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THE DIALECTICS OF CHANGE: THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION AT A CROSSROAD

*Edna Wells Handy**

I. Introduction

Beginning in the summer of 1991, and continuing through the following November, it seemed as if the only news fit to print concerned the New York City Health and Hospitals Corporation ("HHC" or "Corporation"). Its leadership was under attack. Its quality of care was under review. Its contracting practices were under siege. And its financial stability was under threat. In the midst of all this controversy, the question of effective delivery of health care to the poor and the HHC's role in providing this health care needed an "answer." The scope of the "answer" ran from making HHC more like a department of the city to privatizing all or parts of it.

At present, the Corporation is neither fish nor fowl. It is neither a city agency nor a department; nor is it a true public benefit corporation or authority. The dichotomy seems more apparent during these times of fiscal constraint. The move to make HHC more accountable to the city fathers and mothers is understandable in light of the perception of elected officials' responsiblility for what goes wrong within the Corporation. Yet, the move to privatize is just as understandable in light of the immediate benefits to the body politic. It sells off its money losers; it receives an infusion of cash; and it rids itself of actual or potential administrative headaches.

The burdens, however, are no less obvious. If the HHC were departmentalized, all the unnecessary and costly red tape inherent in city bureaucracies would be reinstituted. If the HHC were privatized the guarantee of continuation of the service would be lost; the infusion of cash would be a one-time event; and unfettered public access to a service, once privatized, would not be transferrable or enforceable.

Given the magnitude of the city and state fiscal crises and the central role which the costs of health care play in this scenario — cur-

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rently twelve percent of our nation's gross national product[1] — these calls for departmentalization or privatization are increasing and becoming apparent components of various political agendas. Indeed, the proponents of privatization are repackaging the concept into what is now being called "corporatization."

After spending the last eighteen months as the General Counsel of the New York City Health and Hospitals Corporation, I feel comfortable in suggesting that the "answer" lies not in making HHC something that it currently is not. The key is to allow it to become what it was intended to be.

II. The Early Search for the "Answer"

A. The Heyman Commission

When one thinks of a corporation, public or private, one generally thinks of an independent body whose administrative and financial resources are controlled by a board of directors and operated by a chief executive officer. This is not the case with the Health and Hospitals Corporation. Its history has been rather dialectic. It has witnessed its administrative and managerial prerogatives transferred to the voluntary teaching hospitals and medical centers, and it has seen its fiscal prerogatives reserved to the mayors and managers of the City of New York. This schism came about as the result of other well-meaning searches for the "answer."

One of the earliest responses to the need for effective health-care delivery was the creation of the New York City Department of Hospitals ("Hospitals Department" or "Department"). Although the HHC's beginnings can be traced to the establishment of the Bellevue Infirmary in 1736, it became the Hospitals Department in 1929. Until that time, oversight of the delivery of health care to the poor had been vested in the Health Department and in the independent municipal hospitals.[2] In 1950, the Board of Hospitals, led by five members, including a commissioner who was empowered to appoint the medical staffs at each hospital and to approve proposed regulations, established policy for the Department. This Board of Hospitals was essentially the precursor to HHC's present Board of Directors; however, its ten members were all appointed by the mayor.[3]

1. *See* Felicity Barringer, *City Gives Bush A Health Plan Model*, N.Y. TIMES, Feb. 6, 1992, at A20.

2. INSTITUTE FOR POLICY STUDIES, NEW YORK CITY'S MUNICIPAL HOSPITALS: A POLICY REVIEW 25 (Washington, D.C., May 1967) [hereinafter POLICY REVIEW STUDY].

3. *Id.* at 27.

The functioning of this board and its commissioner was not without its critics, and its described inability to deliver the type of care needed contributed to the next search for the "answer":

> On paper, this [the Board/Commissioner structure] sounds like a strong Commissioner system. But, before 1961, the Department traditionally had functioned . . . as a "loose-knit confederation of separate institutions and activities" in which the individual municipal hospital medical boards functioned as the real "internal power" of the system as "centers of gravity." In the late 1950's more than 75% of the Department's physicians were not Department employees but private practitioners on part-time volunteer duty as attending physicians. They dominated most of the medical boards of the different municipal hospitals and viewed these hospitals essentially as autonomous institutions. In 1960, [it was] concluded that the "opportunities for leadership and initiative by securing internal control [for a Commissioner] [were] . . . severely limited." The Commissioner, [it was] noted is "more nearly a presiding officer . . . than he is its directing head."[4]

