

Liberalism and the Politics of Public Health in New York City

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I came to the Rockefeller Archive Center (RAC) to do research for a book about the political economy of healthcare in New York City in the postwar era. Tentatively titled “Separate and Unequal: Public Health and Private Interests in New York City,” the book examines medical inequality in the delivery of healthcare to New Yorkers. The Rockefeller Foundation (RF) and the Commonwealth Fund (CF) supported a range of healthcare initiatives, including the implementation of pre-paid health insurance in the 1940s, the creation of standards for graduates of foreign medical schools who wished to continue their postgraduate training in U.S. hospitals as interns and residents in the 1950s, and bio-ethical and bio-medical research in community medicine, the training of educationally disadvantaged African-Americans and Latinos in allied health professions, and the rise of innovative medical school curricula in the sixties and seventies.

In 1947, New York City’s public health reformers teamed up with Mayor LaGuardia and philanthropies to form the Health Insurance Plan of Greater New York (HIP). HIP, organized as an antidote to Britain’s “socialized medicine,” was one of the very first group practice prepayment schemes in the U.S. It was a creative organizational response to expensive and unattainable medical specialization, and it addressed rising health care costs by integrating preventive and curative medicine.¹ In its first year thousands of city government workers signed up for the health program. New York City agreed to pay half the premium costs, so that its

employees and their families could receive non-hospital medical care at affordable rates. At the same time, enrollees were advised to purchase Blue Cross hospitalization insurance. This marked the beginning of health insurance as a workplace benefit. The plan was vigorously opposed by the medical societies, the local units of the American Medical Association (AMA), on the grounds that it limited patient “choice” by forcing patients to see only physicians who practiced in the same group.²

Around the same time that HIP was launched, the Scientific Directors of the International Health Division (IHD) of the RF gathered to discuss a “confidential” report prepared by John D. Grant, entitled “Social Medicine.” The mood in postwar Western Europe was for universal health care, and Grant was in the middle of conducting a survey in “International Trends” for the RF’s IHD. In a nod to advances in public health efforts overseas, the RF decided that the IHD was the most appropriate venue in which to undertake a discussion about the direction for health care in the United States. Grant was an obvious choice for setting the terms of the discussion. Before beginning his survey in Europe, he had spent his career working in other countries, first in China and then India. Like his contemporary, William Beveridge, the British economist and social reformer whose work became the basis of Britain’s National Health Service, Grant believed that public health in any society, rich or poor, was an integral part of socio-economic “progress.”³

Grant wrote in “Social Medicine” that the “obstacles” to public health in the U.S. were “more in the field of social knowledge than in the physical or biological fields.” This country, he said, had much to learn from European countries, especially Sweden, where “social evolution under a democracy has reached the point of considering social medicine and public health as an integral part of social welfare.” Public health involves so much more than coordinating

prevention (itself a novel concept in the WW II era) and cure. Grant said that living standards including housing, nutrition, clothing, and even recreation combined with education must be addressed as well. Drawing on what he learned in Europe and in the developing world, Grant thought that the best way to extend health care to an entire population, where some people have access to the best treatment and most had little to none, was to “regionalize” health care by drawing together three or four levels of medical institutions. The teaching hospital or medical school would be at the “apex,” and the community hospital and health clinics at the “periphery.”⁴

The centerpiece of my book about inequality in health care in New York City is the restructuring and integration of the public and private hospital system. This occurred in 1960 as a consequence of the scarcity of interns and residents (house staff) in all hospitals, both voluntary (private non-profit) and public. Although inequality was nothing new, this period marked a new *phase* in the disparity between the very poor (many of whom were black and Latino) and everyone else. Between World War II and 1960, advances in medical technology, drug therapy and the rise of third-party reimbursement made hospitals more crowded than ever. Moreover, a new emphasis on medical research and physicians devoting more time to lucrative private practices, created an even greater demand on hospital house staffs. Nationwide, the number of slots for house staff increased by six-hundred percent and yet, the AMA, and the Association of American Medical Colleges (AAMC), residency review committees and specialty boards limited the pool of trained physicians. Medical schools increased their output by only thirty-five percent.⁵ Hospitals could not function without residents, who are the lifeblood of the modern hospital.

