannot spend full time finding out what the facts are. You don't know what's happening. You have a two-hour meeting. You have lunch, then you have a meeting, and then you are gone. A month later you come back. If management doesn't present things to the Board - and many things aren't - they become administrative decisions, or if they go to part of the Board, or if they are presented in just a casual way. They say there are a few problems here, so we've hired a guy to work on a few things. So you say OK.

The labor leaders on the Board of Directors accepted the leadership of the President, but beneath their acceptance lay a smoldering intent to assert their own power. This would not be done by assuming an active role on the Board of Directors in competition with that of the President, but by replacing the President with someone new. One respondent described the unions as "gunning for" the President for some time. A member of the Board of Directors commented that a key labor leader on the Board was "not a Johnny-come-lately" to the effort to remove the President since he "had been working on this for many years."

Union interest in securing a greater degree of leadership control over H.I.P. occurred in the context of their already expanded role in the determination of health care policy in the City of New York, as represented by membership in such bodies as the Health Benefits Policy Committee. The same labor leader allegedly seeking removal of the H.I.P. President was described as interested in becoming the acknowledged spokesman for his peers in the City on health matters. A health professional stated: "He wanted to be the labor person to

influence health policy" in New York City. Why not advance that purpose by gaining effective leadership control over H.I.P.? To do so required replacing the President, particularly since his views regarding the future direction for H.I.P. were not shared by the unions. It would appear that interest in replacing the President awaited an appropriate opportunity.

In sum, the unions were not fully convinced that the only means of improving the Health Plan was through reorganization. Yet, they were asked by the health professionals to secure resources needed for the success of reorganization. Members of the labor community in New York opposed reorganization and failed to offer assistance to achieve it. Any increased costs for reorganization would be borne by the City of New York, with the likelihood that the City would then reduce the monies available for wage increases to the union members. How would union members respond if they received minimal wage increases while premium payments were raised to a health plan that fewer of them were joining, and that bred dissatisfaction among those members who did join? Would union members feel less positive about their union leaders for pursuing such a policy? Perhaps this was the opportunity to ease the President of H.I.P. out of office and establish the policy control that union leaders sought.

In our view, the combination of these factors led the unions to withdraw their original support for reorganization. When H.I.P. asked the City to provide a premium increase of 36 per cent, the unions failed to use their influence to urge the City's acceptance.

Limited Reform and Leadership Change

The City offered the Health Plan a 10 per cent rate increase. If the City adhered to that figure, H.I.P. faced financial danger, particularly since the organization had already begun to provide money to some medical groups in the expectation that the full increase would be approved. The unified union-city position placed the Health Plan in financial jeopardy. The survival of the organization as an independent prepaid group practice was in doubt. The reorganization program developed by the President had been rejected by the unions and the City, and was challenged by the medical groups.

Leadership changes in H.I.P. now took place. The President and Vice-President of the Health resigned. A five-man management team composed of members of the Board of Directors was appointed by the Board, and was given the responsibility of operating the Health Plan in the absence of a President. The head of the management team was the trade union leader earlier identified as seeking to oust the President. He was closely associated with key leaders of the City's municipal unions. He was described in one newspaper article as a "friend and ally" of the President of the largest civil service union in New York City (New York Post, September 11, 1972). Their relationship was similarly described by several of our respondents. The trade union leader was described in conversations with H.I.P. personnel as "the head of H.I.P." Thus, the unions gained an important degree of control over the Board of Directors and the Health Plan.

The systematic reorganization conceived by the health professionals was not adopted. Instead, selective portions were used as guides for

future action (Group Health and Welfare News, June, 1974). Recruitment of full-time physicians was intensified. By May, 1974, sixty additional full-time physicians joined H.I.P. Hospital affiliation moved forward slowly, but progressively. Medical groups in two boroughs established cooperative arrangements with local institutions, and a medical group in Nassau County began discussions with a local hospital. Under union leadership, H.I.P. continued to emphasize contract conformity, rather than reorganization efforts. New procedures were established for peer review by physicians. An Office of Ombudsman was created to deal with patient complaints, particularly those relating to financial claims against the Plan. Minor changes took place in H.I.P., while the basic structure remained as it had been for more than 23 years.

Whether, and to what extent, the unions tried to create the crisis in H.I.P. that led to their increase in power in the Health Plan, cannot be ascertained in this research. Such allegations circulated within H.I.P. A newspaper article quoted the former President as stating he was "booby-trapped" and, the article continued, the head of the five-man team was "openly pleased" at the departure of the President and was generally believed to have helped maneuver his ouster (New York Post, September 12, 1972).

Again, we cannot ascertain the truth or falsity of such claims. We can say that in this organization there was tension between the different interest groups. We can say that each interest group perceived the goals of the organization differently, and its members acted, both

to maximize the likelihood of realizing their desired goal, and minimizing the likelihood of realization for competing goals. We can say that where organizational survival is threatened, leadership changes are likely to occur, and these tend to result in greater power to those in control of needed resources. Given the existence of an organization crisis, the control by the unions of needed organization resources, the existing schisms between interest groups and the different views among interest groups as to the appropriate future course for the Health Plan, it would not be surprising if the unions did actively seek a greater role in policy determination and policy execution.

CHAPTER VI

THE DEVELOPMENT OF CONSUMER COUNCILS

The development of consumer councils was continuous with the events described in the preceding chapter. The H.I.P. councils grew out of the efforts of health professionals to achieve reorganization of the Health Plan, the efforts of labor unions to achieve new patterns of leadership control and greater contract conformity, the influx of Medicaid enrollees from 1968 to 1970, the uncertain economic position of the Health Plan, the emergence of consumer participation as a social movement, and the potential availability of federal funds to prepaid group practice plans with consumer participation units. The readiness of the interest groups in H.I.P. to develop a system of enrollee representation derived from a convergence of common interest among them which simultaneously co-existed with various negative attitudes toward the formation of consumer councils. The Plan's enrollees began organizing in 1970 to seek both representation in the Health Plan's decision-making system, and improvement in levels of care. The acceptance of the idea of consumer participation by the interest groups and the efforts of the consumers to obtain participation resulted in the creation of councils in 1971.

ORIENTATIONS TOWARD FORMING CONSUMER COUNCILS

In our interviews, we asked respondents to chronicle events that led to the formation of consumer councils, to describe their own attitudes

toward the formation of councils, and to describe the attitudes of other interest groups. Typically, a respondent was asked, "As you see it, how did consumer participation start in H.I.P.? " and "How would you characterize the attitudes of the different groups on the Board toward the formation of consumer councils?" The various responses to these questions, supplemented by additional interview materials, presentations at consumer council meetings, minutes of the Board of Directors, and internal memos, demonstrated a consensus among the various interest groups toward the formation of such councils. The attitudes of any given group, as perceived by others, coincided with the attitudes expressed by members of that group.

From these sources, we identified the primary orientations of each interest group toward the establishment of consumer councils. Labor leaders were primarily interested in councils as mechanisms for achieving organizational change. Health professionals were primarily interested in establishing councils in order to align H.I.P. practice with anticipated federal standards for health care organizations. The medical groups were primarily interested in maintaining the H.I.P. system as it had been; they were negatively oriented toward consumer councils, but accepted them as inevitable.

Labor Leaders

Labor union leaders were interested in changing the organizational leadership system and securing greater contract conformity from the medical groups, as noted in the preceding chapters. Consumer councils were seen as a means for achieving these ends.

As we have seen, the union's position in the rate approval controversy contributed to the resignation of the President and the Vice-President. The available evidence does not allow us to say that the union leaders' stand was taken with that objective in mind, but the data does indicate that the leaders were fully aware of how the consumer councils could help them in their attack on the President and Vice-President. A member of the Board of Directors commented that a key labor leader had been trying to remove the two Health Plan officers for some time. A medical group administrator stated that a meeting of various medical group officers was secretly called by the same labor leader in 1971 to discuss the ouster of the President and Vice-President. One labor leader did, in fact, describe the effort to form consumer councils as a response to a "crisis of leadership" in H.I.P. Several references were made at meetings of the Joint Consumer Council in the summer of 1972 to the effect that the unions were willing to seat consumer representatives on the Board of Directors in the expectation that the consumers would vote with the unions to remove the two officers of the Health Plan. At these meetings, several members of the Joint Consumer Council described consumers as being "pawns" of the labor unions. In an interview, an official of the Joint Consumer Council reported that one labor leader stated, "I needed them (the consumers) for the two seats to get rid of the President and Vice-President."

In the second area of change - contract conformity - union leaders on the H.I.P. Board of Directors had consistently pressed for increased contract monitoring and stronger efforts at contract enforcement.

Members of this interest group tended to perceive consumer councils as potentially able to aid in achieving these ends. A key official of the Health Plan described the union view:

There had been increasing criticism - labor contractors were not too happy with some of the service. They had a great deal to do with reaching some sort of participation. We had that big meeting - When was that? (Turning to an administrator in the office at the time) February, 1970, 1971. Some of this criticism came to a convergence. The labor unions were dissatisfied with the program. A program statement was made by a union leader at that meeting that a consumer movement should go forward. There was not a mass swelling of support. The interest developed out of an interest of a few people.

The events that apparently occurred at that meeting were described in the minutes of the Board of Directors:

Labor members of the Board suggested that the discussion center on means of overcoming existing deficiencies in H.I.P. and raising the standards of performance of the weaker medical groups to the level of performance of the best groups. To this end they recommended that the administration create a Department of Consumer Affairs in the central office whose function would be to help subscribers set up consumer advisory councils in each medical group.

The poor quality of service provided by some of the H.I.P. medical groups had disturbed union leaders in the past. A persistent organizational goal of this interest group has been improvement in levels of service. In an interview, one labor union leader cited the "uneven level in quality of medical care" offered in the Health Plan. Later in the interview he linked improvement of services with the operations of consumer councils, and the following exchange occurred:

The consumer movement would serve as a vehicle for two things. One, get enforcement of the contract and have the groups involved in making H.I.P. a cooperative medical undertaking.

Question: "When you say a cooperative undertaking, what do you mean?"

Answer: An instrumentality to cooperatively resolve areas of problems experienced by the consumer who pays the premium.

Connecting consumer councils to the provision of service by physicians is also evident in this comment by another labor leader on the Board of Directors:

The physician might have his own private patients that he takes before H.I.P. patients. The Consumer Council could look into this . . . keep the doctor on his toes in the manner he treats patients, and do something about priorities. Maybe they are not seeing patients after surgery. There are all kinds of things.

Labor leaders identified potential activities for consumer councils, and these were in the matters of contract conformity and effecting leadership change. Labor leaders had begun to define an appropriate organizational role for the council. In contrast, neither the health professionals, nor the medical group physician had clear conceptions of the role the consumer councils would play.

The Health Professionals

While labor leaders tended to view consumer participation in terms of local H.I.P. issues, health professionals in the central unit tended to view consumer participation in the context of federal initiatives in the medical field. A staff member of the Department of Consumer Affairs states: "The legislation in Washington call for consumer involvement. That's what we're moving toward." The minutes of the Joint Board stated:

Since the proposed legislation on HMO's will make consumer councils mandatory, the President of HIP considered it wise to proceed with this program as rapidly as possible.

Labor leaders were relatively unconcerned with federal mandates for consumer participation. The different views of labor leaders and health professionals emerged in the interviews:

With a health professional: "Do you think the existence of government programs has anything to do with the formation of councils?"

Consumerism is here. Both bills before the legislature, neither of them passed yet, one says consumer participation should be meaningful and one says it should be significant.

With a labor leader: I asked him whether he saw a move from the government toward consumer involvement. He replied, "No." I said many people say consumerism is coming. He replied, "It doesn't look that way to me."

Health professionals sought compliance with federal mandates, but in discussing consumerism as a movement, there were indications of ambivalence among some members concerning its usefulness in the health field and a questioning of the motives of consumers who become active. Health professionals seemed to ask what role consumers could really play in a health care organization, and why they were interested in any role at all. In effect, health professionals accepted the inevitability of a federal mandate, but questioned its wisdom. An administrator at central H.I.P. commented:

There are a thousand issues, if you want to devote yourself to a cause - Vietnam, civil liberties. There a number of voluntary organizations a person can join. I don't see why he would focus on health unless he has a personal stake - he is a health professional

or has some personal experience in the health system. That somebody would voluntarily give up their time and effort to improve HIP - why should he do it?

In an interview, another administrator remarked, "What do they bring to the Board of Directors? Demands for improved services that may or may not be specific." A few minutes later he commented, "Consumers bring not great expertise into the system. Maybe it's part of a check and balance system," and he shrugged his shoulders.

The specific roles that union leaders anticipated for consumer councils in contract conformity were not mentioned by health professionals. While members of this group expressed concern for contract adherence and the achievement of high levels in the quality of care, attainment of these ends was not linked to the development of consumer participation. One administrator at H.I.P. expressed his interest in greater contract adherence and accused the unions of having failed to act in a manner that would achieve this goal:

I wish the unions had been as interested five or ten years ago as they became last year. The unions have not been very demanding; they should have asked for audits . . . They should know how their patients are being treated . . . They should have asked for greater accountability. The unions and all the contractors went after problems in a hopeless piecemeal fashion. They would get one member complaining about Dr. Zilch did such and such, so the union leaders deal with that problem. I don't like to use the word counterproductive - let's just say it takes the pressure off. He apologizes to you and you think the problem is solved or maybe he leaves; but the problem is a long way from being solved.

The same informant did not identify any role for consumers in achieving contract conformity; he called for a more "systematic" approach to

enforcement. Another administrator at central H.I.P., in response to a question regarding low levels of contract adherence, said:

I would acknowledge the truth of that complaint and I would not justify lack of contract enforcement, although many explanations are available for failure to enforce. You must look at the total picture.

This administrator identified some of the ways to achieve higher levels of adherence, but none of these included consumer councils.

Members of the health professional group tended to acknowledge the need for organizational change, as evidenced by their interest in reorganization, but they did not perceive change through any action consumers might take. For example, one health professional discussed the matter as follows:

Changes will take place in the system of care through legislation and financing, but not through consumers. They say you must be accountable to us, but they have the form but not the substance of participation, because they don't deal directly with the doctors. You're deceiving the consumer that he is having an influence. You can't change it by force. You can only do it in two ways - financing and education, working alongside with doctors.

In general, the approach of the health professionals toward improving the Health Plan was through the reorganization program described in the preceding chapter, bringing H.I.P. into conformity with the prepaid group practice model. In general, the approach of the unions might be termed "tinkering," in which the organization would be changed in small ways over a period of time, primarily through new approaches to contract monitoring and enforcement. Support for consumer councils was consistent with this union orientation toward the

Health Plan, in contrast to the preference of most medical groups for maintenance of current organizational patterns.

Health professionals were aware of the apparent intent of the labor unions to work with consumer councils to oust officials of the Health Plan and increase union power in the Plan. Under the circumstances, one can hardly be surprised at the reluctance of the health professionals to support the establishment of consumer councils. An elected official of the Health Plan stated:

I don't think consumer councils were the issue.
The issue was to get the President out of there . . .
They were out to get the President. That was their
objective. It was very personal, an engendered power
play.

A consumer remarked at a Joint Consumer Council meeting at the height of uncertainty regarding city approval of the H.I.P. rate request: "Somebody is out for the jobs of the President and Vice-President and they see it and they feel personally attacked."

Without necessarily pressing for consumer participation, health professionals could accept it by placing participation within the context of the cooperative movement in prepaid group practice. The administrator quoted above, who asked why anybody would want to become active in H.I.P., almost answered his own question by adding, "Of course, they do have Puget Sound," referring to the prepaid group practice in the state of Washington. Another administrator, after describing his personal "disenchantment" with "consumerism" cited an example of a "constructive type of consumerism:" "The GHA Board of Trustees - everyone belongs to GHA and gets care from GHA. That's

what I like about it," referring to the membership of the Board being drawn only from among the enrollees of the Plan (GHA is the second largest cooperative prepaid plan, located in Washington, D.C.). Another health professional admired consumer participation as it functions at Puget Sound and GHA, but thinks the consumer movement in H.I.P. cannot be sustained.

Of the persons in this group, public members may have played the most supportive role in the formation of the consumer councils. A labor leader identified the public members as among those who encouraged the formation of consumer councils. One member of this group stated that the enrollees' participation was almost inevitable in the Health Plan:

The organization of consumer councils was a potential development whose time had come regardless of what was going on at H.I.P.

It was an idea whose time was past so we had to join it.

The Medical Groups

The medical groups did not initiate the consumer council movement, nor did they positively act to further it. They accepted it, within the context of the general trend toward consumerism in society:

A physician at central HIP: "It was coincidental with the consumer movement generally."

A medical group director: "Consumer participation is a response to the prevailing idea of consumer participation in the country."

A medical group director: "It's here to stay. I guess Nader made people conscious of it. When you have people in city government, in government, in charge of consumer affairs, and consumer departments, it's here to stay."

Unlike union leaders, medical group directors did take note of a move toward consumer participation in the nation; unlike health professionals, they described this movement in general social terms rather than referring to specific federal legislation.

Acceptance by the medical groups appears to have been given begrudgingly, almost unwillingly, as evidenced by this description from a labor member of the Board of Directors:

Question: "How would you describe the attitude of the medical groups toward the formation of consumer councils?"

Reluctant. One or two already had skeleton consumer councils. They thought they were safe. That's a ridiculous idea - that you can form a group and keep it on checks and bounds. To do that you need military force.

The primary goal of the medical groups was to maintain the status quo, permitting retention of the same degree and nature of organizational power previously exercised. An administrator of one medical group, who discussed the development of consumer councils with many of the medical group directors, described their attitude:

They didn't want to see them in operation. They were afraid they would interfere with medical practice and the direct doctor-patient relationship.

After seven or eight months they said they didn't mind the councils. They felt they could control it.

A labor member of the Board of Directors stated that the medical groups were opposed to the councils for two reasons. First, "they didn't want review," referring to a system for contract monitoring, and, second, "fear of the unknown. H.I.P. was in a bad position financially. Could

this make it worse?" An administrator at H.I.P. stated, "The medical groups see it as a threat."

Just as the health professionals were aware of a union intent to utilize consumer participation as an aid in reducing their power, so too the medical groups may have been aware of the intent of the labor unions to utilize consumer participation as a means of monitoring contract adherence. In this context, it is hardly surprising that the medical groups perceived the formation of consumer councils as a threat, and that they hoped to be able to control them.

The views of one medical group director toward monitoring by consumer councils were presented in this statement:

We have many monitoring agencies. We are monitored by central H.I.P. We are monitored by the City of New York. We have just gone through a contractual agreement with the Department of Health which allows them to monitor and examine us. These are professionals and they have the ability to do it. Certainly in confidentiality of patient records - consumers have no ability. And it is against the law. If they are suggesting the place is not clean, improved, appointments, these are good suggestions. They have no authority to monitor us, nor to inspect us.

A few medical groups were prepared to meet with consumers from the very beginning, perhaps in the hope of controlling any council that might develop. The medical director of one of these groups spoke of a "partnership for health" in which all elements of H.I.P., including consumers, cooperate together. He helped to establish a consumer council "capable of self-government" at which point he gave "it over to the consumers."