A myriad of factors contributed to the "crisis" faced by the municipal hospital system in the 1960s and to the resulting push for yet another "answer." It is interesting to note that before World War II, the municipal hospitals enjoyed a good reputation and were regarded as desirable institutions sought by residents and interns across the country. Among the medical and scientific breakthroughs pioneered in the New York City municipal hospitals were the following: the first appendectomy, the first ambulance service, the first caesarian section, the first insulin shock treatment for mental illness, the first use of cocaine for surgical anesthesia, the first heart catheterization, the first organ transplant, home dialysis and the Bellevue-Wechsler intelligence test.[5]

Although the structure of the Department of Hospitals certainly helped to change the reputation previously enjoyed by the municipal hospitals, other contributing factors included: (1) the shift in medicine from general care to specialty and sub-specialty care, and the homogenization of patient acuity mix, which limited teaching options and consequently reduced pools of residents and interns upon which the municipal hospitals were heavily reliant; (2) antiquated facilities which rendered work conditions unsuitable and in some instances dangerous; (3) the bureaucratic red-tape of city government which accounted for budgeting shortfalls and equipment purchasing

4. *Id.* at 27-28.
5. *Id.* at 31.

delays and shortages; (4) pay scales which made recruitment of qualified health-care professionals difficult; and (5) the deteriorating physical plants and staff shortages which made passage of accreditation standards problematic.[6]

The combination of the above factors raised serious questions about the quality of care provided by the municipal hospitals and caused a public crisis in confidence.[7] The crisis then, as now, exploded in the press. A *U.S. News and World Report* description of a New York municipal hospital during the early 1960s quotes former Commissioner Dr. Ray E. Trussell as stating:

> A state of crisis developed in the Harlem emergency room. . . . The conditions found were incredible. Injured and sick patients were sitting on benches because there were no more stretchers. People were lying on stretchers because there were no more beds. Patients were waiting eight hours for x-rays of fractures. Patients were lying in bed with fractures five days old which had not been set . . . .[8]

The conditions described at Harlem Hospital were found throughout New York City's public health-care system.[9] Mayor Robert Wagner responded by appointing the Heyman Commission,[10] the first in a series of commissions (leading to the present day Barondess Commission)[11] empowered to find the "answer" to the public health care cri-

6. *Id.* at 33-34.

7. *Id.*

8. *Id.* at 37.

9. *Id.* at 38.

10. *Id.* at 39.

11. *See* James C. McKinley, Jr., *Dinkins Selects Panel to Review City's Hospitals*, N.Y. TIMES, Nov. 9, 1991, at 27. The Barondess Commission is headed by Dr. Jerimiah A. Barondess, president of the New York Academy of Medicine. The commission consists of Carol Bellamy, ex-City Council President; Richard A. Berman, member of the New York State Health Care Financing Commission; June Christmas, former mental health commissioner, mayoral advisor and psychiatry professor at Columbia University; Robert A. Derzon, former deputy commissioner of New York City hospitals; Eli Ginzberg, Columbia University economics professor; Dr. Paul P. Griner, director of medicine at the Strong Memorial Hospital in Rochester; Dr. Robert M. Heyssel, president of Johns Hopkins Hospital in Baltimore; Peter Johnson, lawyer and advisor to Gov. Mario M. Cuomo; Bogart R. Leashore, dean of Hunter College School of Social Work; Stanley H. Lowell, a former Deputy Mayor; Dr. Eric Munoz, director of the University of Medicine and Dentistry at New Jersey's University Hospital; Ilaura Murillo-Rohde, former professor of psychiatry at New York Medical College; Diana T. Murray, former vice president of the New York City Health and Hospitals Corporation; Howard Newman, dean of Wagner Graduate School of Public Service at New York University; Dr. Samuel O. Thier, former chairman of the Yale University Department of Medicine; and Dr. Sterling B. Williams Jr., chairman of the Department of Obstetrics and Gynecology at Harlem Hospital.

sis. The Heyman Commission's recommendations reduced the HHC's ability to control its resources. The commission concluded:

> The Board and the Commissioner of Hospitals should vigorously implement the established policy of affiliating as many municipal hospitals as possible with medical schools or with voluntary hospitals having strong teaching programs . . . [and] obtain funds necessary to bring about and maintain effective affiliations.[12]

It was thought that by affiliating with the major voluntary teaching institutions ("voluntaries"), the municipal hospitals would be better managed and would provide better care. Given the membership of the commission and the mayor's close contacts with the voluntary hospitals and their interests, the recommendation came as no surprise.[13]

It was perhaps the Chairman of the Commission, David M. Heyman, who provided the enthusiasm for embracing the private voluntary model for health-care delivery in the municipal system. As one of the founders of the Health Insurance Plan of New York, Heyman was not reticent to express his views that private was better. In fact, in 1959, when the commission first convened, Mr. Heyman said that his goal was to save the American system from "the way of England — socialized medicine."[14] His proposal constituted "a partnership of free enterprise and government."[15] However, Heyman's "partnership" between government and the voluntaries was one which relegated government participation to providing the money but not the management.[16]

Indeed, there were practices of the voluntaries which were thought to be beneficial to the municipal system. For example, some believed that the municipal system should follow the lead of the voluntaries in establishing full-time medical staffs, in centralizing planning and budgeting, but decentralizing managerial, purchasing and personnel responsibilities and in more closely monitoring the distribution of gen-

12. POLICY REVIEW STUDY, supra note 2, at 63.

13. *Id.* at 44. The Heyman Commission consisted of Mary Lasker of the Albert and Mary Lasker Foundation; Dr. Frank L. Horsfell, Jr., the vice-president and physician-in-chief of the Rockefeller Institute for Medical Research; John S. Burke, president, B. Altman & Co.; John A. Coleman, financier; Henry Friendly, vice president and general counsel, Pan American World Airways; Albert J. Hetchinger, Jr., partner, Lazard Freres & Co.; Mrs. John J. McCloy, the wife of a prominent business and government figure; Howard C. Sheperd, chairman of the board, First National City Bank of New York; and Geroge D. Woods, chairman of the board, First Boston Corporation. *Id.* at 42.

14. *Id.* at 53.

15. *Id.*

16. *Id.* at 56.

eral care beds.[17] It should be noted that adoption of the government/voluntaries partnership model provided a much needed revenue stream for the financially distressed voluntary teaching hospitals, including the more prominent institutions.[18] In fact, it was this knowledge of the troubles faced by the voluntaries which led the heavily weighted commission to make the recommendation for full affiliation.

> [The Commissioners] were concerned about saving the voluntary sector as well as solving public problems. They hoped to achieve a blending of these two purposes . . . . The municipal system needed the quality, recruiting power, and the managerial flexibility of the voluntary sector; the voluntary teaching hospitals needed the additional financial support and access to ward patients for teaching and research purposes.[19]

The views of the commission were shared and, in many ways, shaped by its staff director, Dr. Ray E. Trussell, a noted professor at Columbia University and subsequent Commissioner of the Department of Hospitals following the issuance of the Heyman Commission Report.[20] Indeed, Dr. Trussell's goal was to bring the resources of the great voluntary institutions together with the stability of tax revenues — the most stable source of money that could be designated to an operating agency. He believed that this fusion automatically strengthened the survival potential of the voluntary system.[21]

Given the clear emphasis and background of the commission and its staff towards the voluntary sector, it is a small wonder that little attention was paid by the commission to developing the municipal hospitals into viable entities in their own right. Therein lies the first separation of powers of the HHC. The control of HHC's administrative/managerial resources had been transferred to the voluntaries. Although the New York City Department of Hospitals continued to have legal responsibility for setting general standards and policies and for performing housekeeping functions (supply, maintenance, supplementary nursing), the basic decision-making focus had shifted radically.[22] In essence, the political leverage for such expansions had become not a Hospitals Department in search of expanded and improved programs, but a whole new elite of private contractors in search of expanded city contracts.[23]

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17. *See id.* at 44-52.
18. *Id.* at 45.
19. *Id.* at 53.
20. *Id.*
21. *Id.* at 67.
22. *Id.* at 74.
23. *Id.* at 133.

B. The Piel Commission

Satisfaction with the "answer" provided by the Heyman recommendation for an affiliation plan did not last long. From 1961 through 1966, serious questions about the efficacy and financing of the affiliation arrangements began to surface. The perception was growing that city payments to the affiliates were increasing without corresponding increases in service or performance.[24] The intervening years had witnessed the expenditure of over $200 million of city monies to the affiliates without an improvement in the conditions or services rendered.