To solve the acute problem of supply and demand, hospitals admitted thousands of graduates of foreign medical schools to join their house staffs. In 1954 more than one quarter of

interns and residents working in U.S. hospitals were graduates of such schools. The U. S., in the words of the RF's Wade Oliver, had become a "medical mecca" for graduates of foreign medical schools seeking postgraduate training.⁶ New York City, with twenty-two public hospitals, was the largest financial commitment to medical care in the nation, with the exception of the Veterans Administration (VA) hospital system, and it absorbed twenty-seven percent of all foreign graduates.

This posed a new problem, namely that the foreign graduates were not adequately trained to do clinical work in hospitals. By the 1950s, medical training in the U.S. involved "active" learning through laboratory study and doing real clinical work, stressing thinking and problem-solving, not rote learning and memorization. Foreign medical education still emphasized didactic training. Aubre de L. Maynard, Director of Surgery at Harlem Hospital in the 1950s and 1960s, was born in the West Indies and supported training doctors from developing countries. Years later he wrote that many foreign-trained interns did not even know how to examine a patient, which is a particularly striking deficiency since interns were frequently charged with performing triage when patients were admitted.⁷

At the height of the Cold War, the AMA, AAMC, the American Hospital Association, and the state medical boards teamed up with philanthropies (including the RF), representatives from elite academic medical centers, the U.S. State Department, the Department of Defense, and HEW to develop a screening program for graduates of foreign medical schools. They devised the Educational Council for Foreign Medical Graduates (ECFMG) exam for the nearly six-thousand foreign graduates who were arriving annually to work in U.S. hospitals. In the late 1950s, most of them came from Latin America and the Caribbean to participate in "exchange programs for educational purposes" (portending John F. Kennedy's "Alliance for Progress" that would unfold

a few years later). The State Department's interest in the ECFMG was shaping "potential opinion molders from foreign countries," whose influence would "spread geometrically" when they returned home.⁸ Others, who came from "behind the Iron Curtain" seeking additional training and licensure to practice in the United States, were no less important in advancing the government's Cold War policies.⁹

The ECFMG exam was not a panacea. It set a standard, but it did not solve the problem of ill-prepared members of house staffs taking care of patients, nor did it solve the staffing problems more generally in the public *and* private hospitals. While graduates of foreign medical schools worked in the public hospitals, the voluntaries clamored for graduates of U.S. medical schools. In 1959, New York City Mayor, Robert F. Wagner, set up a Commission on Health Services to determine how to make the voluntaries more competitive for residents trained in the U.S., and to staff the troubled public hospital system. It was headed by David Heyman, an investment banker and medical philanthropist. The result was a new institutional framework that involved a massive transfer of public funds to the academic medical centers to run the public hospitals.

I was surprised to discover that the Heyman Commission's underlying proposal for "regionalization" of healthcare overlapped with some, but not all of John B. Grant's ideas first put forward in "Social Medicine." This is surprising considering Grant's name is not ubiquitous among public health historians in the U.S., and yet by the late 1950s he had become a household name in public health circles. In 1951 and 1952, Grant served on President Truman's Commission on Health Needs of the Nation, and in 1960 (the same year the Heyman proposals were adopted), he was the recipient of the American Public Health Association's prestigious

Lasker Award. By then, Grant had become synonymous with the regionalization of health care services.

Moreover, some of the same public health professionals who went to the United Kingdom after WW II to examine the National Health Service, and meet with Grant's contemporaries, were also involved in the Heyman Commission arranging the new public-private hospital affiliation system.¹⁰ Bypassing Grant's arguments about living standards and education, the Heyman Commission wrote about placing the academic medical center (which included the medical school and voluntary teaching hospital) at the "apex" of the health care pyramid and transforming the public community hospitals – the "periphery" – into teaching hospitals. Significantly, Heyman was less concerned with the delivery of health care to impoverished New Yorkers than making the academic medical schools more competitive in the national matching program that was established in 1952.