THE ENROLLEES ORGANIZE

The impetus for councils among the enrollees themselves began with the organizing efforts of a former employee who, as he reported, "saw things that were wrong." He was working in the Medical Department, reviewing records of medical group adherence to contracts and identifying instances of non-compliance. His efforts in 1970 to bring these to the attention of officials at the central unit did not bring results. Notes from an interview with him contain the following summary of his own remarks:

As part of his job he looked over the yearly administrative reports filed by each medical group. These had received little or no attention in previous years, and each was a thick volume. After a great deal of work, some of it delegated to others, he found that many groups were not complying with many terms of the H.I.P. contract. When he brought the matter to the Medical Director he was ignored. He finally went to the President and was told to keep quiet. No explanation was offered as to why compliance was not sought.

He interested a leader in the Puerto Rican community, whom he personally knew, in forming an organization known as the People's Committee on Accountability. At a meeting of the Joint Consumer Council, he summarized these events:

I worked for HIP. (Tells the meeting of several contract violations) I went to the unions; I went to the consumers; I went to the community. I organized with (the Puerto Rican). We organized a campaign for services.

The Puerto Rican leader described his goals in beginning the consumer movement in H.I.P.:

Two years ago I formed the People's Committee on Accountability because we didn't have a say.

Because we don't have a say it is badly run. We want to administer and change the structure of HIP.

Other respondents confirm the role of the People's Committee as the initiator of the consumer movement in H.I.P.:

A medical group director: The consumer councils were preceded by a committee of various consumers through the HIP Plan. The People's Committee on Accountability, mostly Puerto Ricans, they were concerned with carrying out care, and the power within the Health Plan itself.

A Health Plan administrator: The movement developed out of the interest of a few people, some characters I would say were acting as professional consumers, what I call professional consumer representatives. They were the main sparks of the movement. The criticism developed from outside, from the People's Committee on Accountability.

There is some evidence to suggest that at the time the People's Committee on Accountability was forming other consumer groups were in a nascent phase elsewhere in the H.I.P. system, but they never rose to the surface and became a recognized element of the consumer movement. A member of the Board of Directors described other consumer activities in H.I.P.:

I don't know the exact chronology. I think coterminous with the People's Committee there were consumer groups already organizing. There was a group in the Bronx on services not being delivered. There were welfare groups. They were all beginning in some kind of tumult.

The Committee consisted of a handful of persons who were personally acquainted with each other and were all subscribers of H.I.P. Each had a history of involvement in the civil rights movement of the 1960's. By September, 1970, the Committee began to complain of poor service to H.I.P. officials; to demand reform of the system, including stricter contract

enforcement and elements of the reorganization program; and to seek increased subscriber representation on the Board, as well as representation for the medicaid population. The perspective of the Committee was preserved in documentary material that includes the following statements:

We are seriously concerned about the quality of medical care rendered by most of the HIP groups to our Medicaid population enrolled in HIP. With few exceptions our people are treated as second class citizens, and receive poor discourteous treatment. We call to your attention the fact that over 10% of the total HIP membership are Medicaid recipients, and that they have representation on neither the Board of HIP nor on the boards at the medical group level, nor on the La Guardia Hospital. The lack of accountability of the medical groups to the people they serve has allowed a major breakdown in the quality of medical services to occur.

No HIP medical group has a community or subscriber board.

Black and Puerto Rican employees should be hired for middle and top management positions.

In the last ten years most groups have gotten worse. The doctors have gotten older and care less, the physical facilities are deplorable . . . Each year union members are leaving HIP and the trend during the last eight to ten years seems irreversible.

The administration is unwilling to enforce the contracts with the medical groups and the Medical Control Board standards, which should guarantee a high quality of care. It is nothing more than a sweetheart contract. Where there is a sweetheart contract there is usually collusion or impotence. Do the medical groups set policy in complicity with the administration? Many have said that the Board has abdicated its responsibility.

In the previous discussion of the Medicaid population in H.I.P., we noted the lack of representation for this population in the Health Plan, and described its members as predominantly low-income, minority group persons, more of whom are below age fourteen or above age sixty-five than is true for the other H.I.P. enrolling groups. The People's Committee on Accountability pointed out these characteristics of the Medicaid population in its statements to H.I.P. An official of the Health Plan acknowledged the link between the new enrollment base of the Plan and the emergence of a consumer movement in H.I.P.:

There was support for the concept. There was general support for it in society. Especially in an outfit that was vulnerable as we were because we are non-profit, dependent upon public support, quasi-government in some respects. We do have large segments of enrollees supported by public funds - Medicare and Medicaid - so we're not as immune as General Motors or an organization from the private sector.

The Committee enlisted community support for the changes it proposed in the Health Plan. Manifestations of support included an editorial appearing in the major local Spanish newspaper, El-Diario-La-Prensa, stating that the newspaper was "seriously concerned over the rapid deterioration of medical care at most medical groups affiliated with the Health Insurance Plan of Greater New York" (October 23, 1970).

As several respondents reported, there were "wild confrontations" at central H.I.P., primarily between the President of the Health Plan and members of the Young Lords and the Black Panthers. The administrator of one medical group detailed one of these confrontations:

The People's Committee on Accountability got representatives from the Young Lords, the Panthers, East

Harlem, Central Harlem and the West Side. They actually had a confrontation with the President and the Vice-President. They were not satisfied. They wanted to meet with the Board of Directors, and their commitment was made to employ somebody to set up something on consumers. They had a big argument, people started throwing things. The administration was intimidated by them.

An administrator at central H.I.P. summarized several of the meetings of the Board of Directors that consumers entered:

There were several instances where there were delegations that came to Board meetings where staff people were very disturbed. They saw it as a threat to them in some manner, outside forces were trying to muscle in on HIP. You have to understand the Peoples Committee on Accountability did not act in a normal established manner. The language, rhetoric, was militant. The response of some staff, in thoughts not actions, was in like vein fairly militantly opposed, at least to tactics and language.

Most members of the Board of Directors that we have interviewed believe these tactics slowed the eventual development of consumer councils in H.I.P. One union member of the Board stated:

If they had worked within the organization it would have been easier for everyone. Instead we had confrontations, long statements, charges not germane at all. Everyone wore a chip on their shoulders in the meetings.

At least one Board member, however, believed that the actions of the consumers aided their cause: "If it hadn't been for the militancy, anger and resentment it wouldn't have gotten off the ground."

The criticisms presented by the People's Committee on Accountability were generally accepted as valid by the health professionals. They tended to identify elements of organizational structure as the cause for deficiencies, and chided the consumers for failing to take into

account the limitations imposed upon the Plan by inadequate financing difficulties in recruiting physicians, and medical group resistance to contract conformity efforts. The President of the Health Plan elaborated at a meeting of the Board of Directors:

Many of the allegations are based on incorrect information or show misrepresentation of the data or of the contractual obligations and Medical Control Board standards. In one case, involving payment of supplemental capitation for evening and Saturday hours to a few groups, the accusation was correct; the President acknowledged that an administrative error had been made. Some of the money was recovered retroactively, though not all because the fault lay with HIP for the error and the groups concerned did not receive proper notification. In some instances where noncompliance with standards was charged, it is HIP's considered judgment that rigid adherence to the letter of the standard would have been self-defeating because it would have resulted in a cut-off of medical care in certain specialities. Some degree of flexibility is therefore required in special circumstances.

An administrator at central H.I.P. stated that the consumer movement arose "partly because of abuses that nobody was paying attention to that were going on out there." Alluding to consumer demands for minority hiring, an administrator at central H.I.P. stated that blacks were hired for administrative posts and that "it is fair to say" this was done in response to consumer demands: "whether anybody admits it or not, whether subtly or otherwise, management became conscious of the problem and it was a problem that we needed to respond to." One labor leader agreed that there were inadequacies in the organization: "They had legitimate complaints." Medical group representatives have always tended to reject service complaints, blaming the inadequacies of the system for service delivery problems that may occur.

THE FORMATION OF CONSUMER COUNCILS

In the fall of 1970, about the time the People's Committee on Accountability was presenting demands to H.I.P. and meeting with Health Plan Administrators, a special task force was formed at central H.I.P. to explore the advisability of forming consumer councils at the medical groups. In the spring of 1971, as meetings with the People's Committee on Accountability continued, a Department of Consumer Affairs was established at central H.I.P., with responsibility for organizing councils and serving as a liaison between the councils and the units of the Health Plan. Union leaders recommended an individual to serve as head of the Department and he was approved by the Board of Directors. In September, 1971, the Board of Directors approved a set of guidelines detailing the powers of the consumer councils (See Appendix B). The guidelines assigned the following powers to the councils:

- (1) Report on physical conditions of medical centers and make recommendations for improvement.
- (2) Explore the scope and effectiveness of health services.
- (3) Assess the manner of delivery of health services at an operational level.
- (4) Assess the administrative procedures affecting the delivery of health services.
- (5) Interpret the HIP program to subscribers and the community-at-large.
- (6) Inform subscribers of the manner of organization of each medical center.
- (7) Participate in regional meetings on council activities, including recommendations on policy and action.

- (8) Develop educational programs where provider and user can learn how their attitude and behavior affect the delivery of health services.
- (9) Participate in regional meetings of medical staff and consumers representatives in area-wide planning.
- (10) Participate in regional meetings.
- (11) Record and transmit reports on council activities, including recommendations on policy and action.
- (12) Assist in the enrollment program for new subscribers.

Four consumer councils were encouraged on an experimental basis in 1971, including the Yorkville Consumer Council. By July, 1972, there were consumer councils at a majority of medical groups.

In accordance with the guidelines, each consumer council was to consist of seven to twenty-five members, depending upon enrollment in the medical group. An elaborate system was outlined for obtaining council members, based on the principle of proportional representation for each contracting group enrolled in the Health Plan. Each of these contracting groups was to choose members for the councils, with Medicare and Medicaid representatives to be selected through "consultation with local community bodies, community health federations and similar groups."

With reference to selection of council members the guidelines stated in part:

Members of the council shall be representative of the subscriber components of each medical group, including branch centers. The major contractor groups - trade unions, government agencies, health and welfare agencies, and others with whom HIP has contracts - will designate members on a proportional basis.

The councils were not to be chosen directly by the enrollees, but were to be selected by the contracting groups, which would open to these

groups a direct line of communication with the medical groups that had previously been lacking in H.I.P. If labor unions wanted consumer councils to monitor medical group performance, they would be able to further this goal by selecting the people they

As recruitment of members proceeded, it quickly became apparent that the elaborate system outlined in the guidelines would not be realized. The Department of Consumer Affairs contacted all unions with enrollees in H.I.P., but only a handful of persons came forward to join the consumer councils. Letters to union members from union officials, meetings with union members by organizers of the Department of Consumer Affairs, and notices in union newspapers, elicited few responses. One union leader characterized the response as "glacial." Union leaders on the Board of Directors may have believed that rank and file members would be willing to serve on consumer councils, but few of them did. Approaches to community groups, including those in the minority communities, also drew a minimal response. Meanwhile, the medical directors of the groups were contacting enrollees whom they knew and whom they asked to join the councils. Announcements were posted on bulletin boards in the medical centers, urging enrollees to join their local council. In some instances, subscribers were notified by mail of the first meeting of the councils of the medical group in which they were enrolled. Slowly, a nucleus of a few people developed in a number of medical groups, forming a council, with occasional meetings held for all interested enrollees. By July, 1972, a majority of medical groups had functioning councils. By that time, the H.I.P.

wide consumer council was formed, the JCC. By July, 1973, there were councils at nearly every H.I.P. medical group. In our next chapter, we examine the formation, structure, and operation of one of these councils.

CHAPTER VII

THE FORMATION OF THE YORKVILLE/CIRCLE MANHATTAN CONSUMER COUNCIL

While other medical groups generally resisted the formation of consumer councils, the Yorkville Medical Group encouraged the establishment of one. In this chapter we identify underlying conditions leading to the formation of the council, including changes in the membership base, encouragement from the H.I.P. Board of Directors, and the organizing acts of the consumers themselves.

THE YORKVILLE MEDICAL GROUP

The medical center of the Yorkville Medical Group¹ is located in Manhattan on 84th Street, between Third Avenue and Lexington Avenue. Most of its enrollees are local residents from the area of 59th Street to 125th Street, Fifth Avenue to the East River. To the north of the center, beginning at approximately 96th Street, is the community of Yorkville. The Group is housed in an apartment building, and has its own private street entrance. The center occupies two floors, contains a number of examining rooms, various diagnostic facilities, one large

1. The Yorkville Medical Group is referred to as "the Group" or as "the Yorkville Medical Group" in this paper.

waiting room and several small waiting rooms. Two receptionists answer the telephones and handle appointments. The center is light, clean and modern in appearance, but without such amenities as upholstered chairs and rugs. The medical group has a staff of 32 doctors. Eight of the physicians serve full-time, with practices limited to H.I.P. subscribers. Six of the full-time physicians are family practitioners, and two are pediatricians; the specialists in the group serve part-time.

UNDERLYING CONDITIONS LEADING TO THE FORMATION OF THE YORKVILLE/CIRCLE
MANHATTAN CONSUMER COUNCIL

In 1970, the medical group had an enrollment of approximately 28,000 persons. Patterns of enrollment in this group are consistent with patterns we have described earlier for H.I.P., but with some major variations, as detailed in Table 5. As in H.I.P. as a whole, enrollment from municipal workers and trade union members declined from 1968 to 1970, while Medicaid enrollment increased. However, both the number and the percentage of enrollees from among city workers and trade unions declined in this medical group, while increased Medicaid enrollment was so great that it created an overall enrollment rise, as contrasted with an enrollment decline in H.I.P. as a whole. In our earlier review of conditions leading to the formation of consumer councils in H.I.P., we noted the significance of the rapid rise in Medicaid enrollment within H.I.P. in the late 1960's, reaching 11 per cent of the total enrollment in 1970. In the Yorkville Medical Group, the enrollment had been enormous, so that by 1970, 60 per cent of the group's enrollees were Medicaid recipients.

SOURCES OF ENROLLMENT OF THE YORKVILLE MEDICAL GROUP BY PER CENT
¹
 1965 - 1970

Source of Enrollment	Yorkville Medical Group			HIP
	1965	1968	1970	1970
City of New York	49 %	37 %	21 %	56 %
Trade Unions	29	28	14	12
Other Groups	15	4	2	11
Non-Groups	7	6	3	10
Medicaid	-	25	60	11
Total	100 %	100 %	100 %	100 %
	(9,180)	(17,090)	(28,080)	(744,554)

Source: H.I.P.

1. The figures for the Yorkville Medical group are from a 10% sample randomly drawn. The figures for H.I.P. were originally drawn from a 10% sample and generalized to the entire population by H.I.P.

We also note that the percentage of enrollees in the Yorkville Medical Group drawn from among city workers is lower than the percentages for H.I.P. as a whole. For example, in 1965, about 48 per cent of enrollees in the Yorkville Medical Group were derived from this source, compared with 55 per cent of H.I.P. enrollees. In 1970, only 20 per cent of the enrollees in the medical group were city workers or members of their families, but this group still constituted more than 50 per cent of the total enrolling population of H.I.P.

Medicaid enrollment in the Yorkville Medical Group resulted from specific policy decisions reached by H.I.P. and the medical group itself. Central H.I.P. negotiated with the Department of Social Services of the City of New York and the Social Security Administration to permit the enrollment of Medicaid recipients in the Health Plan, under specified conditions, with premiums for these enrollees to be paid by the government. Each medical group in the Health Plan could participate in the enrollment program at its option. The Yorkville Medical Group decided to do so.

This decision was consistent with the previous actions of the Group, such as providing health care to poverty populations in the area through experimental, government-sponsored programs. The decision was also consistent with the innovative image of the group established over a period of many years. The physicians who founded the group were primarily European refugees from World War II, described by the group administrator as "pioneers," "idealistic" men with the courage to leave their homelands and begin careers in a new nation within a

new organization. In more recent years, the administrator noted, the group "started new programs before they caught on. Before Medicare, we had a program for the old on welfare." He noted that the group offered a special adolescent health care program, which was the only one of its type in the H.I.P. system. The group was one of the first to participate in an experimental multiphasic screening program that functioned for several years in H.I.P.

The pioneering image of the group was pertinent to its activities with Medicaid eligibles. As we have noted, Medicaid recipients were drawn from a poverty, minority population. Nobody could be sure what would happen when this population was integrated into the H.I.P. system, which had always served an employed, lower middle and middle class population. In a similar situation, the Kaiser-Permanente Plan conducted a study in Portland, Oregon to determine the effects of Medicaid enrollment on utilization patterns (Colombo et al., 1969). The Social Security Administration, which managed Medicaid, was uncertain whether prepaid group practice could provide health care for the economically deprived in a more advantageous manner than other health care systems. The medical director of the group was ready to show that it could. He said: "I wanted to prove it's possible to deliver care to the poor through prepayment. I felt Medicaid had opened the door on this." Instead of meeting the health needs of the poor in the usual manner, through the ambulatory care clinics of ghetto hospitals or the fee-for-service system, he proposed to do so within a group practice and through the prepayment mechanism.

In terms of geographic distribution, the enrollment of Medicaid

TABLE 6

AGE DISTRIBUTION OF ENROLLEES IN THE YORKVILLE MEDICAL GROUP

FOR MEDICAID AND NON-MEDICAID ENROLLEES

1

By Percentage
1968 - 1970

Age	1968			1970		
	Total	Non-Medicaid	Medicaid	Total	Non-Medicaid	Medicaid
Under 5	6 %	6 %	5 %	8 %	4 %	12 %
5 - 14	20	21	18	29	22	34
15 - 24	13	15	7	15	12	16
25 - 44	23	23	24	23	30	17
45 - 64	20	26	5	15	23	10
65 -	18	9	41	10	9	11
Unknown	.3			-	-	
Total	100 %	100 %	100 %	100 %	100 %	100 %
	(17,040)	(12,000)	(5,040)	(28,080)	(11,700)	(16,380)

Source: H.I.P.

1. The figures for the Yorkville Medical group are from a 10% sample randomly drawn. The figures for H.I.P. were originally drawn from a 10% sample and generalized to the entire population by H.I.P.

recipients brought a population into the Group that was heavily concentrated in the East Harlem area, north of 96th Street. In terms of demographic characteristics, the enrollment of Medicaid recipients appears to have altered the age, income, and ethnic mix of the Group. In 1970, there were more children enrolled than had been previously, and the group had a higher percentage of children aged 5 - 14 enrolled than are found in the general population of East Harlem and Yorkville. Medicaid enrollment appears to have attracted households with a large number of children. Figures on ethnicity and income for the H.I.P. population were not available, but the geographical area from which Medicaid enrollment was drawn had a higher percentage of non-white residents than other areas from which group enrollment was drawn. The East Harlem area, "El Barrio," contained a large number of Puerto Ricans, and a recent survey of a random sample of East Harlem residents estimated that 45 per cent of the survey's respondents were of Latin American origin (Johnson, 1972). It is reasonable to assume that most of the Medicaid enrollees in the Yorkville Medical Group were members of minority groups.

As Medicaid enrollment increased, the group decided to open a second center, to be located within the East Harlem community. According to group personnel, its purpose was to provide more accessible care to enrollees and to permit recruitment of additional subscribers. The center would be located in a housing complex to be built by the East Harlem Tenant's Council, a non-profit neighborhood association. The complex was funded by HEW, with completion anticipated by the mid-1970's.

