Improving Health Care of the Poor: The New York City Experience

Miriam Ostow
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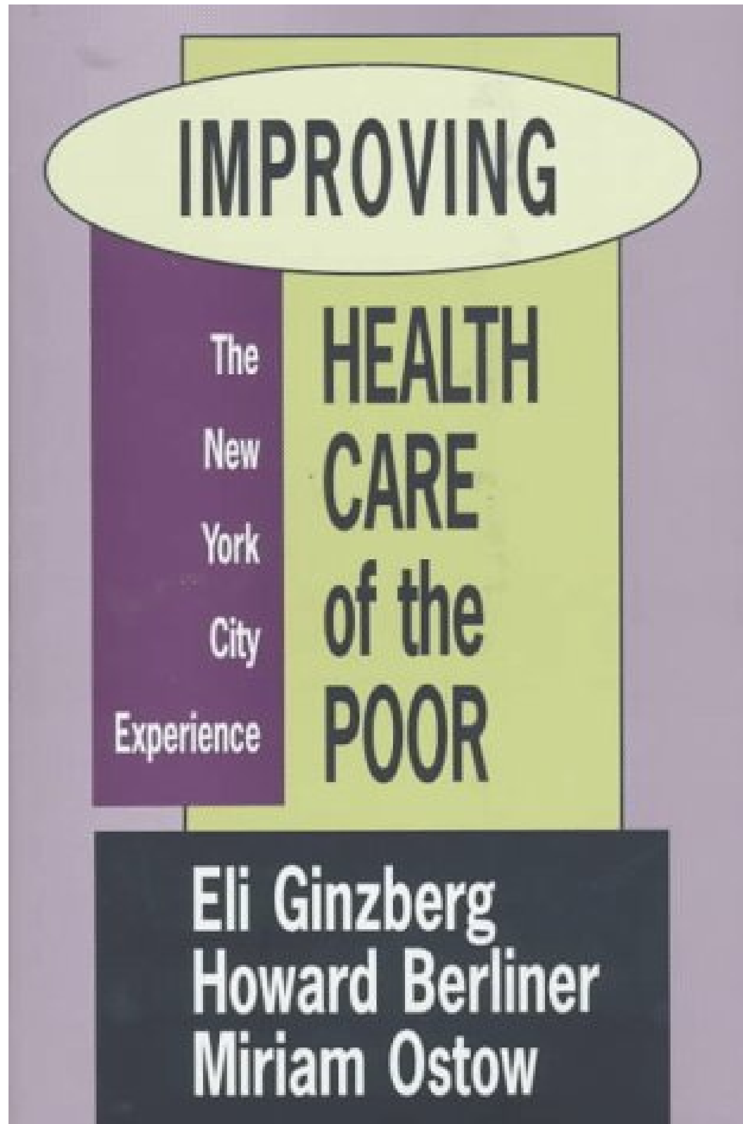

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Miriam Ostow : Improving Health Care of the Poor: The New York City Experience before purchasing it in order to gage whether or not it would be worth my time, and all praised Improving Health Care of the Poor: The New York City Experience:

"I can think of no one more fitting to provide the broad perspective on the City's health system, as well as a specific analysis of the current state of affairs." --James R. Tallone, Jr., President, United Hospital Fund For the three decades

since passage of Medicare and Medicaid, health care service to the American people has expanded. Relatively few studies have assessed the extent to which access to health care have actually improved for specific groups, such as the poor and the middle class. This book is an in-depth assessment of the extent to which Medicare and Medicaid have met expectations of citizens. New York City is the focus because of its long-standing commitment to provide essential health care to all citizens irrespective of ability to pay, its hospital system composed of voluntary and public sectors, and its vast governmental and private funding.