Anxieties about almost all municipal hospitals were raised by a full-page expose by Martin Tolchin in the *New York Times* in June 1966.[25] He emphasized the shocking conditions in the large, undersupplied municipal hospital centers that had been neglected under the recent affiliation agreements. Mr. Tolchin's article highlighted some of the problems with the new affiliation arrangements: loose money, poorly utilized equipment and physician time, internal management conflicts and an over-emphasis on research that led to the dumping and dehumanizing of patients.[26] From that time, throughout 1966, the troubles of city hospitals were on the front pages of newspapers in New York City almost weekly, with a rising tide of concern about the role the once-heralded affiliation arrangements might have played in the continuing difficulties.[27]

Despite these concerns, affiliation agreements were expanded and extended to unaffiliated hospitals. And although there were demands for increasing levels of scrutiny, the affiliates were calling for more autonomy and more money. In an effort to balance the considerably powerful forces on both sides, Mayor John Lindsay convened yet another commission to search for the "answer"—the Commission on the Delivery of Personal Health Services, known as the Piel Commission.[28]

The importance of the Piel Commission lies in its recommendations regarding the restructuring of the Department of Hospitals. By the time of the establishment of the Piel Commission, it had become painfully clear that the "answer" to the problem of delivering health care to the indigent within the city was not the Department of Hospitals.

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24. *Id.*

25. Martin Tolchin, *Serious Troubles Plague City Hospitals As Medicare Approaches*, N.Y. TIMES, June 27, 1966, at A1.

26. *Id.*

27. POLICY REVIEW STUDY, supra note 2, at 159.

28. *See* COMPREHENSIVE COMMUNITY HEALTH SERVICES FOR NEW YORK CITY, REPORT OF COMMISSION ON THE DELIVERY OF PERSONAL HEALTH SERVICES (Apr. 1975) (Piel Commission Report).

After extensive debate and study, the Piel Commission laid out the blueprint for what became the Health and Hospitals Corporation.

The Piel Commission reviewed a number of options for the governance of a new health-care delivery entity: having the state take control, improving the present system, extending affiliations, leasing or selling all municipal hospitals to the voluntaries, converting each municipal hospital into a voluntary, placing all hospitals under public control or forming a public corporation and/or authority. It was eventually decided that the Department of Hospitals would become a public benefit corporation. Although the distinction between a public corporation and an authority is sometimes blurred, with respect to the HHC, the distinction between the two is significnat.

In New York State, a public authority is considered a type of public benefit corporation,[29] which can be created only by a special act of the New York State Legislature. All public authorities are subject to the control of the New York State Public Authority Control Board. However, these authorities are generally regarded as autonomous bodies, not subject to the budget and other fiscal constraints of the state or local governments.[30] It is this later consideration which became the primary reason for establishing a public benefit corporation for the delivery of health care in New York City as opposed to a public hospital authority.

The present Health and Hospitals Corporation was decided upon because it allowed the city to retain control. In 1967, Joseph Terenzio, the Commissioner of Hospitals, stated that the primary consideration should be to retain for the city's elected officials the responsibility for delivering personal health services to the medically indigent. He also suggested that the Corporation should function under and be controlled by the Health Services Administration.

A second reason for reserving the right to control the Corporation was the disagreement in 1968 between state and city officials as to the conclusions of the New York State Investigation Committee's Report[31] on the condition of the city's hospitals. The committee seemed

29. N.Y. CONST. art. X, § 5.

30. *See* STAFF REPORT ON PUBLIC AUTHORITES UNDER NEW YORK STATE, TEMPORARY STATE COMMISSION ON COORDINATION OF STATE ACTIVITES (Mar. 27, 1956). This report defines an authority as a government business corporation set up outside of the normal structure of traditional government so that it can give continuity, business efficiency and elastic management to the construction or operation of a self-supporting or revenue-producing public enterprise.