Responsibility for the project was given to an organization formed for that purpose, known as the Pilot Block (New York Times, March 24, 1974). The Yorkville Medical Group signed a contract with the Pilot Block to house the medical center in the project. In a memorandum of intent between the Yorkville Medical Group and the Pilot Block, the Yorkville Medical Group was declared the only medical group, and H.I.P. the only health or insurance plan to which space would be rented in the project.¹ Pending completion of the project, the center would be located on 124th Street, between Third Avenue and Lexington Avenue.

The Yorkville Medical Group specifically sought community support for the center in East Harlem. The medical director stated, "I decided for us to go to East Harlem without developing contact with various organizations would not be good." In the summer of 1970, as the center was ready to open, the group convened two meetings of community organizations. These were designed to "tell them [the community] what we were doing, what H.I.P. was," stated the medical director. A medical student helping in the planning of these meetings added that their purpose was "to establish a continuing dialogue between the community and the new H.I.P. group and to allow the community to represent itself in the formation of a board." At the meetings, according

1. The group was also given the first option on additional space within the housing complex designated for health care facilities. The written consent of both the group and H.I.P. was required before any space could be rented to any particular physician or dentist.

to persons who attended, a strong desire was expressed for some form of community participation in the East Harlem Center. A list of seven persons who might wish to participate in forming a community board was compiled by the medical student and given to the medical director, and minutes of the community meeting were sent to those attending.

In the meantime, enrollment at the East Harlem Center continued, services were being provided, and arrangements for the housing complex were moving forward. Within H.I.P., consideration was being given to the formation of consumer councils at each medical group. In September, 1970, two months after the community meetings in East Harlem, a task force was established at central H.I.P. to define the possible roles for such groups. By October, a formal report was presented to the President of H.I.P. outlining the powers, structure and methods of selecting members for consumer councils (see Chapter 6). H.I.P. was moving to formulate a Plan-wide approach to the development of consumer councils, and the efforts of the Yorkville Medical Group were consistent with these. By July, 1971, the Yorkville Medical Group was selected by the central Board of Directors as one of the first in which formation of a consumer council would be encouraged and sanctioned.

Within the community of East Harlem, few people showed any interest in joining a consumer council at the group after the initial community meetings. Whether by implicit agreement among the associations, or as a consequence of lack of interest, the Pilot Block emerged as the most interested local organization and, in effect, it became the spokesman for the interests of the East Harlem community, as well as for its own interests.

These events appear to have created the underlying conditions leading to the development of the Yorkville Consumer Council. As we have indicated, Medicaid was the source of thousands of new enrollees in a short period of time. By 1970, sixty per cent of the enrollment in the Yorkville Medical Group consisted of Medicaid recipients. These enrollees were drawn from the predominantly black and Puerto Rican population of East Harlem in contrast to the white working class and middle class enrollees of the Yorkville area. Unlike enrollees from other subscriber groups, such as unions, Medicaid enrollees were without representation on H.I.P. decision-making bodies. Their enrollment took place during an era of client participation in service bureaucracies and, specifically, in a community with a history of seeking such participation. For example, residents of East Harlem supported the move toward community control of neighborhood schools in the City of New York (Rogers, 1969). As an additional factor, the Yorkville council was forming at the time H.I.P. established a Department of Consumer Affairs, encouraging the development of consumer councils.

THE FORMATION OF THE YORKVILLE/CIRCLE MANHATTAN CONSUMER COUNCIL

The Yorkville Consumer Council

The individual who had initiated the People's Committee on Accountability lived in the area served by the Yorkville Medical Group, and received his care from that group. The Puerto Rican leader he had interested in H.I.P. was a subscriber of the Health Plan, and attended the community meetings in East Harlem. An executive officer of the Pilot Block was interested in forming a consumer council. By the

spring of 1971, the Board of Directors of H.I.P. had authorized establishment of consumer councils at four medical groups, including the Yorkville Medical Group. The head of the newly formed Department of Consumer Affairs at central H.I.P., and the first organizer hired by that department, assisted in the formation of the Yorkville Consumer Council. The organizer, a Puerto Rican, was particularly able to bring this project to fruition, as she had worked for many years as a community organizer for the East Harlem Tenant's Council, and was familiar with the neighborhood and its residents.

The organizer described her efforts to begin a council in the Yorkville Medical Group:

We didn't know how to start a consumer council, there had never been such a thing before. I went to friends who I knew were H.I.P. subscribers . . . we had long discussions about the crisis.

Question: "What did you see as the crisis at that time?"

Non-service of subscribers. The major . . . doctors coming late, uncleanliness, antiquated equipment - some of the centers have modern equipment, but some of them! I was a subscriber for many years, but I only used it for an emergency. I didn't have any confidence in the group I selected when I was in the Union. I remember I went in with a cold. The doctor spent three minutes with me. He was very cold. When he listened with his stethoscope he grunted. I still don't know what that grunt meant. So, knowing the shortcomings, and not knowing the subscribers, I figured let me scout to friends who are community-minded and articulate enough to help me.

Among those the organizer approached was a teacher, serving as an official of the East Harlem Tenant's Council. She agreed to join the council and serve as its first leader, in response to urgings by the

organizer and the former employee of H.I.P., both of whom were personal friends. Although a member of H.I.P. for many years, she had little knowledge about it and agreed to aid in forming a council primarily because people she knew had asked for her help. She commented, "They came to me, saying, give them a break with H.I.P." Later in the interview she noted, "They approached me and I agreed that I would allow myself to be chairman."

By the spring of 1971, the official of the East Harlem Tenant's Council, the executive director of the Pilot Block, the Puerto Rican community leader, and the former H.I.P. employee constituted the core of the consumer council. They contacted other persons whom they knew in the community, and a group of about ten persons began to meet in May, 1971, as the Yorkville/East Harlem Consumer Council. Until the fall of 1971, this group met semi-monthly, with the four leaders we have described attending regularly, and others attending one or two meetings. In September, 1971, the council merged with the consumer group of the Circle Manhattan Medical group to form the Yorkville/Circle Manhattan Consumer Council.

The Circle Manhattan Consumer Council

The Circle Manhattan Medical Group is located on 79th, between Amsterdam Avenue and Columbus Avenue, in a converted townhouse. The building is old and sparsely furnished. The center served about 9,000 enrollees during 1970.

The Circle Manhattan Consumer Council began forming about the same time as the Yorkville Consumer Council. The stimulus was provided

directly by the administrator and the social worker of the group, with the support of the medical director. Enrollment patterns in this group were similar to those in Yorkville; half the enrollees in 1970 were Medicaid eligibles, compared with eleven per cent of the enrollees in the H.I.P. system. In the Circle group, the initiation of a council did not appear to be linked to the new enrolling base, but seemed to derive from the perspectives on consumer participation held by the administrator and the social worker. Implementation of a philosophy favoring consumer participation appears to have been the goal, rather than seeking support for a new center to serve Medicaid enrollees, as occurred in Yorkville. That philosophy was in accord with the general view prevailing in society at the time, as described in Chapter 2, that persons receiving services from an organization should participate in decision-making bodies of that organization. In an interview the administrator stated his views:

Unless the individual who uses the medical facility, the individual dependent upon a certain facility, is able to exert authority, able to determine the priorities of the institution, make the administration and the physician understand a partnership must be developed - the standards of medical care will not change. There must be a direct involvement in the policy-making process.

Participation was linked to improvement in services. Emphasizing such a link, the social worker stated, "The only reason to want an input into services is because they are not getting the services they want."

To begin a council at the Circle Manhattan Medical group, the social worker drafted a letter informing subscribers of the intent to start a council, placed it in the quarterly bulletin of the Circle

TABLE 7

SOURCES OF ENROLLMENT IN THE CIRCLE MANHATTAN MEDICAL GROUP BY PERCENT
¹
 1965 - 1970

Source of Enrollment	Circle Manhattan Medical Group			HIP
	1965	1968	1970	1970
City of New York	36 %	34 %	20 %	56 %
Trade Unions	36	30	16	12
Other Groups	12	1	1	11
Non-Groups	17	15	10	10
Medicaid	--	20	53	11
Total	100 %	100 %	100 %	100 %
	(4080)	(5760)	(9580)	(744,544)

Source: H.I.P.

1. The figures for the Circle Manhattan Medical Group are from a 10% sample, randomly drawn. The figures for HIP were originally drawn from a 10% sample and generalized to the entire population by HIP.

TABLE 8

AGE DISTRIBUTION OF ENROLLEES IN THE CIRCLE MANHATTAN MEDICAL GROUP

FOR MEDICAID AND NON-MEDICAID ENROLLEES

1

By Percentage
1968 - 1970

Age	1968			1970		
	Total	Non-Medicaid	Medicaid	Total	Non-Medicaid	Medicaid
Under 5	5 %	4 %	8 %	7 %	3 %	11 %
5 - 14	14	11	24	24	15	32
15 - 24	8	8	10	15	12	18
25 - 44	27	28	22	22	25	19
45 - 64	32	33	28	20	28	14
65 -	14	16	8	12	17	6
Total	100 %	100 %	100 %	100 %	100 %	100 %
	(5,760)	(3,620)	(2,140)	(9,960)	(4,870)	(5,090)

Source: H.I.P.

1. The figures for the Circle Manhattan Medical group are from a 10% sample randomly drawn. The figures for H.I.P. were originally drawn from a 10% sample and generalized to the entire population by H.I.P.

Manhattan Medical group, and included a card for people to return if they were interested in joining such a group. The administrator described these first steps as carried out by the social worker:

He was given the assignment to develop plans for a consumer council to work jointly with the medical group and not be controlled by it. He drafted a letter, put in our bulletin, with a rip-off card to return for people interested. Based on the returns, he called a meeting.

About 35 people returned cards and about 10 appeared at the meeting. The social worker must have been disappointed; he commented that, "I thought there would be a lot showing." The consumers met periodically, discussing "specific problems they themselves had." Shortly afterward, the Department of Consumer Affairs was formed at central H.I.P., but it had little involvement in the Circle group since a council had already been formed there. The administrator stated, "There was little input from H.I.P." and the social worker added that the Department of Consumer Affairs "contacted us to see what we were doing" rather than offering assistance.

Members of the Yorkville Consumer Council and the Circle Manhattan Consumer Council were in contact with each other during the spring and summer of 1971. The administrator of the Circle Medical group was involved with the Pilot Block and at least one member of the Circle Manhattan Consumer Council was personally acquainted with the Puerto Rican leader active in the People's Committee on Accountability. A network of communication existed among the members of these two councils. The members were aware that under pending regionalization plans of H.I.P., the Yorkville Medical group and the Circle Manhattan Medical group would be merging

and decided that the two councils would also merge. The administrator of the Circle Medical group described these events:

They invited our executive committee to their meetings, and we invited theirs to our meetings. We decided to merge the groups to one, since the medical groups would be merging, since we had already signed the contract calling for the merger.

Two of the persons who originally joined the Circle Manhattan Consumer Council persisted in their membership and joined with the Yorkville Medical group in September, 1971.

Below is a chart summarizing the social characteristics of the seven consumer leaders of the Yorkville/Circle Manhattan Consumer Council in September, 1971. Identified as leaders are the four persons from Yorkville, previously described, who attended at least four of the five meetings held in the summer of 1971. Included as leaders are two persons from the Circle Manhattan Consumer Council who held council positions in that body and who remained members when the two councils merged.

With one exception, each of the six active consumers were employed in some type of public, or public service endeavor. One leader had been a dean of a New York City college prior to his death in 1971. Two leaders were employed by the New York City public school system for many years. One leader was active as a health plan consultant to several labor unions, including at least one whose members belong to H.I.P. Another leader held an executive position in the Pilot Block; another was an organizer in the Puerto Rican community, and one was a retired businessman.

Most of the council leaders were white, while the population of the area from which enrollees were drawn was predominantly black and Puerto Rican. None of the leaders were Medicaid recipients, but more than half of the enrollees in each medical group were. There was only one female consumer leader, but the majority of enrollees in both the Circle and Manhattan and Yorkville Medical Groups were female. In terms of their social characteristics, the leaders of the council were not representative of the enrollees in the two medical groups.

The consumer leaders have long experience in community organization, particularly in efforts to secure community participation in service organizations. One leader described himself as having been involved "in the 201 thing", referring to efforts to secure community control of Intermediate School 201 in East Harlem. Another referred to his participation in "civil rights battles". As previously noted, one individual referred to her "eighteen years in community organization," while another was described as "having the ability to speak for some people" in his capacity as a representative of the Puerto Rican community.

The organizational experience of the consumer leaders was undoubtedly greater than that of most enrollees. This is consistent with the leadership pattern in other consumer and community groups, in which persons already active in community affairs tend to become organizers and participants on consumer boards. In neighborhoods with a poverty population it is not the poor themselves who are likely to initiate client participation in service bureaucracies (Clark and

TABLE 9
 CHARACTERISTICS OF CONSUMER LEADERS OF THE YORKVILLE/CIRCLE
 MANHATTAN CONSUMER COUNCIL
 September, 1971

<u>Characteristic</u>	<u>Number</u>	¹
<u>Sex</u>		
Male	5	
Female	1	
<u>Ethnicity</u>		
White	3	
Puerto Rican	2	
Black	1	
<u>Age</u>		
Under 30	0	
30 - 45	4	
Over 45	2	
<u>Employment</u>		
Public Service	5	
Retired	1	
<u>Previous Involvement in Community Organization</u>		
Yes	6	
No	0	

1. (N=6)

Hopkins, 1968). In general, the poor have low rates of participation in voluntary associations (Wright and Hyman, 1971). Weighted down by a sense of powerlessness, the poor have generally not been participants in organized communal activities. The beliefs that were part of the consumer participation movement aroused some of these persons to action, but even with the elaboration and dissemination of these ideas few of the poor became involved in the participation movement (Marris and Rein, 1969). Lack of involvement tends to be a self-perpetuating cycle in which lack of familiarity with such matters as chairing meetings, writing letters to the president of a governing board, or protesting to the administrator of service unit inhibits any tendency toward joining in communal action.

A consumer constituency that consists exclusively of the poor may be one that is unlikely to become organized into a participation unit because the leadership capability is lacking. The presence of persons in H.I.P. enrolling groups with experience was an enabling factor in the formation of the Yorkville/Circle Manhattan Consumer Council.

THE STRUCTURE AND MEMBERSHIP OF THE YORKVILLE/CIRCLE MANHATTAN CONSUMER COUNCIL

In December, 1971, the Yorkville/Circle Manhattan Consumer Council called its first subscriber-wide meeting. Notices of the meeting were mailed to all enrollees of both medical groups. About 100 persons attended. After that, meetings were held on a monthly basis until June, 1973, when the two councils dissolved their merger and functioned as a loose federation (the Yorkville Medical Group and the Circle

Manhattan Medical Group had not merged, and, as a consequence, the consumer council decided to dissolve its merger). The observation of meetings for this research began in May, 1972, and continued through May, 1973, when the merger was dissolved.

Attendance at meetings averaged about seventy. In general, those attending were middle-aged or elderly, and members of minority groups. Meetings were held in a private school, a temple, or a church. These were typical locations for consumer council meetings in the H.I.P. system. The cost of meetings was borne by the Department of Consumer Affairs of central H.I.P., and included expenses incurred in mailing notices of meetings to all subscribers of the medical groups. In the fall of 1972, the Department curtailed these mailings, citing financial problems of the Health Plan, and acting after its own budget was limited by the Board of Directors. Leaders of the Yorkville/Circle Manhattan Consumer Council protested the action to the head of the Department of Consumer Affairs. The Joint Consumer Council protested the limited Department budget to the Board of Directors. Funds were not increased; notices were sent only to those who had already attended council meetings.

The structure and governing rules of the council were formally agreed upon at the subscriber meeting in April, 1972. The chairman of the by-laws committee reported in an interview that he designed a "flexible" structure capable of being altered by the council whenever it might wish to do so. In a paragraph of the by-laws that might be considered a statement of the purpose of the council, flexibility of structure was stressed:

One goal of the Consumer Council is to gain consumer control of the Board of Directors of HIP, and of the aspirations of each of the Medical Groups so that they will be accountable to subscribers for the Medical Services they provide. We cannot at this early stage predict what form of organization will best perform these tasks; the Structure Committee feels that the Consumer Council can best operate at this time with the loosest possible structure and the maximum possible leeway for change as need arises.

The rules specified semi-annual elections for the position of Chairman and Vice-Chairman. Officers of the council were elected in October, 1972, replacing those designated through informal consensus in 1971, but no further elections were held. The council could create as many committees as it felt desirable. Established committees included emergency services, newsletter, pharmacy, geriatrics, grievance, and personnel. The elected officers, committee chairmen, and any other persons appointed by the consumer council chairman constituted the executive committee, although in practice this group rarely met.

Of the committees, geriatrics and emergency services met at least once a month, while the other committees met sporadically. In general, committee membership consisted of a few active persons in each committee. The work of some of these bodies will be detailed in the following chapters, but a sense of their activities can be gained from descriptions provided by the council secretary in an interview:

Grievance Committee: They sent out questionnaires. They got about 300 back, which is pretty good, not bad. There were 125 complaints. People didn't detail them. About 50 did and we plan to act on these.

Membership Committee: The membership committee will put out a newsletter in September. It will be mailed every three months. It will be published in union papers.

Geriatrics Committee: They have about six active senior citizens. They are really terrific. They devised a sticker for wallets. I have to check with H.I.P. - that was supposed to go out.

The history, membership, and structure of the Yorkville/Circle Manhattan Consumer Council have been reviewed in this chapter. The next section of this report examines the processes by which the role of this council became elaborated and defined through interaction within the Plan as a whole among the organized consumers, the health professionals, the union leaders, and the medical group physicians.

CHAPTER VIII

CONSUMER COUNCIL MEETINGS: A FOCUS ON ORGANIZATION MATTERS

When the Yorkville/Circle Manhattan Consumer Council began meeting on a monthly basis, with what issues was it concerned? What did consumers talk about? What topics emerged at council meetings? These are the questions considered in this chapter. Following chapters analyze processes of interaction at meetings.

TOPICS AT YORKVILLE/CIRCLE MANHATTAN CONSUMER COUNCIL MEETINGS

Data on meetings of the council were collected from May, 1972, to May, 1973. A total of eight council meetings were held during that time, of which six were attended for this study. Events at each meeting were recorded in small spiral notebooks. Using this record, subject matters of concern at each council meeting were identified, studied, classified, and counted. Subjects were counted each time they occurred; where sub-topics developed, they were also included. The topics are listed in the following table.

It is striking that all of the matters arising at consumer council meetings pertained to organizational affairs - to the structure of the Health Plan as a complex organization. Consumers were concerned with understanding and directing their specified area of activities, as outlined in the organization's guidelines, with learning more about the

TABLE 10

TOPICS OF CONCERN TO THE YORKVILLE/CIRCLE MANHATTAN CONSUMER COUNCIL

May 1972 - May 1973

Topic	Total Number of Times Discussed
<u>Consumer Affairs</u>	(76)
Activities of Consumer Council Committees	33
Yorkville/Circle Manhattan Consumer Council Structure and Procedures	20
History and Rationale of the Consumer Council	19
Membership of Consumer Councils on the H.I.P. Board of Directors	4
<u>H.I.P. Structure and Services</u>	(32)
Nature and Availability of H.I.P. Services	13
Organizational Structure of H.I.P.	10
Current Reorganization Plans	9
Total	(108)

delivery services in H.I.P. and with ascertaining more about the organizational structure of the Health Plan.