The best way to attract the most "desirable gifted young interns and residents," said the Report, was to locate public hospitals near "topflight" medical schools or strong voluntary teaching hospitals. All future construction of public hospitals should place them in proximity to the best medical schools, but since it was too late to do anything about those hospitals that were embedded in the communities they served, institutional affiliations would bridge the geographic divide. Public-private hospital affiliations would solve the problem of what the Commission called "professional isolation," whereby a reserve of patients languished in public hospitals could be treated by out of the range postgraduate interns and residents, who needed clinical experience in order to complete their training.¹¹

The fact that the public and voluntary hospitals were unequal before the hospital system was restructured in 1960 is a given. It did not take very long for the new system to produce new

inequalities. In 1966, State Senator Seymour Thaler, a Democrat from Queens, and a ranking minority member of the Joint Legislative Committee on Public Health and Medicare, accused the Department of Hospitals and the academic medical centers of fiscal and ethical medical improprieties. He said that patients in city hospitals, “most of them Puerto Ricans and Negroes,” were being used “as human guinea pigs without their consent” in government-sponsored medical research projects.¹² He also charged the medical centers with payroll padding and diverting medical and laboratory equipment purchased with taxpayer dollars into the private medical centers. Doctors from area academic medical schools “make Dillinger look like a babe in the woods,” said Thaler. Paid physicians in the city hospitals, moreover, were not putting in their hours and they were double-dipping, accepting insurance payments and city paychecks for the same work.¹³ Thaler convinced Governor Nelson A. Rockefeller to look into the abuses in New York City’s public hospital system.¹⁴ The result was a Blue Ribbon Panel on the Municipal Hospitals of New York City, chaired by State Health Commissioner, Hollis S. Ingraham.¹⁵

In 1969, the New York State Legislature passed the Health and Hospitals Commission Act for New York City, which established the Health and Hospitals Corporation (HHC), a public benefit corporation to run the city hospitals. The HHC was organized to cut through the bureaucratic red tape that made running the public hospitals so challenging. It had the authority to bypass civil service regulations in hiring, and it was able to purchase equipment and make its own arrangements for hospital and clinic construction and repairs, without going through the Department of Public Works. Like other public services the new public benefit corporation would increase its revenue by issuing bonds.¹⁶

While Rockefeller’s Blue Ribbon Committee was busy investigating New York City’s troubled public hospital system, “medical activists” who had emerged from the civil rights

movement in the South, convinced President Johnson's Office of Economic Opportunity (OEO) to include health care in its 'War on Poverty.' Two years later, in 1967, the OEO funded the Student Health Organization (SHO) summer project sponsored by Albert Einstein College of Medicine (AECOM) in the South Bronx, and the Montefiore Hospital and Medical Center in the North Bronx. AECOM was established in 1955 by refugees from Eastern Europe. In 1966, when it undertook an affiliation with the public Lincoln Hospital in the South Bronx, it drew explicitly on the work of Henry Sigerest at Johns Hopkins University, arguing in much the same way as Beveridge and Grant, that health indicators should include housing, education, nutrition, and even "purpose" in life. During the summer of 1967, SHO sent fifty-seven medical, dental and nursing students to work in community health programs. Under the direction of a Public Health Service Officer they worked as "patient advocates," teaching poor people how to get the medical services they needed and assisting them with patient interviews and exams in a Neighborhood Maternity Center, Neighborhood Service Center, Head Start, and outpatient departments at the public Lincoln Hospital and also at Morrisania Hospital, another public hospital in the South Bronx.¹⁷

Also in 1967, AECOM and its voluntary teaching hospital affiliate, Montefiore Hospital, organized its Department of Preventive Medicine and Community Health, to undertake research in the delivery of healthcare in impoverished and underserved communities, and to train medical students to work in those communities. Martin Cherkasky became chair of the new department and he was the president of Montefiore Hospital, and a major player in public health circles in New York City and nationally. Cherkasky had also worked on the King-Anderson Bill in 1962, which ultimately led to Medicare and Medicaid legislation. He was an advisor on health affairs to Mayor Ed Koch in the late seventies as well.¹⁸