31. RECOMMENDATIONS OF THE NEW YORK STATE COMMISSION OF INVESTIGATION CONCERNING NEW YORK CITY'S MUNICIPAL HOSPITALS AND AFFILIATION PROGRAM (Mar. 1968).

to place a great deal of the blame on poor planning by city officials. The city felt that the committee's analysis of the problems, however, showed a lack of understanding of the city's health concerns and a poor knowledge of the working of the city hospitals. They felt that the major problem was a failure to provide timely capital funds and execute construction. Thus, the city's apparent distrust of the state reinforced its preference for a structure which would not operate under state auspices, as a true authority would.

The Health and Hospitals Corporation was subsequently formed as a public benefit corporation.[32] The HHC's governing legislation, its structure and corporate documents, the enabling legislation, its corporate by-laws and the operating agreement between HHC and the city, reflect the continuing role sought by city officials in the delivery of services to the medically indigent. Accordingly, policy and fiscal control of the HHC, which would have been vested in its own governing body, was reserved by the city through the mayor's office and the Health Services Administrator who, according to the by-laws, could dominate the Board of Directors.

The Health Services Administrator serves as the Chairman of the HHC Board and the mayor appoints ten of the fifteen members. Moveover, the Corporation must submit its budget to the city to be included in the mayor's executive budget; the delivery of health services must be in accord with the policies and plans of the Health Services Administrator; and the Corporation must obtain approval by the mayor and by the City Comptroller before issuing debt for the construction of facilities. Further, the Corporation's personnel practices and union negotiations and policies are tied to those of the city.

Thus, with the establishment of the Health and Hospitals Corporation, pursuant to the recommendations of the Piel Commission, and the compromises as to its fiscal and policy control, the second separation of the powers of HHC as a corporation took place. This retention of control of HHC by the city is akin to the control the city exercises over its own agencies and departments.

III. The Health and Hospitals Corporation Unbound: A Modest Alternative to Present "Answers"

If we look at HHC then and now we see many parallels: a crisis in public confidence, deteriorated facilities, questions as to quality of care, a decrease in funding and difficulties in recruiting. We also see

32. New York City Health and Hospitals Corporation Act, N.Y. UNCONSOL. LAW ch. 214-A, § 2 (McKinney 1992).

many voluntary hospitals with fiscal troubles similar to those which were prevalent at the time of the creation of the affiliation plan. It would be safe to state that none of the prior "answers" have proven effective or sustainable. Thus, I would submit that the answer to the problems facing HHC in the 1990s is not to revisit the answers provided in the past. Nor is it a time for further polarization of HHC control between the voluntary sector and the city managers. Instead, the answer should encompass a program for the full utilization of HHC's corporate powers as they presently exist. Further, these powers should be expanded through a broad interpretation of HHC's current function as a public authority.

The HHC is clearly at a crossroads. It finds itself calling for the exclusive management of its resources. This call, however, is no mere wish. It will become an operational imperative as the dominant concern in health care shifts from quality and access, with cost taking a back seat, to cost and quality, which, by necessity, will require restricted or severely controlled access.[33] The challenge will be to reduce costs while maintaining and increasing quality. For HHC, however, controlling access implicates its mission: "To provide and deliver high quality, dignified and comprehensive care and treatment for the ill and infirm, both physical and mental, particularly to those who can least afford such services."[34] However, to contain cost while maintaining unfettered access would be a managerial improbability for even the most effective of management operations. For HHC, it would be nearly impossible given its separation of powers. Moreover, it would be a political and administrative nightmare for those viewed as having the ultimate responsibility for quality care within the system — city officials.

Operationally, it is inefficient and illogical to have resource control centers residing outside of the entity charged with the responsibility for implementation. If HHC is to meet the challenge of delivery of health care in the 1990s, there must be a synthesis of that control. Returning to the concepts generally associated with corporations, one must again think of the resource control center as residing in the Chief Executive Officer through the Board of Directors. Thus, to synthesize the control centers now located in city government and the affiliates, HHC needs strong independent leadership at the Board level, the Corporate Chief Executive level, and at the level of Hospital Chief Executive Officer.

33. Testimony of Dr. David B. Skinner before the Barondess Commission, Feb. 25, 1992.

34. Health and Hospitals Corporation By-laws: Statement of Purposes (a)

A. Synthesizing Control over Policy and Finances

1. Board of Directors

The question of the role of city officials in a hospital authority was addressed during the debates following the findings of the Piel Commission: "Are City officials to be involved in the Authority for the purposes of policy control, or in order to add the weight of their influence to policies which are for the most part developed independently by the Authority?"[35]

There is certainly the perception that the former approach, policy control, dominates on the HHC Board. It is, perhaps, time to revisit the latter argument so that there will be a merging of the reality and the perception that no one entity has more power than any other Board member, except the power to appoint and remove. It would appear that a legislative initiative would be needed to accomplish this task. And while there may be those reticent to revisit HHC's enabling legislation, it may be time to review it with this synthesis in mind.