Of the 108 separate events at council meetings during the period of this research, 76 pertained to consumer matters. Reasons for the particular focus upon consumer matters and actions taken with respect to them are explored in the following chapter. At this point, we wish to establish that the topics of concern at council meetings fell within the broad heading of organizational issues, and to explore the significance of that finding.

The committees of the consumer council were discussed 33 times during the six meetings attended. Committee reports dealt with consumers' efforts to alter the Health Plan with respect to the delivery of care. The chairman of the grievance committee described proposed changes in the system of presenting grievances to the medical groups. The chairman of the emergency services committee described the existing programs of emergency services and the changes consumers sought. The geriatrics committee reports described a proposed identification card for the elderly and a patients' rights book to be written.

Council procedures and structure were considered at every council meeting. At one meeting, the group's by-laws were adopted; at another officers were elected; on several occasions a meeting agenda was altered to include additional topics. Voting rights at meetings, announcements that the evening's proceedings would be translated into Spanish to accommodate Spanish-speaking enrollees, and reports of the late mailing of meeting announcements were among the topics in this category.

Statements by council leaders concerning the history and rationale for consumer councils in H.I.P. included references to the origins of the Yorkville/Circle Manhattan Consumer Council, the goals of the council, and the premises upon which the movement in H.I.P. was based. These statements are analyzed in detail in the following chapter.

The nature and availability of services in the Health Plan were discussed as enrollees asked whether senior citizens were eligible for specific services, and how to process complaints against specific physicians in the Plan. The adolescent health program and the mental health services provided by H.I.P. were discussed by the physicians in charge of each program.

At the time these council meetings were taking place, there was frequent discussion in local news media of the financial difficulties of the Plan and of leadership changes within it. Enrollees were concerned for the viability of the organization, and Plan leaders, including members of the Board of Directors and medical group officials, sought to reassure enrollees that the organization would persist. Elements of the Plan's current status, such as financial arrangements, medical group mergers, and continuity of services were described to enrollees. Among the topics discussed which pertained to the basic organizational structure of the Plan were the premium rates of H.I.P., the proposed merger of the Yorkville and Circle Manhattan Medical Groups, and the enrollment regulations of the Plan.

At four council meetings the subject of consumer membership on the Board of Directors arose. Reports were presented on progress toward

that end, or there was a discussion of such progress, or a decision to act on the matter was taken. Consumers had been trying to gain entry onto the Board of Directors from the time the councils were formed, and the subject was of concern throughout the year of research observation.

THE DIVISION OF AUTHORITY BETWEEN PHYSICIANS AND NON-PHYSICIANS

A Normative Statement

The foregoing analysis of the topics of the council meetings indicates consumer concern with the structural context of care, the delivery system, and problems of system governance - those aspects of medical organization that Freidson identifies as the application of knowledge. His views are presented in a review of the roots of physician autonomy in health care organization in which he identifies this area of organizational affairs as an appropriate one for non-physician involvement. We do not present a full review of his book here, but it is of interest to consider his definition of a professional. Unlike Goode (1957), Barber (1963), and others who identify professions on the basis of specialized knowledge, shared values, long training, service orientation, and control over recruitment and training, Freidson emphasizes the position of the occupation in the division of labor. A profession is characterized by control over the determination and evaluation of the technical knowledge used in its work, so that it has command over the division of labor pertaining to its area of activity. It is "autonomy of technique" that is at the core of profession (1970:45). So long as that autonomy is retained, Freidson argues, the professional

status of the occupation is not threatened when it loses command over the social and economic terms of the organization of work settings.

Specifically, Freidson distinguishes areas of work in which physicians have a right to exercise professional control from those in which laymen may join with physicians in decision-making. First, he isolates four elements of the content of work: (1) the etiological notion of disease; (2) the designation of some human states as diseases; (3) knowledge of the character of illness states and techniques for treatment; and (4) occupational usages pertaining to the management of disease states. In the designation of disease states, forms of participation between physicians and laymen are appropriate, for such decisions are beyond the specialized knowledge of the physician. They are moral questions for the society as a whole to decide. How the treatment modalities that the professional identifies as efficacious are to be structured and offered to the patient are matters for joint determination. With respect to occupational usage, a joint role is particularly appropriate, for these are not so much matters of scientific knowledge as customs derived from the practice of medicine by the profession; they therefore lack a sound scientific base and cannot be isolated from public involvement.

The crux of Freidson's argument is that technical activities for patient care can be separated from the social organization and administration of medical institutions. The medical profession may appropriately claim exclusive autonomy in matters pertaining to the knowledge of illness characteristics and their methods of treatment. However, the medical

profession must share with others the determination of how to structure treatment settings in which this knowledge is applied. Both physicians and non-physicians should be part of formal decision-making bodies in these matters. The influence of the profession should be curbed with respect to determining the conditions of its own members' work and the structural and procedural arrangements through which patients receive health care.

Freidson presents what may be termed a normative view, in that he states a desired human condition rather than presenting an empirical description of the actual conduct of human affairs. The data reported in this research provide an empirical demonstration that such a division of professional and lay tasks can be obtained.

An Empirical Description: Activities of Consumer Participation Units In Health Care Organizations

Consumers do not desire to tell physicians which drugs to use, or the rehabilitation techniques appropriate to persons with broken limbs, or when to have patients x-rayed, or when to inoculate children against infectious diseases, or any other matter within the technical area of physician labor. What consumers want is an organizational mechanism that functions to its maximum capacity to deliver services to them.

The focus upon organizational matters that characterizes the Yorkville/Circle Manhattan Consumer Council also characterizes consumer participation units in other health care organizations. Our review of recently published literature indicates that such units manifest interest in service and service eligibility, personnel policies and practices with respect to non-professional staff, community related issues and

definition of the consumer role. In prepaid group practice plans interest has primarily been in the areas of services and definition of the consumer role.

Within the last few years there have been studies of community planning boards (Brown, 1972; Brieland, 1971); consumer advisory boards in Neighborhood Health Centers (Wise, et.al., 1968; Davis and Tranaquada, 1969; Campbell, 1971); participation by enrollees in decision-making processes within prepaid group practice plans (Colombo, et. al., 1969; MacColl, 1966; Schwartz, 1968); joint consumer-provider ambulatory care committees in hospitals (Bellin, et. al., 1972; Metsch and Veney, 1973); and community activity in health as channeled through the Model Cities program (Douglas, 1973). Through a review of this research common areas of activity for consumer participation bodies can be identified even though these units operate in varied institutional settings, with charges of responsibility that differ in scope and depth of decision-making power, and with membership obtained through methods that range from self-selection, appointment by public officials, institutional selection and selection by consumers.

In a review of Neighborhood Health Centers, Zwick describes several common areas of activity, including efforts to secure more comprehensive services, additional benefits, and better accessibility to the health facility:

Consumer 'demands' for health services in Neighborhood Health Centers have been generally in line with comparable expressions among other consumer groups. Usually interest has focused on needs and desires for more comprehensive services. Increases dental care and drug abuse control services, additional hours

of service and better arrangements for transportation and child care have been frequent interests. The desires for broader benefits are notably similar to those reported from consumers involved in prepaid group practices. They also appear consistent with the tendency of purchasers of private health insurance to prefer more comprehensive benefits. The common concerns of consumer representatives about the sensitivity and attitudes of physicians and other health care providers attest to the continuing importance assigned to personal care and the doctor-patient relationship (1974:341).

Our review of the literature indicates that consumer activity in four major areas is widely reported: (1) services and service eligibility; (2) defining the consumer role and the structure of the consumer body; (3) personnel policies and the hiring of non-professional staff; (4) health related issues in the community.

Nearly all consumer bodies are active in matters pertaining to services and service eligibility. In a study of a Neighborhood Health Center in Cleveland, Campbell (1971) states that consumers were interested in three major issues: the appointment system, comprehensive care, and the sufficiency of services. Colombo et. al., (1969) report that a neighborhood advisory committee in a prepaid group practice plan established methods to determine eligibility for the Plan's services in a special OEO program for Medicaid recipients. In a newly developing, federally funded prepaid group practice, enrollee representatives participated in determining enrollment eligibility and benefit levels (Getty, 1973). In a survey of consumer participation in Neighborhood Health Centers, Sparer, et. al., (1970) report that consumers and staff members worked together to establish service priorities and set the hours of the centers. In a review of participation in OEO sponsored community

advisory boards, Brieland (1970) concludes that such boards can play a part in determining program practices, service boundaries and center hours. Comparing prepaid group practice plans under consumer sponsorship with those under physician sponsorship, Schwartz (1969) finds that the Boards of Directors of consumer plans place greater emphasis upon increasing benefit levels and providing additional services than do Boards of Directors of physician sponsored plans.

A second area of activity has been in the selection, training and retention of non-professional staff. Hollister (1971) describes recruitment by consumers of non-professional staff for a Neighborhood Health Center. In a special program funded by OEO, Colombo, et. al., (1969) states that residents helped to select local outreach workers from the community. One newly forming prepaid group practice reports that community members aided in recruiting non-physician staff members (Browneller, 1973). Ehrenstein and Ehrenstein report that the consumer advisory body to the Gouverneur Hospital health center in New York succeeded in convincing management to rescind the transfer of a clerk:

In one case, a Chinese-speaking clerk who doubled as a translator for Chinese patients, was suddenly and inexplicably transferred to an evening shift, leaving the Chinese patients to shift for themselves. L.E.S.N.H.C.S. protested the transfer, and, after some tense discussion, the Chinese clerk was reassigned to the day shift (1971:274).

Involvement in personnel matters has tended to be confined to either Neighborhood Health Centers or to prepaid plans that are in the process of being established. Already functioning prepaid plans do not report such activity. In Schwartz' study of prepaid plans he found that

Boards of Directors in physician sponsored plans more frequently discussed personnel matters as they pertain to the professional staff than did Boards of Directors of consumer sponsored plans. In neither type of plan were matters pertaining to the non-professional staff discussed frequently, with the exception of the remuneration for such employees, which was discussed by at least three of the six consumer plans studied.

A third area of activity has been within the localities in which health care facilities are situated, as consumers become more active in health related issues in the community. Wise, Levin and Kurahara (1968) describe action by the consumer advisory body of a Neighborhood Health Center in the Bronx, in which residents sought to expand the provision of mental health services in the area and formed a youth auxilliary to assist teenagers in meeting their health needs. Stokes, Banta and Putnam (1972) note that the Health Board of the Columbia Point Health Center in Boston surveyed sub-standard housing conditions in the area served by the Center. Partridge (1973) reports that of the 319 topics discussed by the consumer advisory boards of the Neighborhood Health Center she studied one-third of the topics concerned community-related matters. Involvement in community-based health issues appears to be related to the purposes of Neighborhood Health Centers. These facilities were designed to raise the quality of life in the communities in which they were located. They were not designed merely to provide medical services, but to serve as a focal point for neighborhood change relevant to health. Zwick summarizes the goals of these centers:

Their concerns encompassed improvements in access to services, reform in health care delivery, extension of community participation, utilization of new types of health workers, relationships between health care delivery and other forms of community action and economic and social development, medical care quality and financing, transportation and out-reach and a host of related problems (1974:332).

Concern with community-based matters, such as housing, is consistent with the goals of such centers.

A fourth area of activity has been specification of the consumer body's structure and its role in the organization in which it exists. As we have noted, consensus has not yet developed regarding the expected role for consumer bodies in organizational decision-making in the field of health. Common expectations regarding such a role, and appropriate sanctions to ensure conforming behavior, have not yet emerged. Consumer units that are presently formed and operating test their ability to carry out the powers granted to them and, in addition, seek to expand the areas of their jurisdiction and the nature of the powers they may exercise within those areas. There is continuing activity to ascertain the validity of granted powers, and a continual seeking of additional powers. Until a consumer role is accepted within health care organizations we would expect such probing to continue. For example, in Neighborhood Health Centers a number of authors report conflict between consumer advisory boards, local agencies charged with management responsibilities for the center, and the OEO as consumers seek to achieve a greater degree of formal decision-making power than is contained in an advisory role (Stokes, Banta and Putnam, 1972; Hollister, 1971; Campbell, 1971). The consumer bodies may seek a decision-making role in specific

organizational matters, such as budget approval, or they may seek a broader role that includes the full range of decision-making responsibilities that generally characterizes a Board of Directors. Davis and Tranaquada (1969) identify the problem at one Neighborhood Health Center:

"It is primarily the different orientations of the community, the university and the OEO regarding the relative importance of program goals which has led to conflict over who shall have control in the decision-making process." The authors describe organizational problems that result when the community seeks a decision-making role "while the university holds the pursestrings and the OEO has the final say."

Speaking at the HEW sponsored HMO Consumer Development Conference, held in San Francisco in 1973, representatives from the prepaid cooperative at Puget Sound discussed the desire of enrollees in that plan for broader participation in the decision-making processes of the Plan.

Rouse, et. al., (1971) describe the formation of a patient's council at a county tuberculosis hospital in the mid-west. The patients sought the right to present grievances pertaining to living conditions at the sanitarium, while hospital administrators and physicians denied that this was an appropriate area for patient involvement, and the local health authorities were uncertain whether or not it was

That consumer bodies focus attention upon clarification of their own organizational role is not surprising, given the uncertainty that prevails in the health care system as to their appropriate role. The Yorkville/Circle Manhattan Consumer Council devoted much of its time

and energy to a similar effort at defining its role, as described in the following chapter.

Thus, consumer bodies become active in matters pertaining to services and service eligibility, non-professional personnel health-related community activities, and definitions of their own organizational roles. Organized consumer bodies seek participation in the administration and policy-making tasks of health care organizations. It is the organizational context of care that is of interest to consumers.

CHAPTER IX

CONSUMER COUNCIL MEETINGS: AMONG ORGANIZATION MATTERS A FOCUS
ON CONSUMER AFFAIRS

The substantive area in which consumers expressed interest at council meetings was exclusively that of organization affairs, and within that area attention was particularly directed toward consumer matters as the consumers sought to define the activities in which they would engage. Would consumers become involved in the selection of new Health Plan leaders? Would they press for greater contract conformity? Would they challenge the power of the medical groups?

When the councils were being formed, neither the labor leaders, nor the health professionals, nor the medical group physicians knew what to expect from them. Once the councils were formed, nobody knew what they would actually do, including council leaders. Interviews indicate that in each interest group there was a feeling that the activities in which the councils would actually engage would only emerge slowly, over a period of time, and that the process was still taking place in 1973, two years after the first experimental councils were formed and one year after most of the councils had been established. One union leader stated: "We had no idea how it would turn out." A set of formal guidelines was written and approved by the Board of Directors, but it was not assumed that consumer activities would

necessarily conform to the guidelines. These rules detailed activities that were allowable as defined by the Board of Directors, but which of these activities would consumers really pursue, and which of these did the interest groups wish they would pursue? A health professional at the central administrative unit stated in an interview that exact consumer powers would emerge through interaction, that "it will be an existential thing". A union leader stated that consumer councils will have whatever powers they show themselves able to handle.

Uncertainty in the interest groups about the activities the councils would pursue can be analytically distinguished from the uncertainty about the activities they hoped the councils would pursue. It is possible that the interest groups had clearly defined activities in which they wished the councils to engage but were uncertain whether the councils would do so. This was true for the labor leaders who had a clear set of goals for the councils in the areas of contract conformity and leadership change, but it was not the case for health professionals or the medical group physicians (See chapter 6).

Once the councils were formed, one might suppose that council leaders would emerge with a clear program of action in mind. Even among consumer leaders, however, there was evidence of uncertainty. A leader from the borough of Queens commented that council powers would "evolve." One leader from Manhattan stated that the councils should be able to "control budget, policy, staff" of the medical groups, but did not mention any specific activities. Even when queried, consumer leaders did not present specific program ideas. Lack of definition

was exemplified in the comments of a consumer leader from Brooklyn that "councils should have a voice in policy . . . a very determining voice in non-medical matters." However, the only specific activity he identified for the councils was involvement in determining the "people who meet us, the receptionists, the nurses" and the formation of a "joint committee of medical men and consumers" to consider subscriber grievances.

Thus, lack of specificity in expectations of council activities were apparent in the comments of a wide variety of organization members, including consumer leaders, physicians, members of the Board of Directors, and administrators. One is tempted to consider such answers as evasive. Perhaps they were a deliberate effort to refrain from stating true opinions; perhaps, behind these answers, lay carefully considered judgments about what the councils actually would be doing. We reject this possibility for, on the one hand, there is no evidence that the stated uncertainty is feigned and, on the other, there is evidence from other studies of consumer participation in health care organizations of pervasive uncertainty regarding the consumer role (Campbell, 1971; Partridge, 1973; Wolfe, 1971).

It is not surprising that such uncertainty occurs. In general, the involvement of consumers in organizational decision-making is a new phenomenon, so that the role for such bodies is still relatively undefined and vague. The lack of clear expectations means that consumer groups face the critical problem of translating the general beliefs about consumer participation and the general character such participation should assume into appropriate action. The nature of

these beliefs is illustrated by the recommendations of the Citizen's Board of Inquiry that consumers have "the dominant role at all levels of the decision-making process of the health-care system" (1972:131), and the statements of representatives of minority and anti-poverty groups, at a conference of the American Hospital Association, that consumers have the "chief say" in operating health care programs (Gosset, 1971). The initial task of H.I.P.'s consumer council was to make statements of ideal goals applicable to concrete problems within the context of a specific organizational structure serving a given clientele at a particular time in the life of both clientele and organizations. Among the councils grappling with this task was the Yorkville/Circle Manhattan Consumer Council.

DEFINING THE CONSUMER COUNCIL ROLE: THE COUNCIL LEADERS' INITIATIVE

The problem of defining consumer goals and their implementation was brought to the council by council leaders: the chairman, other council officers, heads of the various committees. It was the leaders who formulated and presented the issues that consumers considered; they established the framework within which the council acted. Council leaders defined the issues for consumer concern, set the pace at which these issues were discussed and resolved, and defined the alternatives for consumer action. They frequently acted as the conduit for ideas formulated in committees which they chaired. It was the leaders who defined the role of the council, the goals to be pursued, and the means to be used. The council affirmed this definition by silent acceptance of the proposals brought to it or by agreeing to action programs proposed

by leaders. This does not mean that the leaders had a clear, well-organized, detailed program of action to present to the council. Indeed, the opposite is true. The leaders appeared to be groping their way through the H.I.P. system developing and refining their ideas in the process of continuing interaction with H.I.P. officials in the medical groups, officials of the central H.I.P. unit, the Board of Directors and other consumer leaders in the Plan. Nonetheless, the proposals considered by the council were placed before it by the leaders.

History and Rationale of Consumer Councils

Why should there be consumer councils? At one meeting an enrollee asked that question, and a consumer leader responded:

I will tell you why you are here. You work hard. H.I.P. controls your money. We're here to see if we can unite our forces, because they are a big Board, the Mayor, the big union leaders. We want to get Puerto Ricans and Blacks on the Board so we can get better service. That's why you're here.

The statement contains several prominent themes in the rationale for a consumer movement in H.I.P. First, a premise is given upon which the movement is built: enrollee money supports the Health Plan and therefore enrollees should have a voice in determining how their money is spent. A second premise frequently presented is that their status as service recipients entitles consumers to be members of the Health Plan's decision-making bodies. One leader stated: "We see consumers as having a primary stake in the medical services. We see ourselves as full partners in providing medical care." Definitions of the basic reasons for a consumer movement were not mentioned often; they were

given little emphasis in comparison to emphasis on forms that participation ought to assume.