From The New England Journal of MedicineThe system of health care for the poor in New York City is unique among U.S. cities both because of the size of the poor population and because of the city's commitment through most of this century to provide health care to those who cannot afford it. Two million New York City residents are on the Medicaid rolls, 1.5 million are uninsured, and several hundred thousand have inadequate insurance for a major illness -- the total of approximately 3.7 million is half the population of the city. More than half of those covered by Medicaid are treated in voluntary hospitals, but most of the uninsured are treated in the largest municipal hospital system in the country, the New York City Health and Hospitals Corporation (HHC), which now has 11 acute care hospitals with 7000 beds plus 2 chronic care hospitals, 4 nursing homes, its own health maintenance organization (HMO), and many ambulatory clinics. Before Medicaid and Medicare, in 1965, the city budget allotted $325 million ($1.6 billion in 1995 dollars) for health care. A large part of this was in the form of subsidies to voluntary hospitals for the care they provided to indigent patients. The introduction of Medicaid and Medicare in 1966 provided a huge infusion of federal and state funds into this system of care for the poor. Between 1965 and 1975, private spending for health services in New York City rose by 120 percent but public spending rose by 640 percent. By contributing $6,000 per beneficiary, Medicaid in New York State provides twice as much as the next most generous state, California. The infusion of cash produced some remarkable changes. Affiliation contracts with universities were implemented for all the public hospitals, providing new and badly needed skilled staff for many of them. The numbers of nurses and supporting staff increased dramatically. Laboratories were brought up to modern standards in terms of quality and availability. The hospitals were taken out of the City Health Department, and the semi-independent HHC was set up, with the idea that Medicaid and Medicare would make it possible for the hospitals and clinics to become financially independent and eventually to function in the same way as the voluntary hospitals. Unfortunately, many of the hopes for the new system foundered with the New York City fiscal crisis of 1975, from which the city's health system has never fully recovered. It is true that conditions are much better than before 1965 and that good care for acute illness is available. It is also true that the present system, in which reimbursements to Medicaid hospitals are pegged to the reimbursement rate for Blue Cross, has made many HHC hospitals self-sufficient and that there is quite reasonable compensation for patients who have no insurance. But this financial stability is tenuous in view of the Medicaid cuts proposed for next year. Moreover, it has been achieved at the price of eliminating amenities that might be considered essential in a voluntary hospital. In the new mandatory Medicaid managed-care system in New York State, all Medicaid patients are scheduled to be enrolled in an HMO by the end of 1998, and patients will be given a choice of where they will go for care. In what is clearly a two-class system, if patients really do have a choice they are not likely to choose to go to the HHC hospitals. This book, which might better have been titled Financing Health Care for the Poor in New York City, reviews the impact of new sources of funds on the health care system in the city, analyzes the proposed changes in financing that will go into effect in 1998, and on the basis of the authors' conclusion that a drastic restructuring will be needed, makes some concrete proposals for creating a new system. It is hard to read. A tremendous amount of complicated financial and demographic information is scattered throughout the text that might better have been presented in tables. The 15 policy conclusions presented at the end include some that are crucially important and others much less so, leading to some confusion for the reader. But Professor Ginzberg and his staff have long experience studying the New York health system. Their conclusions are timely and deserve attention. The main conclusion is that the health of the poor has improved since 1966, especially among the elderly and the disabled, who have had a chance to move into the main-stream. Nevertheless, the gap between the haves and the have-nots has remained about the same, the two-tiered system for the uninsured and those with Medicaid coverage persists, and the improvement that has occurred is not commensurate with the amount of money that has been spent. Ginzberg and his associates believe that the main beneficiaries of increased funding have been hospitals (most voluntary hospitals have improved their financial position and public hospitals have been able to stay alive); physicians, whose incomes have greatly increased even though the supply of physicians has also increased; and hospital workers, whose numbers have increased from 185,000 in 1985 to 295,000 in 1995. They believe that the HHC has failed to achieve its objectives and that the prospect of failure is inherent in any hospital system that is totally dependent on public funds and therefore subject to the inefficiencies of government control and recurrent fiscal crises. They point out that the greatest defect of Medicaid coverage has been the very low fees ($13 per visit) charged for private primary care visits, which have blocked the development of independent primary care services in large areas of the city, leaving Medicaid patients in these areas no alternative to hospital clinics and emergency rooms for primary care. They show in some detail how an interlocking, often duplicated, two-tiered health system with total expenditures (55 percent public and 45 percent private) of $44 billion

per year has grown up in New York without any serious effort to coordinate its development. As for the future, they understand that the financing system of the past 30 years will soon be gone, with federal, state, and local governments committed to reductions of 25 percent in Medicaid spending and almost as much for Medicare and with almost all the publicly funded care to be provided through HMOs. They see no evidence from the experience with Medicaid managed care in New York or other localities that this approach will succeed in reducing costs and providing needed services. The probability of this prediction is reinforced by the recent financial troubles of the private HMOs. Since there is general agreement that there are at least 20 percent too many hospital beds in New York City -- which is roughly the number of beds in the HHC system -- and since Medicaid patients seem to prefer the voluntary hospitals, Ginzberg and colleagues make the logical proposal that HHC should stop providing inpatient care and that the city and the academic health centers should work together to change the present HHC into a system of community health centers that will provide good-quality primary care to the poor of the city. The implication is that at present the main function of the HHC is to provide some protection to the voluntary hospitals from their responsibility to provide care for the poor, especially those who are uninsured. It is hard to argue with these basic conclusions. The main causes of excess mortality and morbidity in poor New York communities have been cardiovascular disease, cancer, homicide, and AIDS and other infections. These conditions put a heavy burden on hospitals, but putting more money into hospitals without doing anything about the risk factors for these diseases, the underlying poverty and inadequate primary care, would not be expected to improve health much, and it hasn't. The likely failure of mandatory Medicaid managed care will probably force a complete restructuring of health care for the poor in New York. If reasonable funding could be made available, good things could come out of this. But before we put representatives from city government and academic health centers into a back room to plan the new system, there are some important qualifications. Despite notable success, the academics have always been more negative than positive about their relation with the city health system, and now, when all of them are desperately struggling to fashion their facilities into tertiary referral centers, it is not logical to expect them to have a major role in developing community health centers. In the past year two academic health centers have canceled their affiliation contracts, and two relatively new HHC hospitals have never been able to form such an affiliation. Furthermore, the system of community health centers in New York is much smaller and weaker than in many other cities, especially the part of it that is run by the HHC. Time will be needed to make the transition from hospital-based clinics to other kinds of primary care. During this time it should be possible to develop and test models of free-standing clinics associated with secondary care hospitals of various kinds, linked to private practitioners in the community, funded by an adequate Medicaid fee structure or adequate capitation from an HMO, and affiliated with, but not funded by, academic health centers. There are already good models of this sort, started by Lutheran, Montefiore, and Presbyterian hospitals, but they serve relatively small parts of their local populations. The reluctance of the sponsoring hospitals to assume financial responsibility for larger populations is an obstacle to expansion in at least some instances. Independence could give them the chance to expand on their own, but systems of governance need to be developed. In view of their past record, it seems unlikely that either the city government or the academic health centers will be the best choice to guide this development. ed by Colin McCord, M.D. Copyright copy; 1998 Massachusetts Medical Society. All rights reserved. The New England Journal of Medicine is a registered trademark of the MMS.About the Author Eli Ginzberg (1909-2002) was A. Barton Hepburn Professor Emeritus of Economics and director of the program on Conservation of Human resources at Columbia University. He is the author of more than eighty books (many published by Transaction)mdash;all with a human resource policy impact.