There were additional community medicine efforts in New York City. Mount Sinai School of Medicine (MSSM), organized with a social mission, admitted its first class in 1968, and was the first medical school in the country to make its Department of Community Medicine equal to its clinical departments. Dean George James, MD, a former New York City Commissioner of Health, began with a mandate from his Board of Trustees to “relate the School and the entire Mount Sinai patient-care complex,” (the voluntary hospital and outpatient departments), to Spanish Harlem. The new Mount Sinai Medical Center is located at the nexus of Spanish-speaking East Harlem and the tony Upper East Side of Manhattan. Epidemiology was an important part of the community health center model. In its first year of operation MSSM’s Department of Community Medicine, led by community health pioneer Kurt Deuschle, worked with East Harlem residents and organizations to produce a detailed health survey of the neighborhood and to develop neighborhood health centers closely associated with the Medical Center’s outpatient clinical and social services. The Department of Community Medicine established a Health Services Research Unit at Elmhurst Hospital, its public affiliate, in Queens. Dr. Michael Stewart ran the OPD, which included a Methadone Clinic and a Home Care Clinic, where Mount Sinai students rotated during all four years in medical school.¹⁹

In 1968 Stanley Bergen, Chief of Community Medicine at the Brooklyn-Cumberland Medical Center, organized a Family Health Center in Fort Greene, Brooklyn, another impoverished and medically underserved community in New York City. He modeled his Family Health Center on the Columbia Point Project in Boston (the very first OEO-funded health center demonstration project in the country), which the physician activists Jack Geiger and Count Gibson organized a few years earlier through the Tufts Medical Center. Geiger had studied with Sidney Kark, who had organized what might have been the very first community-oriented

primary health care center in Pholela (KwaZulu/Natal) in South Africa before 1948 (ultimately destroyed by the apartheid regime).²⁰ Like Columbia Point, and Sidney Kark before that, Bergen organized teams to deliver healthcare to residents in Fort Greene and Bedford-Stuyvesant, with a non-professional Family Health Worker (apparently always female) recruited from the community as the “real backbone of the operation.” The Family Health Worker maintained regular contact with the families assigned to her care, alerting the social worker to non-medical problems (health indicators described above) as they developed. Because she came from the community that the Health Center was serving, she was able to provide the health care group with an “awareness” that enabled the physicians to provide health care in the context of the patient’s “total environment.”²¹ Coinciding with the OEO’s principle of “maximum feasible participation,” this was a successful example of community involvement in the delivery of healthcare to an underserved community.

Columbia University’s late arrival to community medicine, as well as its approach to the problem, underscore and illuminate the simmering tensions between the University and the Harlem community. In 1971, the Medical School established an Office of Community Health and Medical Care, and it invited representatives from the CF, the RF, and the Carnegie Corporation to meet with Executive Directors of the private voluntary St. Luke’s, Roosevelt and Presbyterian Hospitals to attend a planning “symposium” for the new program. While Dean Paul Marks acknowledged that this was a “fairly radical departure” from CU’s “present posture” of remaining aloof from the needs of the surrounding community, he said that medical school faculty were prepared to participate “directly with community physicians in patient-care enterprise[s].”²² Carol Ann Richards and Margaret Mahoney from the Carnegie Foundation, perceived a “bias” at Columbia’s Medical School, and they were not sure that such a “powerful

bioscience and clinical science institution” would be able to “perceive or deal with community health science.”²³ Indeed, absent from the roster of attendees was the Executive Director of the Harlem Hospital Center, representatives from the Harlem Community, including the Harlem Drug Fighters, which a year earlier had taken over the Department of Psychiatry at Harlem Hospital, and Dr. L.S. “Mike” Holloman, a black internist who had served as the president of the Medical Committee for Human Rights in Mississippi. Holloman had teamed up with an attorney from the NAACP to initiate an affirmative action claim against Columbia University in 1967, on behalf of a black doctor that the Medical School had demoted. Holloman was also a past president of the black National Medical Association and had a private practice in Harlem. He would become the second president of the Health and Hospitals Corporation.²⁴