The leader's statement given above identified membership on the Board of Directors as a goal of consumers. Leaders rejected the concept that prestigious community members can adequately represent enrollees, a concept stressed at the founding of the Health Plan and characteristic of community-sponsored prepaid group practice plans. The Board of Directors of H.I.P. was described as composed of "the Mayor, the big union leaders;" that is, it did not represent the enrollees because its members were drawn from the powerful elements of the community. As another consumer leader stated at a meeting: "On the H.I.P. Board poor people don't have power." In discussions at meetings Board membership was seen as a way of securing representation for segments of the enrolling population now unrepresented or having levels of representation lower than their proportion in the enrolling population. Of the thirty Board members in 1972, two were black and two were Puerto Rican. Of these four, only two were specifically elected to represent the poverty population. However, more than 50 per cent of the enrollees of the Yorkville and Circle Manhattan Medical Groups were Medicaid recipients and most of them were apparently minority members. Leaders did not detail these facts; they simply stated that minorities ought to be on the Board. For example, one leader remarked:

You should sit here ← Blacks and Puerto Ricans.
A couple of you should make up your minds to
sit on the Board. Read on it if you don't
know anything about it. Whites and Blacks who
do know will help you.

It was assumed that there was a causal relationship between

representation and quality of service. As one leader put it, "Because we don't have a say it's badly run." The corollary, that Board membership for the poor and minorities will result in better services, was also assumed as axiomatic.

Board membership was not the only means for improving service. The council itself was perceived as a means for bringing about change. As one leader remarked: "People shouldn't be too humble. There's a council now." Emphasis upon committee activities indicates that use of already established structures for participation were perceived as routes to service improvements.

The twin themes of representation and Board membership were contained in the following statement of the consumer council's history provided by the chairman of the council at one meeting:

We seem to have many new members here. I'll explain about our consumer council. The Committee on Accountability, a city-wide group of consumers, asked that the people who use the medical care service have a right to set policy for H.I.P. And now there are consumer councils in the medical groups of H.I.P. Since the Circle Manhattan and Yorkville Medical Groups are merging, it seemed that the consumer councils should merge also. After talks all summer last summer the consumer councils merged in the fall.

We, and I mean by we all the consumers who have been working with the consumer council, we see consumers as having a primary stake in the medical services. We see ourselves as full partners in providing medical care.

H.I.P. has many different types of subscribers, and so our consumers come from different groups - but when we come here we represent ourselves.

The members of the Manhattan consumer councils have been meeting on a borough-wide basis because some of our programs are presented to us on a borough-wide basis.

Are there any questions about the council?

The service goals of the council were stated by leaders in broad, vague terms, e.g., "better service," or improving a system that is "badly run." It was in the council committees that these goals became specified ends; "things that are wrong" became those which were highlighted in committee reports.

Activities of Consumer Council Committees

Reports presented to the council by committee chairmen typically contained the following components: (1) a partial description of a program or service offered by H.I.P., (2) a statement of changes that the committees desires in this area, and (3) a statement of what consumers have done to bring about these desired changes. Committee reports identified activities of the Health Plan that were perceived as deficient; they defined alternative structures or processes by stating consumer proposals to remove these deficiencies, and they described consumer efforts to achieve these reforms. These elements might be presented separately but were usually interwoven together, so that description led to statements of what consumers have done, which in turn led to further description of the service to be reformed and additional statements of consumer action. Descriptions of H.I.P. services did not fully present the nature of services provided, nor the structural context in which they exist; they were pieces of the total picture. It was left to those attending the meetings to fill in the pieces.

For example, the chairman of the emergency services committee gave the following report at one meeting. It began with a description of aspects of the emergency services program:

Well, everything that could be a mess is a mess.

Slowly, they've taken away the all-night service. The doctors took it away. H.I.P. doesn't really administer it; the doctors in each borough do. The doctors voted to kill it because the Yorkville representative wasn't there. I understand there is a request for a recount.

The chairman continued, stating consumer goals with respect to emergency services:

There should be meetings about the emergency service. This should be for all boroughs. It shouldn't just be borough-wide. Emergency services should be run by consumers with some people at H.I.P. we can work with. Meanwhile we are arranging for services at Yorkville till 12 at night.

He ended his comments by pointing to activities by consumers to improve the emergency services program.

A report in which description, statement of consumer goals, and summary of consumer activity are mixed together was presented by the chairman of the geriatrics committee:

Someone asked before how old you have to be to be a geriatric. Sixty.

We all have the problems mentioned tonight, and some of our own. I listen tonight and I get sadder and sadder. We need more patients' rights, more and better human services.

The health educators, they're from H.I.P., want to work hard for the geriatric subscribers. We are planning to make a sticker to put near the telephone. On this sticker you will have

all the information - your doctor, the drugs you are taking. It's being done and very soon you will receive it. How do you like that? I hope you do. We will also have an identification card with the same information. You will always keep it in your wallet.

We all need more information about the insurance company. We are going to write a booklet, and tell you what your rights are. There are riders and they have letters. Some have letter A - does your card have an A or an I? At central H.I.P. they know what they all mean. Do you? We are now having a booklet . . . we hope we can assure H.I.P. that this is so important . . . we want to help all our subscribers. Jay is the health educator and we've pointed out to him that you are entitled to all the information you want. We want to establish the relations you remember you all had with your doctors years ago.

DEFINING THE CONSUMER COUNCIL ROLE: THE COUNCIL RESPONDS

How did enrollees respond to these presentations? Did they accept the goals advocated? Did they agree on the nature of Health deficiencies? Did leaders confront a questioning, hostile, reluctant constituency or a plaint, agreeing, accepting one?

Of the 108 separate events identified at council meetings, enrollees listened in silence to presentations in about two-thirds, or 76 of the events. They did not question, demand, inquire or object - they merely listened to what was being said. That the silence did not imply hidden anger, controlled frustration, or alienation is indicated by the character of those situations in which there was a response from enrollees.

In 22 events, there was discussion, typically initiated by questions from enrollees directed toward council leaders. These were primarily questions of clarification in which members were seeking

additional information. Some of the questionnaires sought information on consumer activities. For example, when activities of the grievance committee were described, and committee volunteers requested, one man asked, "How do you do this work? Do you sit at a desk?" The chairman replied, "Yes," to which the enrollee countered that he would not like to do that because "it gets me nervous." The chairman, anxious to get a volunteer, said that she would send him some company while he worked, but he did not join the committee.

However, few of the questions pertained to consumer activities. The goals of the leaders, the deficiencies that were highlighted, and the alternatives outlined in committee reports were received in silence. Enrollees did ask questions about the services provided by H.I.P. They tried to learn more about what was available to them. Questions were not a prelude to enrollee suggestions for improvement but, rather, they were asked in order to help enrollees use the services. The nature of the questions indicate that where they were uncertain or needed more information those attending meetings were not reluctant to ask questions. A report by the chairman of the emergency services committee began with a description of those services, which evoked the following question and the ensuing dialogue:

Subscriber: We are sitting here so complacently.
Suppose something happens in the
middle of the night. What are we
supposed to do?

Consumer
Leader: I was out at H.I.P. this afternoon.
H.I.P. doesn't understand. The head
of emergency services [at central
H.I.P.] he understands.

Subscriber: What can we expect during reorganization?

Consumer

Leader: Oh God, during reorganization. What we really want is a hospital, like La Guardia has. We need a hospital where we can go. We had Sinai. We hope to have Flower Fifth.

Subscriber: What about the ambulance?

Consumer

Leader: The ambulance will take you to the doctor, or the doctor to you if needed. You know Circle and Yorkville are the only groups where you can get a house call. They said it would be abused, but it hasn't been. And there will be emergency services until 12..

Comments and questions at meetings did not suggest hostility toward leaders. The prevailing tone was one of quiet admiration. When one leader completed a report on efforts to obtain a prescription drug program at the East Harlem Center, one subscriber responded, "You people are doing a good job." When elections for new officers were held, the present chairman was nominated. He declined. The subscriber who had placed his name in nomination pleaded with him to reconsider: "Take one more year to get it going. You kept the ship afloat and it was in danger of sinking." Another enrollee announced, "I nominate you by acclamation" but the chairman insisted that "one year is enough" and a new chairman was elected.

On only one occasion were council leaders challenged by enrollees, and this was on a relatively minor matter. At one meeting an enrollee argued with the chairman of the council, the chairman of the grievance committee, and the chairman of the geriatrics committee about the title for the patients' rights book. He objected to calling it "Patients' Rights" because, he said, people would think they had a

right to services that, under terms of the H.I.P. contract, they did not have. Other enrollees at the meeting did not agree with him, but, rather, argued for the title suggested by the leaders. The debate, as recorded in field notes, is presented below:

The enrollee raised the question of what to call the book. It should not be called "Patients' Rights" he said, but should refer to services. He stated, "This is because you have subscribed to it, so you have the right to services." The first enrollee replied that when you talk of rights, "something happens." Another enrollee said, "We should demand what is ours." The first consumer replied that he was forgetting about cost, that all these things that were being demanded would cost money.

The chairman of the geriatrics committee indicated that the section on rights and responsibilities of the book would offset the sort of thing he was objecting to. He replied that his premium might go up, and, he continued, "If you say rights people will demand it."

The chairman of the council said that the matter could be discussed at a later time and, she stated, "Before this goes out to be printed this group must approve it." At this point, another consumer leader became quite angry. He said, "We are all consumers. We all pay premiums. And some people sit here and object. They resent what other people are doing, but they don't sit on committees and do any work." He looked directly at the enrollee who had raised the question of the book's title and said, "You never volunteer for anything." The enrollee replied that he was doing that now, he "was being involved in important issues." The chairman again repeated that the title could be discussed at a later date.

My summary of this exchange ends with the sentence, "And that was the end of the subject."

Of the 108 events occurring at council meetings, there were 13 in which the council took action (an action is defined as either approval or disapproval of formally presented motions or a consensus

that emerges even when a formal motion is not being debated). In each case, the proposal for action was initiated by council leaders and not by the enrollees. Enrollees approved each of the leader proposals. The manner in which leaders defined the consumer movement, the deficiencies they brought to the attention of the subscribers, and the alternatives for action they proposed were accepted by their constituents. That leaders initiated action proposals that were accepted further indicates that the process of specifying goals moved from the leaders to the members.

Seven of the 13 events pertained to operation of the council itself. In four instances, the agenda was altered; on two occasions there were council elections; at one meeting, the council structure was revised. In these events, no action was taken on basic consumer goals, such as Board membership, and there was no effort to reform services or assert consumer control over aspects of the Health Plan.

The six remaining events pertained to the structure of the Plan or to the delivery of services. Responding to the chairman's suggestion the council asked the Department of Consumer Affairs at central H.I.P. to inform council officers of the budget for that department and how money was allocated among councils in H.I.P. The council affirmed support of the adolescent health program. When the mental health program was discussed by the physician in charge one consumer leader suggested that such services be provided to drug addicts. The enrollees attending did not respond to the suggestion; their silence became acquiescence to the leader's suggestion when the physician in charge of the program agreed to take steps the following day to

implement the proposal. The council approved a title for, and the printing of, a patients' rights booklet (however, as will be shown in the following chapter, this book was never printed). Finally, the council acted to chastise the Joint Consumer Council for its procedure in nominating persons for membership on the Board of Directors, and approved a leader intention to object to these procedures by writing directly to Board members.

The Issue of Contract Conformity

As the council leaders slowly defined issues and identified goals one organizational matter that was virtually ignored was contract conformity. Since the existence of contract violations were widely acknowledged in the Health Plan and union leaders had supported the formation of consumer councils as a means of furthering contract conformity, it is reasonable to inquire why this was not an issue of concern to the leaders of the council. While there is no direct data bearing on this point, the question can be considered from two perspectives: (1) what the interest groups perceived as the basic source of H.I.P.'s service delivery problems, and, (2) the interest group structure of H.I.P.

It has already been shown that interest groups in the Plan had their own views as to the basic flaws of the Plan that contributed to the poor levels of service provided by some medical groups. Health professionals stressed the lack of hospital affiliation as well as the Plan's primary reliance upon part-time physicians, while labor leaders stressed the lack of sufficient conformity by the medical groups to the existing contract terms. Both interest groups pursued

strategies to remedy the flaws they identified. Health professionals initiated a broad reorganization effort in 1970 that labor leaders at first supported but then rejected in favor of a more piecemeal approach that focused on new mechanisms for contract conformity.

Similarly, the consumer leaders of the Yorkville/Circle Manhattan Consumer Council had their views. They perceived the basic flaw of H.I.P. as a lack of consumer representation on the Board of Directors. It was presumed by them that improved care would occur primarily as a result of majority membership on the Board of Directors, rather than through either contract conformity or restructuring. Consistent with these beliefs the basic strategy of reform developed by the leaders of the Yorkville/Circle Manhattan Consumer Council was directed toward achieving membership on the Board of Directors while pursuing limited goals in specific service matters identified by consumer council committees.

Lack of consumer involvement in contract conformity may also be considered in terms of the position of the Yorkville/Circle Manhattan officers vis-a-vis union leaders on the Board of Directors. The officers of the Yorkville consumer group identified union chiefs as among the powerful persons in the City to be dislodged from leadership control of the Board. They would be replaced by consumers. Yorkville leaders expressed the view that union chiefs did not represent the poor or the minority groups enrolled in H.I.P. These were the very groups that constituted more than 50 per cent of the Yorkville and Circle Manhattan enrollment, and whom the leaders of that council represented. Further, the Yorkville leaders stated that union chiefs

had failed to carry out responsibilities to those whom they could claim to represent - union members. For example, literature distributed by this council stated:

Union representatives on the Board for the most part are out of touch and do not represent the rank and file membership - do they represent our needs?

Therefore, we demand the mass resignation of this Board! They must be replaced by consumers who know their needs and pay for these health services that they are not now getting.

If consumer leaders perceived union heads as their opponents in a struggle for organizational power, how could consumers adopt as their own issue a matter the unions had identified as the appropriate activity for the council? To do so would have been a tacit admission that union leaders correctly understood the problems of the Plan but had been unable to bring about improved care because others failed to act properly on contract conformity.

To do so would have ceded an aspect of role definition to the unions at the very beginning of the consumer movement in H.I.P.

CLARIFYING THE CONSUMER COUNCIL ROLE

The different interest groups in H.I.P. were uncertain of the role the councils would play in the Plan. The Board of Directors adopted a formal statement of guidelines but these could not detail the routine activities in which councils would engage, the individuals with whom council members would interact, nor the goals that would be pursued. These would emerge through interaction among the organization members after councils began to function.

Council leaders faced the critical problem of translating general beliefs of the consumer participation movement in health into actions pertinent to the H.I.P. scene. Leader initiatives in presenting and defining issues at consumer council meetings were a means by which general beliefs became transmitted from more active, involved individuals to those more marginal to the consumer participation movement. The leaders of this council had a background in community affairs and had been active in other institutional settings. They brought to H.I.P. experiences and beliefs acquired in other spheres. Enrollees, in effect, were being instructed by their elected officers on the consumer movement, its reasons for existence, and the direction it ought to take.

The emphasis at council meetings was upon receiving information rather than upon taking action with respect to that information. Events at meetings can be considered in terms of the group problem solving phases identified by Bales. The small groups he studied moved from an orientation phase in which information was collected and presented to the group, to an evaluation phase, where courses of action were considered, to a decision-making phase. If the meetings of the Yorkville/

1. The Bales categories apply to groups of persons previously unknown to each other, meeting in continuous session, and solving specific problems constructed for the purpose of the social experiment (Bales and Strodtbeck, 1960). While the Yorkville/Circle Manhattan Council does not meet these criteria the concepts of orientation, evaluation and decision are useful for understanding the types of activities in which the council engaged.

Circle Manhattan Consumer Council are considered in these terms, it may be concluded that most of the events at meetings focused upon orientation. Of 108 events, 76 involved the presentation of information to enrollees about the council or the Health Plan, clearly an orientation activity. Twenty-two of the 108 events involved some discussion, yet most of these also fall within the orientation phase for they involved clarification of already received information rather than discussion of alternative actions. Only 13 events involved action or decision. Thus, it may be said that at council meetings concern was primarily directed toward understanding the organization of which the council was a part and understanding the consumer role in that organization.

Enrollees wanted to know what services were available to them and how to enhance their access to these services. They were there to learn. Council meetings were a means by which enrollees gained information they desired. Meetings were a mechanism for consumer education as well as for consumer participation. Council leaders not only presented information regarding consumer activities but also presented information on H.I.P. services and structure or brought Plan officials to meetings who could do so.

In what constitutes a division of labor, council meetings focused upon orientation while committees of the council focused upon evaluation and decision. The determination of goals and the selection of the course of action to realize goals took place within the committees. It is those activities that are reported in detail in the following chapter.

CHAPTER X

CONSUMER COUNCIL COMMITTEES: STRIVING TOWARD GOALS

There were three active committees of the Yorkville/Circle Manhattan Consumer Council: the grievance committee, the geriatrics committee, and the emergency services committee. These groups met on a monthly basis. Each was chaired by the same person during most of the research period and membership was stable, though limited. Enrollees were requested to join these committees at every consumer council meeting but few did. The grievance committee consisted of three people; the emergency services committee consisted of three or four persons, but met regularly with emergency services representatives of the other consumer councils in Manhattan; the geriatrics committee consisted of about six persons. These small groups were the source of innovation in this consumer council.

As stated in the preceding chapter, the initiatives of the committees were never rejected by the council, and supportive action by the council was taken when requested. In this chapter committee goals and achievements are reviewed, and comparisons presented with other studies of consumer participation units in health institutions.

THE GRIEVANCE COMMITTEE

This committee was established to receive complaints from enrollees and present them to the Group. The goals were stated by the committee chairman at a council meeting, as summarized in field notes:

Two hundred complaints were on file from last year's questionnaire. These would be tabulated.

The committee would also seek a more concrete system for establishing grievances. The chairman of the committee described the grievance tables. These would be manned by volunteers who would sit in the Yorkville and Circle Manhattan Medical Groups and solicit and write down complaints on a form the committee would draw up.

At least 200 complaints were received by the grievance committee through a questionnaire mailed to enrollees. The committee reviewed these complaints and selected a few to present to the medical director of the Yorkville Medical Group, choosing those considered to be serious, in which the problem was specified, and the physician against whom the complaint was being filed identified. In an interview a member of the grievance committee described the screening process:

Each member of the committee was given a certain amount of questionnaires and whichever letter had the severest complaint we would read to the other members and we would decide whether to vote up or down.

Question: "What kinds of complaints did you decide to do something about?"

Answer: "Ones where people were unafraid. How shall I say this - where they mentioned names, they named the doctor, the specific cause for the complaint."

The medical director reserved the right to act upon the complaints by following already established procedures. He would review complaints and discuss those he judged to be serious with the physician against whom the complaint was lodged. If this procedure did not satisfy the enrollee the matter could be appealed to the Joint Review Committee for Improved Medical Care. The medical director stated his position in an interview:

Question: "How about grievances against doctors already practicing in the Group. How do you think this should be handled?"

Answer: "This is done through the administration of the Group. I wouldn't want to see revolutionary tribunals trying doctors. It's handled through the administration of the Group."

The role the consumers identified for themselves was one of collecting enrollee grievances and presenting them to the medical director. The consumers did not seek a role in the resolution of these grievances, nor was one offered by the Group. The role the consumers defined for themselves was one the Group could accept. The medical director envisioned the grievance committee as a "more formal vehicle for consumers to express dissatisfaction" than presently existed in the group. Similarly, the grievance committee chairman described the committee as a means by which enrollees could "express dissatisfaction."