The "affiliations" of Board members should be reviewed with the same goal. If one were to review the membership on the boards of trustees/directors of the voluntaries, it would look like a "who's who" of the city's political, medical and social elite. Given the magnitude and scope of HHC responsibilities, its Board should also reflect this ability to access "power, influence and money" in similar respects. Thus, in addition to adding more "civic-minded" individuals and members of the medical establishment, there should be places reserved for bankers, philanthropists, business executives and other notables so that HHC may radiate the aura of a "high-powered, management-oriented institution."[36]

However, one of the most pressing administrative concerns is that although the Board may ostensibly establish policies, an outside entity controls the financing of these policies. This ability to set one's policies and priorities without having the ability to finance them is most problematic. Efforts must be made to address this dichotomy in order to allow the Board to control its own destiny. The success of these efforts may behold the future of the HHC.

2. The Chief Executive Officers

To implement these policy and fiscal priorities as established by the

35. OFFICE OF THE MAYOR; OFFICE OF ADMINISTRATION, RESEARCH AND PLANNING UNIT, ALTERNATIVE ORGANIZATIONAL FRAMEWORK FOR THE DELIVERY OF HEALTH SERVICES IN NEW YORK CITY 63 (Sept. 1967).

36. *Id.*

Board, HHC needs strong, independent executive leadership. Presently, however, the "shelf-life" of a chief executive officer of the Corporation is notorious for its brevity. A key contributing factor is that the present selection and appointment processes provide no insulation from the shifting winds of political change. New city administrations and changing political alliances at the local level impact upon the permanency of those in these positions. It is no wonder that the HHC suffers most acutely from leadership instability. Thus, HHC is in need of a mechanism to ensure continuity of independent leadership.

One alternative would be a specified term of office exceeding those of elective positions. Employment contracts with specific "for cause" removal provisions could also be adopted in order to regulate conduct during this term. Clearly, there are risks attendant to such provisions. However, the risk can be no greater than that which endures in the current system, which experiences three or four turnovers of executive officers in a given year, or an average eighteen-month tenure for the corporate chief executive.

B. Synthesizing Control of Administration

1. The Affiliation Contract

The present atmosphere of contract negotiations with the affiliated voluntary teaching institutions and medical centers has taken on an intensity unlike that attending prior negotiations. The reason is simple: HHC's draft contract seeks to place the chief executive of the facility, not the affiliate, as the primary manager of the institution. Thus, there are now outside lawyers involved in the matter, along with public relations consultants and media strategists, because the stakes are currently perceived as being higher than those of prior years.

Throughout the relationship, managerial and clinical expertise has been developed and has remained on the side of the affiliate. HHC is now demanding an uncoupling of management and clinical expertise, so that its managers may exercise the prerogatives they need to maximize efficiencies and minimize costs. In the balance looms the question of who controls the $400 million in yearly affiliation costs.

Regulators, such as the Joint Commission on Accreditation of Hospital Operations and the New York State Department of Health, have placed increased responsibility on the chief executive officer for the efficient running of hospitals. Further, the Public Health Law is clear that an entity may delegate duties to provide quality care; yet it can-

not delegate the responsibility to provide that care.[37] While the genesis of the affiliation relationship may have been characterized as one of "partnership," present realities place the burden of improper care on HHC. If the responsibility is neither shared nor shifted, then the right to rule should not be either.[38]

2. *Defining the Needs of HHC*

If one were to review the standard affiliation contract, one would perceive a curious omission. The contract fails to state terms of quantity, e.g., how many providers are needed to staff a given service. When reading the contract, any lawyer may be reminded of a legal tenet which, in effect, will allow a court, in the absence of stated terms in a contract, to supply a term, with the notable exception of the quantity term.[39] The reason for this is clear. Practice in the trade can be used to provide other significant absent terms, such as the details of delivery. However, no one but the contracting parties can assess their individual needs and determine what a desirable quantity of a given item might be.