Given the mutual agreement, were the consumers able to carry out this role? Our evidence indicates that they were not. Of 200 complaints collected, only a few were ever given to the medical director for review. The committee was hampered by the reluctance of complainants to identify themselves and to specify the name of the physician or

staff member against whom they were lodging a complaint. How could a specific complaint be presented if the physician against whom it was filed was not named, or the particular series of pertinent events not detailed? A member of the grievance committee commented:

You know when we had the table - well, we don't have it anymore - people were afraid to sign their names to complaints. They can't be thrown out of H.I.P. [referring to the consumers]. They should raise their voices, persist to make it a good system.

A council leader affirmed the lack of specific response to the questionnaire:

People didn't detail them. About 50 did and we plan to act on those. We'll be sending out a second questionnaire thanking them for the first questionnaire, saying we found many left out names of doctors, the specific complaints, and we need these so we can set up a mechanism for working with the medical centers.

Lack of specificity may be an endemic problem in the presentation of grievances, apart from the unwillingness of enrollees to identify themselves to the consumer council. The medical director described complaints he received directly from enrollees: "There are general complaints - the girls at the front desk are rude. I try to get the patient to be specific." He described other types of complaints: "Or, 'my father had chest pains. I called emergency services.' I get alot of complaints about that. Again, I need to go into specifics, try to pinpoint the sequence of events."

In dealing with complaints the medical director sought a complete account of the event in order to determine whether there was a justifiable complaint in terms of the formal rules of the Health Plan. The

medical director and the administrator of the Yorkville Medical Group had been with H.I.P. for many years and presumably were familiar with the rules of the Health Plan, were aware of the complex processes involved in handling grievances, and were generally cognizant of the medical issues (using Friedson's definition of the content of medical work, as described on pp 162 ff.) involved in any particular complaint. However, patients did not frame their complaints in these terms. They were generally not aware of organizational rules, they were not experienced in handling grievances, nor were they knowledgeable of the medical issues involved. As a consequence of the different perspectives, patient complaints lacked the specificity that organizational rules and norms required.

The lack of understanding among consumers of organizational definitions of specificity was exemplified by the mail questionnaire the grievance committee developed to collect enrollee complaints. Enrollees were asked to list any "specific instances" of incivility or insufficient attention to needs by doctors, nurses, or receptionists, but there was not indication what the term "specific" meant and enrollees were not told to include such data as the date of the alleged incident or the location where it occurred. Respondents were asked to indicate whether they had "specific complaints" about treatment received at the Plan, but¹ they were not asked what those complaints were.

1. However, we would guess that even if responses did fit the criteria of specificity grievance committee members would not have been given a

Thus, both consumers and providers agreed that a consumer role in filing grievances was acceptable. The medical director was ready to receive grievances collected, and in that sense was willing to cooperate with the consumers. Yet, even under these favorable conditions, the consumer activities were not carried out. Lack of knowledge among consumers of organizational standards prevented them from taking advantage of role consensus. Given the acceptability of this consumer activity, and medical group willingness to cooperate in the matter, an educational program for consumers regarding the grievance system of the organization might have aided the consumers in meeting their goals. Consumer education is widely suggested as a key to effective participation, in terms of permitting consumers to achieve their goals (Parker, 1970; Salber, 1970). This research generally does not support that conclusion, pointing instead to the ability of the organization to control consumer effectiveness

role in the resolution of complaints. In an interview the medical director of the Group characterized grievances that enrollees of the Plan presented as "not medicine" because they were "about the way care is delivered." In effect, he identified two different areas of medical group activity - arranging for the delivery of care through an organizational structure and directly providing care through the interaction of the doctor with the patient. Later in the interview the medical director stated that "ultimately the administrative and medical practice is the responsibility of the Group." Thus, even though grievances fell outside "medical practice" they nonetheless were the rightful responsibility of the Group. He further characterized grievances as "emotional responses to a situation."

If both administrative and medical practice are defined as ultimately the responsibility of the Group, if the types of issues raised by consumers are considered to be relatively insignificant, and if grievances themselves are viewed as emotional responses to health care situations, consumer participation in resolving grievances is highly unlikely.

by controlling access to organizational resources needed by the consumers. In the instance of the grievance committee, where role consensus existed and there was willing medical group involvement, it may be presumed that education could have been helpful.

THE GERIATRICS COMMITTEE

The geriatrics committee pursued three different goals during the period of this research. First, the members wanted to obtain a list of names of persons over the age of 60 enrolled in the Yorkville and Circle Manhattan Medical Groups. Second, they tried to distribute a medical information sticker, or card, to all elderly enrollees of the two medical groups, a card that would identify the individual, briefly note his medical history, and list persons to be notified in the event of an emergency. Third, the committee wanted to develop a booklet describing the benefits for which enrollees were eligible under terms of H.I.P. contracts.

Early in 1972 the committee requested a list of names of those over the age of 60 enrolled in the Yorkville and Circle Manhattan Medical Groups. Approximately four months later a list of those over age sixty-five was provided by the Department of Consumer Affairs of the central unit. The Health Plan told the committee that its information storage system did not permit identifying those between ages 60 and 65. The committee was not satisfied with this response and again requested such a list. It was never provided.

The suggestion for an identification card began as a request by one of the members of the geriatrics committee, as described in minutes

of that committee in the winter of 1972:

. . . an emergency sticker should be devised for elderly people with important information (i.e. name of doctor, hospital, address, telephone number, person to notify in case of emergency). This sticker should be devised by HIP Central for all subscribers and sent to the senior citizens with clear directions to be placed on the door, next to bed or bathroom. Many senior citizens either live alone or are homebound and in case of emergency this information is never present. A committee of three members will work to coordinate this project.

The committee decided that the card should also include a brief medical history. Major illness of the enrollee would be listed, as well as medications to which the individual was allergic. The request was presented to the head of the Department of Consumer Affairs in the spring of 1973. In the ensuing months the printing and mailing of these cards was promised several times, but the cards had still not been distributed one year later. During this time, H.I.P. experienced the financial and leadership challenges previously described and the committee was told by the head of the Department of Consumer Affairs that H.I.P. lacked funds for the cards.

The consumers were discouraged. They were confused as to the strategy they should pursue. At a committee meeting the chairman said, "I don't know whether we should complain or be charitable, with the crisis in H.I.P." But the consumers did persist in their efforts to obtain the cards, believing that the elderly needed such identification in cases of emergency. At meetings committee members spoke of the plight of the elderly, as they knew it from their own experience, emphasizing the isolation and loneliness of that population. They spoke of the

need for an identification card so that if emergency help was offered by a stranger, the vital medical history would immediately be available. One man said that "the reason I suggested it [the card] is because people die in their rooms alone." He described the death of a neighbor recently: "Nobody knew he was dead for several days. I spent four days trying to locate a burial place for this man. I couldn't even arrange a ceremony for him." Another committee member reminded those attending that "people get sick. It's not only the dead." Clearly, these consumers felt a responsibility toward others like themselves. They persisted in their efforts to obtain identification cards.

A third committee goal was production of a booklet describing enrollee benefits. Before this research began the geriatrics committee had discussed the possibility of including in the medical group bulletin a description of the benefits to the elderly contained in the H.I.P. contract. According to committee minutes of February 1972, the information would be "written up in plain layman language in both Spanish and English." By May 1972, when field work began, the committee had expanded its original goal and now sought to present this information in the form of a patients' rights booklet in which rights and obligations of the elderly enrollees would be detailed. By the summer of 1972 the goal was further expanded by the committee's decision to write a booklet for all enrollees in the two medical groups. At a committee meeting in June it was stated that the booklet would include "how to choose a doctor, have a medical check-up, make an appointment," and would specify service benefits available under the various contracts of enrolling groups within H.I.P.

In preparing the booklet the consumers turned for help to social workers and health educators and other health professionals in H.I.P. Drafts prepared by these persons were reviewed and revised at committee meetings. Physicians in the medical group whose aid was requested by the consumers did not attend committee meetings, nor comment on proposed drafts. At one meeting the chairman of the committee remarked that the medical director "wanted to read this. We haven't reviewed his reactions. We should wait for him." However, she was unhappy with his failure to communicate with the committee and to appear at the meeting and added, "He has had it for four or five weeks now. That's too long." The committee decided to continue its work without the response of the medical director. The effort to draft a patients' rights booklet remained one limited to the consumers and the health professionals. Periodic reports on progress were presented to the full consumer council.

A draft of the handbook was being completed at the time of the organization's financial problems. A member of the Department of Consumer Affairs cautioned the committee that money might not be available to print the booklet because the Health Plan had "limited funds." The committee chairman responded that "They [the Plan] should at least communicate with our consumer council.

The initial interest of the geriatrics committee in this project was slowly replaced by a sense of frustration. The group could not get cooperation from the Department of Consumer Affairs, printing of any completed document was uncertain, and physicians did not aid the

consumers in their efforts. One member of the committee stated at a meeting, "I'm going to resign if this keeps up." The chairman wondered aloud whether it was worthwhile to continue her committee activities. Finally, consumers stopped attending committee meetings. At about this time the officers of the council, with the approval of the committee, assumed responsibility for the booklet, removing it from the jurisdiction of the grievance committee. Meetings were held at central H.I.P. by consumers and H.I.P. health professionals, but a booklet still did not appear. Whether it will ever appear remains an open question.

In order to achieve each of the committee goals - a list of names, an identification card, a patients' rights booklet - resources of the Health Plan were needed. The names of geriatric enrollees were known to the organization, and the Plan's willingness to provide the names of some of these enrollees allowed a partial realization of consumer goals. Funds from H.I.P. were needed to print and distribute the identification cards. By controlling available funds the Department of Consumer Affairs prevented realization of this consumer goal. Progress on the patients' rights booklet was affected by the limitations placed on the availability of funds and the relative lack of involvement by physicians. By withholding services, an organizational resource, physicians slowed consumer progress toward that goal.

Failure by the consumers on the grievance committee to achieve their goals was a consequence of the H.I.P. central organization's refusal to provide needed resources. Goal failure, in turn, induced frustration among the consumers, and, ultimately, apathy. Ineffectiveness led to

a lack of attendance. A similar relationship between inability to bring about change and lowered attendance was reported by Partridge in a study of a Neighborhood Health Center (1973). The advisory council of the center was composed of twenty community people and six professionals at the time her study began. The council had only limited ability to affect decisions of the center's Board of Directors, and was perceived by its members as "weak". One of the consequences of its "weak intervention" capacity was an "uncertain and unstable" membership and attendance pattern. One year after the research began, there were only 12 community members remaining, and attendance at meetings had averaged nine persons.

That failure to achieve goals leads to member apathy has been described by Zald and Ash (1969) as a general characteristic of organizations within a social movement. Such organizations are by their nature attractive to persons seeking to achieve some specific goals of change in society. As the prospects of achieving these goals appear diminished, member incentive to remain within the organization declines. Failure to achieve goals leads to apathy and, ultimately, to withdrawal of participation.

Among the resources needed by consumers in H.I.P. was information from the physicians in the Group. They did not provide it. To the consumers, physician review of the patients' rights book and aid in developing an identification may have seemed simple, easy tasks to perform, but from the Group's point of view these consumer requests may have appeared as a challenge to the sphere of authority considered to be rightfully theirs.

In general, the medical groups in H.I.P. operated with a high degree of organizational independence. For example, services of the central unit were accepted by the medical groups at their option, and sanctions available to the central unit's Medical Department to enforce contracts were weak. Further, medical group power in the Health Plan had been increasing since the mid-1960's, with the formation of the Joint Board in 1965, membership of additional medical group representatives on the Board of Directors in 1970, and the successful challenge to the exclusivity clause in 1972. To be willing to accept direction from consumers, when it had been largely rejected from other more traditional quarters seems highly unlikely. For the Yorkville Medical Group to aid the consumer council in a matter initiated by the council, in even as small a matter as the identification cards, was to permit an intrusion into autonomy and a reduction of power inconsistent with the above trends in H.I.P. Even though the Group had agreed to the formation of the council, when it actually began to function the Group resisted active involvement with them.

EMERGENCY SERVICES COMMITTEE

The emergency services program of H.I.P. was designed to provide care at hours when the medical centers were closed. In 1971 the program had three components: a telephone answering and advisory service, home visits by physicians, and emergency services facilities in the Health Plan service area. The telephone answering service was located at the offices of central H.I.P. and functioned during the hours the medical centers were closed. Enrollees telephoning their centers at those hours were transferred, through an automatic switching device, to the

answering center where specially trained operators received their calls and relayed information to physicians in an adjoining room. A physician returned subscribers' calls and, depending on the nature of the problem, might provide medical advice on the telephone, or request that a house call be made, or advise the patient to go to the emergency room of a hospital. H.I.P. provided special physicians for house calls.

The leaders of the Yorkville/Circle Manhattan Consumer Council were interested in the provision for emergency services in H.I.P. from the time the council was formed in 1971, and the present emergency services committee developed from these earlier activities. The leaders were unhappy both with the operation of the existing system and with the lack of certain components in that system. In 1971 the consumers wanted to establish an after-hours emergency center for the borough of Manhattan, a transportation center to bring enrollees to and from the center, and "one-dime screening," in which an enrollee telephoning the emergency switchboard would immediately be connected with a physician rather than¹ waiting for him to return the call.

The Yorkville Consumer Council had several meetings at central H.I.P. to discuss these proposals with those administering the program,

1. In a motion passed at a council meeting in August, 1971, the consumers proposed the following emergency services program: (1) The drop-in center be open at all hours that the medical groups is closed; (2) that the center provide an ambulette service, with a nurse in attendance, to bring sick subscribers to the center; (3) that HIP hire a full-time Board Certified internist (preferably an HIP physician) to supervise the screening and house call physicians; (4) that home calls be made for any subscribers who request them; (5) that the Emergency Services Program for Manhattan be decentralized.

and with the President of H.I.P. No agreement could be reached. At some of the meetings consumers brought community residents with them, some of whom were not H.I.P. enrollees. (One consumer who encouraged this procedure stated that the emergency services program concerned the community, and, therefore, the participation of non-enrollees was legitimate.) These meetings were generally characterized within H.I.P. as "confrontations" occurring in an atmosphere of implicit physical violence. One participant described them as "wild."

In the fall of 1972 the consumers decided to present their demands directly to the Board of Directors, and about thirty persons, including community residents, entered a Board meeting, uninvited, to state their proposals. This was generally described within the organization as the meeting the consumers "crashed." The tone of the meeting was described in an interview by a health professional on the Board of Directors as "antagonistic."

Nonetheless, the consumers' criticisms of the emergency services program were considered valid by members of the various interest groups in H.I.P. In interviews one union leader described the consumer ideas as "constructive;" a member of the health professional interest group admitted that "there were reasons to complain about the emergency services program. The directors of several medical groups believed the system needed improvements.

Our respondents and Board minutes report that there was considerable discussion of the proposals at the meeting. The consumer demand for house calls was officially rejected by the Board as organizationally unfeasible; the minutes note that "unlimited home calls are impossible because the manpower that would be required is not available." Board

members and consumers agreed that the judgment of the screening physicians on the need for a house call would be accepted, and that an additional physician would be hired by H.I.P. so that more home calls could be made. As an experiment, all home calls requested in the Yorkville and Circle Manhattan Medical Groups areas would be met.

The Board agreed that a drop-in center was needed in Manhattan, and it also agreed to recommend to the Manhattan emergency services committee that arrangements be made for the use of a hospital as the site for an emergency center to be open when the medical centers were closed. A system of transportation, using ambulettes, was established to bring patients to and from the emergency center at the Yorkville Medical Group on 84th street which was functioning in the interim.

The emergency centers of H.I.P. were within the jurisdiction of each borough, with policy-making authority lodged in a committee composed of one representative from each medical group and two representatives from the Health Plan. When the Manhattan committee voted on the Board of Directors motion in the spring of 1972, representatives from the central unit and from two medical groups approved creation of an all-hours center while representatives from the other medical groups voted in opposition. A compromise motion was passed, which authorized operation of a center at a hospital to be open until midnight and for limited hours on Saturday and Sunday. After the center was in operation for a short time, the hours were further reduced; the center closed at 11 P.M. and opened at a later hour on week-ends.

In the spring of 1972, following these events, the Yorkville/Circle Manhattan Consumer Council formed an emergency services committee to

continue to press for an all-hours center and by May 1972, the consumers had formed a committee of delegates from other consumer councils in Manhattan to deal with this issue. This committee, chaired by a leader of the Yorkville/Circle Manhattan Consumer Council, persisted in efforts to secure a center. The committee had periodic meetings with representatives of the Medical Department of central H.I.P., but the Department did not support the goals of the committee. The consumers sought a meeting with the medical groups' Manhattan emergency services committee, but were refused. Activities of the committee were reported to the full Yorkville/Circle Manhattan Consumer Council and enrollees were interested both in the services provided by the Health Plan and in the reports of consumer activities.

Even though it was acknowledged within the Health Plan that emergency services needed reform, that the consumers had been able to focus organizational attention upon the problem, and that the proposals of the consumers contained merit, the opposition of the medical groups prevented enactment of the specific reforms proposed by the consumers and approved by the Board of Directors. The fate of the consumers' proposals on emergency services shows that the consumers were effectively shut out of the decision-making process of H.I.P. Unlike the other two committees, the emergency services committee's goals involved a decision related to basic organizational policies, a decision entailing potential reallocation of resources. Even raising the problem as an organizational issue was difficult. Could emergency services have become part of the Plan's agenda without resort to "confrontational

tactics?" But, once having raised the issue, and presenting proposals which were conceded to have considerable merit, there was no way the consumers could further participate in the decision-making process. The fate of their proposals was determined by a power struggle between the Board of Directors, the central unit and the medical groups.

This situation suggests that the existing distribution of decision-making authority within an organization largely determines the consumer role within the organization. How much power consumers will exercise will be determined by the groups who already have power; their denial of power to the consumers effectively defined at least one facet of the consumer role.

REPRESENTATION ON THE BOARD OF DIRECTORS

Four of the Yorkville/Circle Manhattan Consumer Council leaders, including the chairman, were representatives to the Joint Consumer Council (JCC). The single issue dominating meetings of the JCC during the period of our research, other than the body's internal structure, was consumer representation on the Board of Directors. This topic was discussed at each of the nine JCC meetings held from July, 1972 (when meetings began), to June, 1973 (when field observations of the Yorkville/Circle Manhattan Consumer Council ended).

Members of the Yorkville/Circle Manhattan Consumer Council supported the idea of a Board composed solely of enrollees to be selected by elections within the consumer councils. The goal of full consumer

membership was to be achieved gradually as a network of consumer councils was formed. An interim step was to be majority membership of consumer council representatives on the Board of Directors. In January 1972, prior to the formation of the JCC, the chairman of the Yorkville/Circle Manhattan Consumer Council wrote to the chairman of the Board of Directors, stating the goals of the council in this matter.

The letter said, in part:

You are aware of the concern of consumers that the HIP Board be composed of subscribers who are affected by the services provided, and that this Board be selected in a manner which permits consumers to have a decisive voice in the selection process. The appointment of HIP subscribers to vacancies on the Board of Directors, and the screening of prospective candidates by a representative group of subscribers represents an important first step in the direction of a Board that is composed of, and accountable to HIP subscribers.

The views of the consumer council were summarized in a "Report of Activities" of the council, dated June 1972, written about the time that the JCC was forming:

Early in the game the Council membership defined its role as that of the decisive policy-making body for the local medical groups. In addition, it pledged to work with consumer representatives of the other HIP medical groups to create a democratically selected central Board of Directors of HIP which would be composed of and directly accountable to HIP subscribers.

At meetings of the Yorkville/Circle Manhattan Consumer Council leaders stated to enrollees that there should be greater representation on the Board of Directors for consumers, particularly those of black and Puerto Rican origin. The Board of Directors was described by council leaders as consisting of "rich people" and "big labor boys."

A consumer leader exhorted enrollees: "We can get Puerto Ricans and Blacks on the Board" and pointed to persons in the room saying, "We would like to get you, and you, and you on the Board." These statements were not questioned by those attending Yorkville/Circle Manhattan Consumer Council meetings, and occasionally were received with applause. In an interview in May, 1972, the chairman of the council stated that in "six months consumers will be elected to the Board." Looking into the future he stated that "in one and a half years there will be a broad election to the central Board through borough-wide councils of consumer representatives."

Early in 1972 the Board of Directors responded to the requests of the Yorkville/Circle Manhattan Consumer Council for a consumer majority on the Board. The Board wrote that any decision on this matter could only be reached after consumer councils were formed in more of the medical groups. By June 1972, this had taken place; the Joint Consumer Council was formed and included representatives from all the active councils in the Health Plan, totaling about twenty groups. In July 1972, the 30 member Board of Directors offered to seat as members two representatives nominated by the JCC. The Board did not offer additional seats, nor would its members make commitments to do so in the future. Our interviews with members of the Board indicated their unwillingness to offer consumers either majority membership or exclusive membership. One Board member stated that "you can't have consumers as a majority on the Board because consumer domination would throw it into a continual state of crisis." Another remarked that "the consumers

want 51 per cent of the Board, but that's going for big lumps." If consumers pressed for a majority another Board member believed that the medical groups would resist: "There would be an altercation." The respondents in this research perceived a place for all interest groups on the Board of Directors, including the consumers, but they did not perceive any possibility of excluding existing interest groups from membership.

In July and August 1972 the JCC debated whether to accept the offer of two places, and on two occasions rejected the proposal. The JCC hoped to be given additional places on the Board, but no further offer of seats was made. In September the President and Vice-President of the Health Plan had resigned. The solvency of the Plan was in doubt, and its future direction was uncertain.

In September the question of Board membership was brought to the JCC a third time when a member of that body introduced a motion to reconsider the earlier decisions. A parliamentary debate ensued regarding rules governing reconsideration. Two of the three leaders of the Yorkville/Circle Manhattan Consumer Council attending the meeting unsuccessfully opposed the motion to reconsider. Passage of the motion by a large majority implied that the JCC would approve acceptance of the two seats. As the debate was about to begin the two representatives of the Yorkville/Circle Manhattan Consumer Council "quietly got up and left," according to field notes. When a JCC member asked that they remain, one of the leaders replied, "I've sat through this for

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three months. I'm not going through it again."

In the debate that followed few persons argued against accepting limited membership. The latter stressed that it would mute the ability of consumers to criticize the Health Plan, and they questioned the motives of the Board in offering such "token" membership. Those supporting acceptance, including the remaining Yorkville leader, argued that it would permit consumers to have a voice in decisions affecting the Health Plan's future and that it did not preclude future efforts to obtain majority representation on the Board. These views were

1. One leader of the Yorkville/Circle Manhattan Consumer Council who had worked with the council in seeking majority membership for consumers on the Board changed his mind by September and no longer held that view. He voted with the majority at the JCC meeting. He explained his position at the next meeting of the Yorkville/Circle Manhattan Consumer Council:

The issue is that all the decisions will be made in the next month - whether we merge. Decisions that affect whether it's H.I.P. or nothing; it's dissolved. The question was whether to hold out for pie in the sky for consumer councils a year from now or take the seats and ask for new seats. If we want to be on the outside now I think it would be a mistake. We can find out what the budgets are, what the finances are.

Those attending the meeting disagreed with him and supported the motion of the majority of council officers to inform the Board of their opposition to placing only two consumers on the Board. The dissenting council leader played only a minor role in council affairs thereafter.

presented, for example, in statements by two different members of the JCC:

I know no other way for consumerism in H.I.P. to continue in a viable form. If we don't put somebody who represents us on the Board - that bunch of thieves - we will have nothing . . . I'm tired of coming here and listening to people I'm in agreement with on principle and talking. I don't see any other way to cut through it. Sometimes, as in a strike situation, there's nothing to do but accept a compromise or cut and run.

It seems clear to me - two seats are small for the short run. It's all we have, but we should take it with a statement that it's insufficient. Power comes from going in an electioneering and more. We are in a position where we must go in and shout but we have to do it from the inside.

Leaders of the Yorkville/Circle Manhattan Consumer Council remained opposed to accepting any proposal other than majority membership on the Board of Directors. At the next Yorkville/Circle Manhattan Consumer Council meeting, these leaders asked approval from the members for further action in opposition to the Joint Consumer Council decision. Approval was obtained and a letter was sent to the Board of Directors stating the council's disagreement with the JCC decision. No further action was taken on the matter and the two persons nominated by the JCC became members of the Board of Directors.

The goal of the Yorkville/Circle Manhattan Consumer Council to secure majority membership for consumer council representatives on the Board of Directors was not achieved. The ability to do so depended, initially, upon support from other consumer councils in the Health Plan that were represented on the Joint Consumer Council. That agreement was not obtained. As a body whose members are drawn from most of the medical groups in the Health Plan, the JCC includes representatives

from several ethnic groups, various social classes, different geographical areas and a range of ages. As noted in Chapter 4, the 28 medical groups in H.I.P. are located throughout the five boroughs of New York City and extend into the suburban counties of Nassau and Suffolk. Enrollees include civil service workers, trade union members, professionals, and welfare recipients and members of these different populations are part of the Joint Consumer Council. They may all be concerned with the same issues, but have different views as to how to resolve them. Consumer agreement on issues cannot be assumed merely because all consumers occupy the same status in an organization. Agreement must be actively sought but in a heterogeneous group such as the Joint Consumer Council this may not be easy to achieve. The condition of heterogeneity permits the development of factions in social movement organizations (Zald and Ash, 1969), and that is what occurred here. In general, leaders of factions are accountable to different constituencies among organization members. Medicaid enrollment in H.I.P., with its predominantly black and Puerto Rican population, was concentrated in the Yorkville and Circle Manhattan Medical Groups. While total Medicaid enrollment reached 11 per cent in H.I.P., it was more than 50 per cent in these two medical groups. Issues of representation were especially pertinent to these enrollees, since there were no representatives of the Medicaid population on the Board of Directors, and few representatives of minority groups. It was not as significant an issue to constituencies whose members belonged to labor unions already part of the governing system of the Health Plan. Leaders of the Yorkville/Circle Manhattan Consumer Council needed to secure

agreement from other consumer units to achieve their goal of majority membership on the Board for consumers, but agreement could not be secured in the heterogeneous body of the Joint Consumer Council.

A further block to achievement of this goal was the reluctance of members of the Board of Directors to increase the number of consumer representatives on the Board. The Board is the only body in the Plan with the authority to approve new Board members; it is a self-perpetuating body. For members to agree to a consumer majority would constitute a willing removal of themselves from power, which would appear to be a highly unlikely event.

Very limited consumer membership on boards of directors in health care organizations is reported by several authors. A review by Law (1974) of the boards of directors of Blue Cross plans across the nation shows that few consumers are on such boards, other than those persons drawn from the wealthy and professional segments of the community. A recent survey by the Associated Press, reported in the New York Times (August 6, 1975) concludes that consumer representation on Blue Cross boards is very limited, and that such representatives are not selected by the enrollees of the Plan:

In response to the increasing pressure in recent years - including pressure from Blue Cross and Blue Shield headquarters - many state and local plans have added 'public members' to their boards to represent subscribers. But the A.P. investigation found that many of these public members were chosen - under the self-perpetuation concept - by incumbent board members and not by subscribers. In some cases - Tennessee, Florida, Idaho, Los Angeles, for example - state medical societies or hospital associations make the selections.

Studies of hospitals indicate a similar pattern. A review of membership on Detroit's hospital boards by Goldberg and Hammelgarn (1971) shows that two-thirds of the members are business executives, with the remaining members coming from the legal, accounting and medical professional. In a review of consumer sponsorship of health care organizations, Sheps (1974) concludes that membership on the boards of voluntary community hospitals begins "restricted to the richest, most influential and aristocratic members of the community" but that, with the passage of time and greater community involvement in hospital matters "changes in representation on the governing board have been taking place." However, it should be noted Sheps is not referring to the withdrawal of the wealthy from such boards but merely to the addition of one or two representatives from local political pressure groups, such as ethnic groups.

The actions of the Board of Directors in H.I.P. in rejecting a consumer majority are consistent with the patterns described above. Those directly served by a health care service are rarely part of the governing body of that organization and when they are, they are likely to be selected by the body itself rather than by other consumers. The result is very limited consumer membership on boards of directors in health care organizations. The consumers of the Yorkville and Circle Manhattan medical groups sought to change that pattern in H.I.P., but were unable to do so.

SUMMARY

The committees of the Yorkville/Circle Manhattan Consumer Council sought achievement of the following goals: (1) active involvement in presenting grievances; (2) issuance of identification cards to geriatric enrollees; (3) securing the names of enrollees over the age of 60; (4) writing and distributing a booklet describing patients' rights in H.I.P.; (5) bringing about full emergency coverage at hours when the medical centers were closed; and (6) electing a sufficient number of consumers to the Board of Directors so that group would constitute the majority of Board members. The consumers failed to achieve nearly all these goals. They were only able to present a few grievances to the Yorkville Medical Group; names of enrollees were obtained but only for those over the age of 65; an identification card was distributed but it required nearly a year of effort for this to be accomplished; a patients' rights booklet was not printed; and only some of the desired changes took place in the emergency services program.

In terms of the issues raised in this research we may say that the role consumers identified as appropriate for themselves was not fully carried out. At meetings of the consumer council there was acceptance of the programs developed by council committees, so that consensus emerged among the consumers of the Yorkville and Circle Manhattan Medical Groups. In carrying out the agreed upon programs consumers experienced resistance from members of the Health Plan. The response of other organization members, such as medical group directors,

the head of the Department of Consumer Affairs, members of the Board of Directors, to the specific programs of the consumers was generally negative. Because the Plan controls resources needed by the consumers to carry out their program organization members were able to enforce their own views and therefore limit consumer accomplishments. Further, agreement for consumer proposals had to be secured from formally authorized bodies of the Plan and in most instances this could not be obtained. The medical groups in Manhattan rejected consumer proposals for changes in the emergency services program and the Board of Directors refused to place a majority of consumers as members.

The evidence indicates that the ability of consumer groups to affect decision-making in a health care organization is markedly affected by the organizational context within which participation occurs. If consumers do not have control over the resources needed for program implementation they will have to "beg" from the organization, becoming dependent upon institutional acquiescence. If decision-making authority is fragmented, as it is in a multiple leadership system, agreement for programs will have to be secured from a number of different organization bodies. In such situations consumers must develop coalitions with other internal interest groups, for it is through negotiation and compromise that decisions are reached in multiple leadership environments. As noted in more detail in the concluding chapter, the ability of the Yorkville/Circle Manhattan Consumer Council to build such a coalition was hampered by their dependency upon the Health Plan for resources, the lack of internal support for the concept of

participation, and the diminished support for participation generally in the external environment of the Health Plan.

Part of the process of achieving role definition is establishment of consensus among the consumers themselves. This was accomplished by the Yorkville/Circle Manhattan Consumer Council among its own members. Could the same result be achieved with other consumer bodies in the Plan? Failure of the Joint Consumer Council to approve majority consumer membership on the Board of Directors as an immediate consumer goal constitutes lack of consensus. For this goal to be reached leaders of the Yorkville group not only needed to secure agreement from other interest groups in the Plan but from other consumer leaders as well. The structure of the Plan created barriers to that accomplishment. As developed by the Yorkville leaders, representation on the Board was primarily a group minority issue, compounded by questions of social class. Minority enrollment in H.I.P. was concentrated in a few medical groups, particularly the Yorkville and Circle Manhattan groups. While total Medicaid enrollment reached 11 per cent in the Plan, it was more than 50 per cent in the two medical groups. The constituency represented by the Yorkville/Circle Manhattan leaders was different from that of other councils. Issues pertaining to color and class had a saliency to Yorkville that was lacking among leaders from other councils. Membership on the Board of Directors was not as significant to other council leaders whose constituents belonged to labor unions already part of the governing system of the Health Plan.

The goal that the Yorkville group required consumer consensus in order to achieve was one on which consensus was unlikely to be achieved.

CHAPTER XI

A CONCLUDING REVIEW: THE DECLINE OF CONSUMER PARTICIPATION AS A SOCIAL MOVEMENT

A new meaning emerges for consumer behavior in modern societies with the shift of service provision out of the home and the immediate community to other institutions, such as schools and hospitals. The consumer is not only the purchaser of tangible goods, as he is conceptualized in traditional economic theory, but the utilizer of services as well. A major economic distinction between an advanced industrial economy and a less well advanced one, between a primary economy and a tertiary economy, is the extent to which employment is concentrated in service production. In these terms, the United States is the first service economy in the world (Fuch, 1968). What does this mean with respect to consumer behavior?

More and more people are recipients of services, whether purchased directly, such as payment for college education, or provided by society at the tax-payers' expense, such as primary and secondary education. Thus, more and more people are exposed to, and occupy the status of, service consumer and many of these people are presently dissatisfied with the services rendered and the manner in which they are delivered. A rumbling is heard throughout the land as consumers meet with each other, share complaints, and seek redress through organizations they form, such as the National Welfare Rights

Organization and the National Consumers Health Organization. Consumers assert their right to full membership in the decision-making systems of human services organizations.

This dissertation examines the nature of these moves in the health field, and describes the behavior of consumers as decision-makers in one health care organization, the Health Insurance Plan of Greater New York (H.I.P.), a prepaid group practice serving 750,000 persons.

THE ORIGINS OF THE H.I.P. CONSUMER COUNCIL

Consumer Participation: The Strengths and Weaknesses of a Social Movement

Consumer participation in service bureaucracies, and specifically in health, may be treated as norm-oriented social movement, as defined and analyzed by Smelser (1963). Consistent with this framework we have shown how social strain, belief development, and participant mobilization contributed to the emergence of the consumer movement in health. We have discussed social strain as the perceived discrepancy between expectations of health care delivery and the realities of care provided, heightened by the impact of bureaucratization, affluence, and the growing emphasis upon egalitarianism inherent in the civil rights movement. We have shown how the process of bureaucratization contributed to the development of a consumer movement by generating client groups and engendering consumer solidarity. From both providers and consumers in health, beliefs emerged validating consumer participation in organizational decision-making as a means of reducing service

discrepancies and improving health care so that it would meet consumer expectations.

Yet, the movement in health has been narrower in scope, elicited less commitment from the majority of its members and been generally weaker than similar movement in other service fields. How can we explain this difference? The potential pool of consumers from which to draw members for the movement is limited in health in a manner unlike that of other service fields. Even though the bureaucratization of health has moved forward with great rapidity in recent years, the degree of bureaucratization is less than that of other service fields, such as education and welfare. In other service fields practitioners function almost exclusively in organizational settings on a salaried basis, but in the field of health, group practices, hospital clinics, and government programs have not replaced solo, fee-for-service practice.

The elements of patient power in solo practice have been identified by Freidson (1961) in his distinction between lay-controlled and colleague-controlled practice. In solo practice the patient deals directly with the physician. If the patient is not satisfied with the care received he may terminate his relationship with the practitioner and turn to another for service. The knowledge that this is possible may create a readiness in the physician to accede to patient wishes, which is heightened by the relative lack of colleague contact that characterizes the lay-controlled solo practice. The ability of the patient to transfer his patronage to another physician gives to the patient greater control over the doctor-patient relationship than is

possible in other types of practice situations, according to Freidson. The dissatisfied patient may alter the conditions that led to dissatisfaction either by changing physicians or seeking a change in the care received from his present physician. In either case individual action can alleviate the patient's problem with health care delivery so that collective action is not necessary.

In terms of the discussion in this report, the discrepancy between expectations and reality that constitutes social strain in the Smelser framework and encourages the development of a social movement may be reduced among solo practice patients without recourse to action with others. In this way the structure of the health field, unlike that of other service fields, appears to limit the possibilities for a social movement toward organizational change. Bureaucratization creates the opportunity for a social movement, but the existence of solo practice limits its potential, compared with other service fields.

As we have pointed out, however, individual action provides an illusionary sense of consumer power because it does not alter mechanisms for service distribution, nor the organizational contexts within which solo practice functions, such as hospitals. It is in organizational settings, such as prepaid group practices, that consumers have the opportunity to express their needs and have a means of meeting them.

In accounting for the limited consumer movement in health, one must also look to the beliefs that emerged in that movement. Participation was perceived as a means of improving health care; it was to be a pragmatic solution to problems of accessibility, cost and delivery. Participation was not presented as a symbol for racial equality, or

class solidarity, or community control; it was not presented as having a symbolic value beyond the health field itself. Reform in health was not assumed to be a forerunner of reform in other institutional sectors, nor as a necessary first step to change in other institutional areas. In this respect the consumer participation movement differed from that of other service fields where the ideology of participation stressed social issues broader than the immediate institutional reform at hand. Community control of schools was linked to racial units and black power (Altshuler, 1970). The student movement in higher education stressed that universities were symbols of the larger society and, further, that they were to be used as bases for mobilization to change the society as a whole (Skolnick, 1969). Appealing to institutional change as the beginning of broad social change, these movements had an ideological significance for their members that was not matched by the quest for consumer participation in health. It may be that the symbolic quality of the movement in other fields gave to those movements a degree of member commitment that could not be developed in health. Without intense commitment, a social movement is severely limited in its efforts to persist and gather strength (Turner and Killian, 1972). The lack of commitment, in turn, was reflected in a low level of involvement in consumer participation in health. The passivity of the consumer council reviewed here would seem to indicate the difficulty of arousing to action even those sufficiently interested to join a consumer council. Not even their own complaints about service, or the frequent horatory urgings of council leaders, could move this group to any significant level of activity.

An additional pertinent factor may be the sense of awe toward physicians to which even activists in the consumer movement may be subject. The social prestige of the profession, the gap in knowledge between the patient and the practitioner, and the authority of the physician in the traditional doctor-patient encounters all contribute to the perception of the physician as one above the reproach of the layman. Feeding this perception is the gratefulness felt toward physicians for the crucial services they render. In the popular image it is the physician who is able to save one from death, disfigurement, or disability, so that it is difficult to challenge those on whom one's very life may depend.

Thus, it would appear that the solo practice structure of the health field, the pragmatic nature of the beliefs that emerged in that field and the cultural definitions of physician authority limited the scope and fervor of the consumer movement in health, while, at the same time, the growing bureaucratization of health, and belief in consumer governance as a means of improving care encouraged the formation of such a movement. Requirements for participation were incorporated into an increasing number of programs promulgated by the federal government. The growing dependence of health care institutions upon these funded programs created a readiness to accept the requirements for participation.