Currently, efforts are underway to begin the process of determining staffing needs and service priorities so that they may be incorporated into future affiliation contracts. These efforts are critical since they will assist HHC in regaining control over their own resources, which is essential if future health-care needs are to be met and provided for by HHC. As such, these efforts should be pursued vigorously and given complete support by the medical community.

3. *Restructuring Personnel Practices*

The ability of HHC to control its personnel will forever be compromised if it cannot compete in the marketplace for quality providers. Thus, there must be some uncoupling of HHC personnel practices from those of the city. In these times of fiscal constraints, HHC can no longer expect providers to remain with the Corporation solely out of a sense of loyalty or camaraderie. It is folly to think that these esoteric feelings will predominate over the substantial increases in sal-

37. N.Y. UNCONSOL. LAW ch. 214-A, § 5 (McKinney 1992).

38. This is especially evident in the action of the Long Island Jewish Affiliate, which sought unilaterally to disaffiliate within six months of giving notice. *See* Lisa Belkin, *Long Island Jewish Hospital Will Stop Providing Doctors for Queens*, N.Y. TIMES, Dec. 3, 1991, at A1. Notwithstanding the legalities of its action, it must be noted that partners have a fiduciary obligation to each other which would result in a winding down of the relationship, not a truncation of it.

39. *See* E. ALLAN FARNSWORTH, CONTRACTS § 3.27 (1982).

ary and fringe benefits to be obtained, in some instances, by merely going across the street to a voluntary hospital.

HHC's ability to compete successfully will dictate the extent and duration of its dependency upon the affiliates to staff HHC facilities. Without independence from city personnel practices, HHC will continue to be subject, in varying degrees, to some form of off-site control. In order to rectify this situation, HHC should be allowed to establish wage rates and salaries commensurate with those of the voluntary hospitals.

4. Capital Financing

HHC has the authority to issue its own debt.[40] HHC, however, is currently proposing a bond offering to finance capital projects.[41] This endeavor will provide HHC with the opportunity to establish itself as an issuer independent from the city. To the extent that the city's capital financing suffers from the constraints of austere times, HHC's move into the private debt market to finance capital projects will inevitably be linked to its ability to repay using its own resources. In order for these bonds to be attractive to investors and to protect future bondholders, the HHC must assume greater control over its own costs and resources. That assumption of control is currently being assessed by underwriters and rating agencies. As such, the time could not be more propitious for a synthesis which shifts control of costs and resources back to the HHC.

5. Medical Malpractice

Last year, the city paid over fifty million dollars in malpractice claims filed against HHC. Under its operating agreement with the HHC, the city is required to make such payments. One of HHC's few attractions for health-care providers is the city's agreement to indemnify them against malpractice claims. This attraction, however, is not without its burden.

Unlike the voluntaries or private insurance carriers, malpractice within HHC is not necessarily viewed as an indicator of the quality of care given by a certain provider. This perception exists because there is no direct nexus between the conduct resulting in the malpractice claim and substantiation and disbursement on that claim. No insurance premiums are raised, little peer pressure is exerted to condemn

40. N.Y. UNCONSOL. LAW ch. 214-A, § 12 (McKinney 1992).

41. OVERVIEW OF THE PROPOSED HHC CREDIT, BRIEFING OF CAPITAL AND FINANCE COMMITTEES, NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (Mar. 19, 1992).

the conduct and few practice privileges are lost upon a finding of liability. Without such a nexus, the ability to control malpractice is limited. Cost containments cannot be made without the ability to control the rate and costs of malpractice. Nor will the necessary nexus be obtained without HHC's assumption of the risk in some form.

6. *The "Medicaid Managed Care" Overlay*

For one of the few times in its history, HHC will soon have to compete for its predominant client base — Medicaid patients. In order to compete, the Corporation must shed its current reputation for delivering poor quality care. That reputation is a function of a few notorious cases which have publicized certain negative impressions of HHC. It is also based upon the view that the prevalence of foreign medical school graduates in HHC facilities results in lesser quality care than in institutions with American medical school graduates; the threatened losses of accreditation because of quality of care issues and plant safety concerns; and the general perception that resource allocation in this society is based upon race and income status, with poor people of color receiving the benefit of the least amount of resources. In addition to a restructuring along the lines discussed above, there is a need for a redefinition of HHC's relationship with the affiliates who, themselves, may very well become our competitors in the managed care scramble for paying customers.