The movement's development in any particular health care organization was a result of the confluence of these external forces and of elements specific to the organization. More than general social readiness is needed if participation is to emerge in a specific setting.

Participation must have a special pertinence to the target organization, evoking some response from it. That is exactly what occurred in H.I.P.

The Initiation of Consumer Participation in H.I.P.

Each of the interest groups in H.I.P. seized upon the national movement for increased consumer participation as a means of responding to perceived needs of the Plan. Among the problems facing the Plan were enrollment from new client groups whose care was publicly funded, declining enrollment from traditional enrolling groups, reorganization efforts that weakened the financial stability of the Plan, and efforts by union leaders to gain a greater role in organizational affairs. At the time these changes were taking place, support by the federal government for prepaid group practice plans was being considered. It was anticipated that funds would become available to those plans conforming to federal legislative prescription, which included a plan for participation by enrollees in the governance process. As the interest groups confronted these problems each saw the benefits that would accrue from the formation of consumer councils. Simultaneously, the heretofore unorganized enrollees began to organize and press for participation.

Yet, the initiative for the formation of the councils did not come primarily from the consumers; rather, the initiative came from the established interest groups within the existing structure of the Plan - labor leaders, health professionals, medical group physicians - who defined the councils as a means of coping with problems arising from within and outside the Health Plan. In seeking a resolution to internal organizational tensions H.I.P. decision-makers accepted a

framework of action developed outside the organization. They took into account the consumer movement swirling about in the larger society. The norm-oriented consumer movement became part of the pertinent H.I.P. external environment.

Once consumers in H.I.P. began to organize they pointed to service deficiencies in the Plan. Although H.I.P. seeks to provide quality care to enrollees its ability to do so has been impaired by the utilization of part-time physicians, insufficient funding, inconsistent monitoring policies, dispersed monitoring authority and the relative autonomy of the medical groups. The result has been that standards of care vary from medical group to medical group, with some groups providing inadequate levels of care. Enrollees experience the result as impaired service delivery, but prior to the formation of the consumer councils they had no direct means of addressing this problem.

The services to which subscribers were entitled were detailed in a contract between the Health Plan and the enrolling group, but neither the enrollees themselves nor their negotiating representatives could ensure that the terms of the contract would be met. The only means of direct protest for enrollees was withdrawal of membership. This is a "gross" form of protest since it does not identify the particular features of the Plan which enrollees dislike and provides no means of remedying inadequacies. With the rise of the consumer participation movement a new approach to securing consumer input was possible. Thus, the changing external environment, the altered internal environment, and the acknowledgment of the Plan's shortcomings led to the formation of the councils.

CONSUMER PARTICIPATION IN PRACTICE

Consumer Activities

After consumer participation units form, in what issues do they become involved? Consistent with the beliefs that are part of this movement, the emphasis is upon access to care, modes of delivering care, and system governance. The activities of the Yorkville/Circle Manhattan Consumer Council were limited exclusively to the organizational context in which care was delivered. This finding is consistent with a number of other studies of consumer participation in health (Campbell, 1971; Hollister, 1971; Partridge, 1973).¹ Consumers want an organization that functions to its maximum capacity to deliver care to them; they leave the work of diagnosis and treatment to the physicians. Consumers do not seek to intrude into those areas that have been characterized by Freidson as "technical". It is in those tasks Freidson identifies as "non-technical", including the establishment of policy in health care institutions, that consumers seek to exert some control. This research shows that the task differentiation that Freidson identified as being desirable is also feasible. This research provides empirical evidence that such task differentiation between physicians and consumers in organizational settings can be both established and sustained.

1. An interesting aspect of the consumer movement that has not yet attracted systematic attention are the self-help groups organized by patients suffering from specific diseases, such as emphysema and various types of cancer, and groups developing out of the women's movement. These are not rooted in specific organizations, such as a prepaid group practice, so the thrust of their goals has not been the establishment of organizational policy. Perhaps in these groups an interest may

Goal Realization: Effects of a Weakened Social Movement

Once consumer participation units are formed, what is their fate? The goals consumers identified for themselves in the Yorkville/Circle Manhattan Consumer Council were generally not met. How do we account for this relative failure? Two variables are of particular significance. First, the weakness of the social movement itself, and second, the organizational context in which participation occurred.

Support for the establishment of councils in H.I.P. was premised upon future government acts and current public opinion, but almost as consumer participation in health was gathering momentum, support for such a movement was slowly receding. It was as though the tide brought in a wave, yet beneath that wave was an undertow that would begin to pull it back almost before it crashed to the beach. So it was with consumer participation, where the wave of the future seemed to be arriving, only to be pulled back by an undertow of declining support and changing social conditions.

The federal government approved legislation pertinent to H.I.P. that required no more consumer participation than that already manifest in the lay membership on the Board of Directors. Union leaders could continue to represent enrollee interest. According to the 1973 HMO Act

emerge in such matters as diagnosis and treatment. A careful comparison of these types of groups with those formed by clients of human service organizations is a useful direction for future research.

there was no requirement to develop representative bodies for consumers similar to the council of H.I.P., and only one-third of the Board members had to be enrollees in the Plan.¹ The basic rationale for health professional support for consumer councils in H.I.P. was undermined. Several health professionals mentioned passage of the Act in interviews, pointing to this provision as reducing the need for consumer councils in the Health Plan.

The nature of the provisions in that Act may have been a reflection of the general trend then taking place in the nation, in which support for participation in health was declining. With that decline the premise for support among physicians in H.I.P. for consumer councils became eroded. The values within society that supported consumer participation began to change in the 1970's (Hollister, et. al., 1974). The civil rights movement lost its momentum. It was from this movement, with its stress upon equality and freedom, that beliefs for consumer participation had partially derived. The interest in urban neighborhoods that had contributed to the move for community control began to decline. Federal support for Neighborhood Health Centers was reduced. In the early 1970's the Office of the Budget in Washington, D.C. determined that the 50 centers then in existence constituted

1. As summarized by the Group Health Association of American (1974) the provision states that on a policy-making board of an HMO "members compose at least one-third of the membership."

a sufficient number of demonstration units and refused to fund additional facilities (Hollister, et. al., 1974). Efforts to achieve participation among both consumers and providers had been concentrated in these centers. Lack of support by the government for them weakened the entire consumer participation movement in health.

In general, such shifts away from acceptance of a social movement in the society-at-large affects the ability of any particular organization within the movement to grow. The organization becomes hobbled as the supportive value system derived from social acceptance of the movement crumbles. In their review of social movement organizations, Zald and Ash summarize that relationship:

The size of the organizational base support, the amount of societal interest in the social movement, and its MO's Movement Organizations, and the direction of that interest (favorable, neutral, or hostile) directly affect the ability of the organization to survive and/or grow (1969).

Their conclusions are consistent with the view of organizations adopted in this report as open-systems responsive to the external environment. As the environment of H.I.P. changed from one supportive of consumer participation to one retreating from it, the effects could be discerned in H.I.P.

The basic weakness of a consumer movement in health may also be pertinent here, particularly the reluctance of consumers to directly challenge physicians. For example, it has been noted in this study that enrollees attending H.I.P. consumer council meetings presented complaints against physicians but would not press these in any formal manner that would bring the complaints to the attention of the medical group, the medical director and the physician involved. Constrained

by the prestige and knowledge of physicians, yet feeling that the services provided were inadequate in some way, enrollees became enmeshed in a status conflict which was resolved for many by terminating their involvement with the consumer council. Unless the sense of awe of the medical profession is diminished, so that the physician is perceived as one of several types of professionals providing health care in active cooperation with the patient, sustained consumer involvement in decision-making bodies will probably remain very limited.

Goal Realization: Effects of the Organizational Context

Lack of consumer success can also be attributed to the specific organizational context of H.I.P. Consumers were dependent upon their negotiating agents to ensure that promised services would be delivered, but these agents could not fully carry out such responsibilities within an organizational structure of relative autonomy for the medical groups and a generally fragmented authority structure. A strengthened central body with formally defined powers and centralized control of organization resources was among the goals of those supporting the reorganization of H.I.P., which was to include a reduction in the number of medical groups and primary reliance upon full-time physicians. Failure to reorganize confirmed that there would be no strong centralized authority, and any hopes consumers might have had of ensuring consistently high levels of care throughout the H.I.P. system would seem to have been defeated.

The mere advent of consumer participation in H.I.P. could not itself change the prevailing patterns of decision-making in the Plan. These patterns served as constraints upon consumer ability to achieve

their program goals. Lack of control by consumers over basic organizational resources, such as funds and professional knowledge, inhibited their ability to enter into coalitions in an organization where the fragmented authority structure made coalition membership a necessary condition for sustained affect upon policy decision.

Turning to another aspect of the H.I.P. situation, consumer participation in the Plan was not premised upon a perceived inherent right of service recipients to belong to the decision-making system. None of the interest groups stated that enrollees have a basic right to participate in governance. Bringing consumers into the system fit the needs of the organization, as perceived by medical group physicians, labor leaders, and health professionals. Participation was adopted as a pragmatic innovation. It did not become a value in H.I.P.

If participation was adopted on the basis of its usefulness, support for participation could be reduced or eliminated if its useful consequences were perceived as limited. This is exactly what appears to have occurred. The weakened social movement in the society at large diminished physician support for the councils. The federal government's failure to require extensive consumer participation in prepaid group practices reduced health professional support for consumer councils. The councils did not work with the labor unions to oust the President of H.I.P., and they did not engage the medical groups on the issue of contract conformity. Lack of such involvement diminished the incentive among labor leaders to attend to consumer concerns. As one leader bluntly stated: "What do I need them for" if their area of involvement was not contract conformity.

Cooptation and the Consumer Councils

The process by which councils were formed may be summarized as cooptation. Consumers were given a formally authorized place in the decision-making structure of H.I.P. but were given little or no actual power. As defined by Selznick (1949) formal cooptation occurs when the organizational purpose is creation of public solidarity and legitimation of the governing body of an organization.

The sources of support for consumer councils in H.I.P. can be reviewed in terms of this process. Health professionals seeking federal funds for H.I.P. sought to legitimate the Plan's leadership structure to the federal government by bringing consumers into that structure. Physicians sought to legitimate the Plan to the public-at-large, in response to the perceived acceptance of consumer participation in society. Labor leaders directed their attention to members of the Plan's interest groups and sought to legitimate their own quest for power by showing that the consumers wanted them to assume leadership. None of these interest groups anticipated their own replacement by the consumers, but merely sought to extend the base of leadership to include consumers. At the same time none of the interest groups accepted the premise that consumers had an inherent right to participate in governance. It was not the right of participation that was being recognized, but the usefulness of it to the organization. Given that fact, consumers were not provided any real ability to disturb already established leadership centers.

Where Do We Go From Here

While there is much talk presently of a new "consumer vanguard" capable of affecting institutional decision-making in a society that

is increasingly characterized by a service economy (Gartner and Reisman, 1974), the evidence in this research does not validate the existence of either a widely active consumer movement in the field of health or consumer ability to significantly affect institutional decision-making bodies in instances where participation bodies are formed. Consumer participation has generally been confined to government sponsored programs, leaving relatively untouched the basic health care institutions of the nation. To this date, the beliefs expressed by some consumers and some providers that consumers should be part of policy-making bodies has not yet been translated into effective reality.

APPENDIX A

BOARD OF DIRECTORSHEALTH INSURANCE PLAN OF GREATER NEW YORK

October 19, 1944

Winthrop W. Aldrich	Chairman, Board of Directors, Chase National Bank
Dr. Alfred Angrist	Director of Laboratories, Jewish Memorial Hospital and Queens General Hospital, Associate Professor of Pathology at New York Medical College
Dr. George Baehr	Chief of the First Medical Service, Mount Sinai Hospital
Dr. E. M. Bluestrone	Director, Montefiore Hospital
John S. Burke	President, B. Altman & Co.; President, Altman Foundation, Inc.; The Friedsam Foundation, Inc.
Dr. J. A. Curran	President and Dean, Long Island College of Medicine
Neva R. Deardorff	Assistant Executive Director, Welfare Council
David M. Heyman	Chairman of the Board, New York Foundation
Henry J. Kaiser	Industrialist
Constance Kyle	National Director of Personal Service, National Maritime Union of America, CIO
Mary W. Lasker	Secretary, National Committee for Mental Hygiene
F. H. LaGuardia	Mayor of the City of New York
George Z. Medalie	President, Federation for Support of Jewish Philanthropic Societies

Saul Mills	Secretary-Treasurer, Greater New York CIO Council
Thomas Murtha	President, Central Trades and Labor Council
Dr. Tracy J. Putnam	Director of Services, Neurology and Neurosurgery, Neurological Institute of New York
Gordon S. Rentschler	Chairman, Board of Directors, National City Bank
Dr. Willard C. Rappleye	Dean, College of Physicians and Surgeons
Beardsley Rumi	Chairman, Board of Directors, Federal Reserve Bank of New York
William Reid	City Collector
Gerard Swope	Former President, General Electric Co.
Dr. Philip D. Wilson	Surgeon in Chief, Hospital for Special Surgery
Dr. John W. Wittmer	Personnel Manager and Medical Director, Consolidated Edison Co.
Matthew A. Woll	Vice President, American Federation of Labor

APPENDIX B

BASIC POLICY STATEMENT FOR ORGANIZATION OF CONSUMER COUNCILS

Out of significant concern expressed by the HIP Board of Directors, administration, and subscribers that subscribers should have a more organized voice in HIP, consumer councils composed of HIP subscribers are to be established for each of the thirty HIP medical groups. Through continuing interest in the program, consumer councils will be able to make recommendations for maintaining and improving the delivery of medical services at an operational level. The councils can become important vehicles for members to express their opinions about present operations and exert their influence towards program improvements. These goals can be achieved by active cooperation of the leadership of each medical group, the consumer councils, the Board of Directors, the central staff of HIP, and major contractor groups.

In a variety of ways, the New York City community has implemented the concept that the consumers of services in the health, education, and welfare fields will participate in the process of the delivery of services. In the last five years the notion of continuing consumer involvement through actual activity and programs has become widespread.

Subscriber involvement is not new to HIP. As leaders in the field of prepaid group practice providing comprehensive health care, HIP from its inception has been committed to the involvement of subscribers in the HIP program. In the last 25 years there have been many contacts with subscriber groups where reaction to the delivery of services has been solicited through educational programs participated in by providers and users in the HIP health care system. A few HIP medical groups have begun to develop consumer councils. Those involved in this process report the value of these organizations. Consumers and providers learn, grow, and develop through real involvement with each other in the discussion - - decision-making process.

In organizing such councils it is anticipated that the Board of Directors, the central HIP staff, group center medical directors and medical staff, administrators and non-medical staff, users of the service and their families, major contractors, and other agencies will find the councils valuable.

The functions of the consumer councils will be to:

1. Report on physical conditions of medical centers and make recommendations for improvement.
2. Explore the scope and effectiveness of health services.
3. Assess the manner of delivery of health services at an operational level.

4. Assess the administrative procedures affecting the delivery of health services.
5. Interpret the HIP program to subscribers and the community at large.
6. Inform subscribers of the manner of organization of each medical center.
7. Participate in setting priorities for changes in the program.
8. Develop educational programs where provider and user can learn their attitude and behavior affect the delivery of health services.
9. Participate in regional meetings of medical staff and consumer representatives in area-wide planning.
10. Record and transmit reports on council activities, including recommendations on policy and action.
11. Assist in the enrollment program for new subscribers.

GUIDELINES FOR ORGANIZING A CONSUMER COUNCIL

1. A medical group consumer council shall generally consist of between 7 and 25 members, who are HIP enrollees. It is suggested that there be alternates to insure adequate attendance. The following formula for determining the size of the consumer councils is based on an index of approximately one member for each 1,000 subscribers up to 15,000 enrollment and one for each 2,000 subscribers when group enrollments are larger. This formula is not a rigid required pattern and can be varied to assure effective council membership.

<u>Subscriber Enrollment</u>	<u>Number of Members on Consumer Council</u>	<u>Alternates</u>
Under 10,000	7 Subscribers	2
10,000 - 15,000	11 Subscribers	2
15,000 - 20,000	13 Subscribers	3
20,000 - 25,000	15 Subscribers	4
25,000 - 30,000	17 Subscribers	4
30,000 and over	21 Subscribers	5

2. Members of the council shall be representative of the subscriber components of each medical group, including branch centers. The major contractor groups - trade unions, government agencies, health and welfare agencies, and others with whom HIP has contracts - will designate members on a proportional basis.

3. Each major subscriber component of the group shall designate members for consumer councils in proportion to the number of their enrollees in each medical group.

4. Representatives of Medicare and Medicaid subscribers in each medical group shall be selected through consultation with local community bodies, community health federations, and similar groups.
5. Representatives of direct payees will be selected in consultation with the Consumer Affairs Department, medical groups, and consumer councils.
6. Where subscriber councils already exist, their members can be included with those designated by major contractor groups.
7. Members of the councils shall serve without compensation.

GUIDELINES FOR DEVELOPMENT OF CONSUMER COUNCILS AND THEIR ACTIVITIES

1. The medical group center shall provide meeting space for the consumer council in the medical group center or in other suitable neighborhood facilities.
2. The medical group director, administrator and staff shall cooperate with the central office personnel in operating the council.
3. The medical group director and administrator, or other assigned staff, shall meet with the council.
4. The medical group shall make available appropriate information requested by the council to assist in carrying out its functions.
5. Each medical group will arrange for an initial organizational meeting to plan and organize an on-going consumer council. At the organizing meeting the specific functions of the council shall be clearly defined, and a procedure established for electing a permanent chairman, vice-chairman, and a secretary for the first year.
6. Each council member shall serve for one year, until procedures are developed for insuring continuation of consumer councils.
7. The consumer councils will usually meet about once a month.
8. At the organizing meeting consideration shall be given to a plan to provide council members and medical center staff with the orientation which will enable them to function in their important roles.
9. Expenses incurred for consumer council activities shall be reimbursed by HIP to the group (such as coffee, carfare, mailings, publications, clerical help, etc.).

Participation in the Consumer Councils Shall Assure:

1. The right to full discussion of issues deemed important by the council.
2. The right to consult with responsible officials at central HIP and other outside authorities.

3. The right to make specific recommendations for the improvement of the delivery of services at each medical center and HIP.
4. The right for members, on invitation, to attend executive committee meetings at the group medical center to make presentation of issues discussed.

FUNCTIONS OF THE DEPARTMENT OF CONSUMER AFFAIRS

The Department of Consumer Affairs and its staff and resources shall be available to each medical center:

1. To help develop councils.
2. To help with council meetings and programs in cooperation with each medical group.
3. To serve as a resource arm for each medical group and consumer council by developing needed materials and information.
4. To contact the major contracting agencies and membership organizations for names of individuals to serve on consumer councils in the groups in which they are enrolled.
5. To enlist the cooperation of interested persons and help medical groups establish medical group consumer councils.
6. To help each medical group establish effective patterns of consumer participation to meet the needs of the subscribers being served and the medical groups.
7. In cooperation with the HIP Publications Department and the Health Education Department, to develop publications which will assure an exchange of ideas and information on activities and problems related to consumer councils.
8. To receive reports of consumer councils and participate in the implementation of recommendations.
9. To organize regional committees of consumer council representatives and provide staff services.
10. To organize a city-wide committee of consumer council representatives to meet with central HIP.
11. To publish reports on consumer council activities.

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