IV. Conclusion

City administrations from the time of Mayor Robert Wagner have had to contend with the ills of the municipal hospital system. Finding the "answer" to those ills became a part of one of his election platforms. Mayor John Lindsay, for his part, sought refuge in his formation of the Piel Commission to address the ills which befell his administration. Later, the Koch administration had to weather the storm caused by the decision to close several municipal hospitals.[42] Finally, the problems faced by the present administration of Mayor David Dinkins have occupied the headlines almost since his inauguration in 1989.

These problems will not go away. In fact, they will worsen because government monies for health care are shrinking. Factors such as AIDS, TB, chemical dependency, mental illness and homelessness are causing costs to increase. Also, the hiring pools from which munici-

42. *See* Ronald Sullivan, *A City Hospital In Fort Greene Will Be Closed*, N.Y. TIMES, Aug. 11, 1983, at B3.

pal hospitals have been able to staff their facilities are drying up. Even if these problems were not growing, upcoming national, state and local elections, in which the health-care crisis will be a major issue, will cause a heightened awareness of the situation. The ability of our health-care delivery services to deal effectively with these issues will be severely tested in the coming years.

The question thus facing any city chief executive is whether the benefits to be derived from continued control over the municipal hospital system are outweighed by the burden. One of the benefits accruing from the control one may obtain in directing policy is providing health care to the indigent. Another benefit is the ability to influence the direction of business emanating from a three billion dollar corporation, which includes the ability to direct the flow of services to those areas deemed appropriate. The burden, however, is clear. The health-care crisis will result in the assignment of responsibility for matters which are growing increasingly out of the fiscal and managerial abilities of city officials to control. To return to the cost/access analysis,[43] access will have to be controlled. Controlling access to the municipal hospitals may mean closing facilities completely, shutting down services or regionalizing them. No matter what option is decided upon, political forces will rally against them because every locality in which a municipal facility is now located wants, and will continue to want, what it considers to be a full-service facility.

The matter of insulating HHC chief executives was discussed earlier. Here, the matter of insulating the city's officials is addressed in a proposal which recommends that the HHC synthesis be allowed to take place. A suggested consideration on this point is the following example of such insulation. Two tragedies occurred around the same time last year: the Yankel Rosenbaum case[44] and the 14th Street train accident.[45] Both cases involved allegations of gross negligence. The aftermaths of the two events differed markedly however, and it is suggested that one of the reasons for this difference was the fact that the Transit Authority is just that — an authority under the umbrella of another authority, the Metropoilitan Transit Authority ("MTA"). Following the Rosenbaum story, it became incumbent upon city officials to review the management of the crisis and the quality of the care provided by HHC, and to institutionalize that review through

43. *See supra* note 33 and accompanying text.

44. *See* Josh Barbanel, *Criminal Query is Begun in Care Given to Hasid*, N.Y. TIMES, Sept. 26, 1991, at B3.

45. *See* John McQuiston, *At Least Five Dead and 150 Hurt as Subway Derails*, N.Y. TIMES, Aug. 28, 1991, at A1.

the investigation of an independent counsel, Stanley Lowell, Esq., and the establishment of the Barondess Commission.[46] While there was a similar review following the 14th Street crash, city officials were not viewed as the party of ultimate responsibility. Thus, there was no need for an institutionalized review of the Transit Authority, unlike the investigation of HHC.

A second example is posited for consideration to demonstrate the "hard choices" that must be made in containing costs of health care. The MTA recently increased fares. City officials were able to decry the increase and to align with a natural constituency, the "straphanger." Should one of HHC's hard choices be a user's fee (as suggested in the New York State Legislature only last year and which became one "choice" made by the City University of New York), city officials may not be able to avoid the responsibility and political repercussions for the actions, omissions or "outrageous fortunes" of HHC as presently constituted.

My tenure with HHC has been most illuminating. I discovered an amazing corporation teeming with talented, dedicated and energetic employees. Those employees are waiting for a chance to make HHC all that it can be and all that it was intended to be. I respectfully submit that the only way in which HHC can reach its potential, as envisioned by its "framers," is vesting, in the hands of HHC, its Board and its Chief Executives, complete control for the responsibility it has to meet the health-care crisis our city faces and the health-care needs our citizens deserve.

46. *See supra* note 11 and accompanying text.