Some of these programs were more successful than others and some have left a thumbprint that exists to this day. All of the community medicine programs functioned in the context of the public-private hospital affiliations. Community hospitals, neighborhood family care centers, and outpatient departments in the public hospitals were run by private entities with public money. This complex mix of public and private interests sets our health care system apart from virtually every other system in the world. Ultimately my book, once completed, will outline the institutional arrangements for what the economist Paul Krugman calls the “cruel paradox” of advanced state-of-the-art medicine that is “bad for many Americans’ health.”

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The ideas and opinions expressed in this report are those of the author and are not intended to represent the Rockefeller Archive Center.

ENDNOTES:

- ¹ HIP received start-up funds from the Commonwealth Fund and the Rockefeller Foundation. Enrollees were advised to purchase hospitalization indemnity insurance, such as Blue Cross, see Commonwealth Fund, Box 142, Folder 1294; Rosemary Stevens, *American Medicine and the Public Interest: A History of Specialization*. Berkeley: University of California Press, 1971, pp. 422-423.
- ² See Box 35, Folder 274, Medical Interests, Rockefeller Family, RAC; Elmer Kleefield, "Health Insurance Plan of Greater New York." *JAMA* 143: 16 (1950), pp. 1445-1446; For an overview of the conflict between the AMA and public health initiatives, including health insurance, see John Duffy, "The American Medical Profession and Public Health: From Support to Ambivalence." *Bulletin of History of Medicine* 53: 1 (Spring 1979).
- ³ See Conrad Seipp, editor. *Health Care for the Community: Selected Papers of Dr. John B. Grant*. Baltimore, Maryland: Johns Hopkins Press, 1963. In *American Journal of Hygiene Monographic Series*, No. 21, June 1963, Baltimore, Maryland: Johns Hopkins Press, 1963; "Medical Care," 22 December 1946, John. B. Grant, MD, Program and Policy, Medical Care Reports, RG 3, Series 900, Box 25, Folder 197; John B. Grant Bio File, Rockefeller Foundation, RAC.
- ⁴ Grant, "Medical Care," RAC.
- ⁵ Willard C. Rappleye, "The Hospitals of New York City." *Bulletin New York Academy of Medicine* 37: 8 (August 1961), p.527; Ludmerer, pp. 163-165.
- ⁶ 30 October 1954, W.O. Diary, Washington, D.C., Medical Sciences, Box 126, Folder 1116, RF.
- ⁷ Ludmerer, pp. 6-10; Maynard, pp. 193-194; for a description of what interns were expected to do when they joined house staffs see Theresa Falaguerra, "The Internship: An Exploratory Analysis," prepared for the New York Committee for the Study of Hospital Internships and Residencies, 1957, Box 72, Folder 72, Grants 18:1, Commonwealth Fund, RAC.
- ⁸ 20 April 1956, Ivan Nelson, Conference on Foreign Medical Credentials, Washington, D.C., Medical Sciences, Box 126, Folder 116, RF, RAC.
- ⁹ 30 April 1954, W.O. Diary, Medical Sciences, Box 126, Folder 116, RF, RAC.
- ¹⁰ Willard Rappleye, "National Health Service of Great Britain," 8 November 1949, Box 35, Folder 273, Rockefeller Family; Ray Trussell Travel Grant (1955-1961), Box 123, Folder 1083, RG 1.2, Series 200A, RF, RAC.
- ¹¹ Report of the Commission of Health Services of the City of New York, Adopted 20 July 1960, New York City Department of Records, City Hall Library.
- ¹² Murray Schumach, "'State Opens City Hospitals' Investigation Today," *New York Times*, 28 December 1966.
- ¹³ Martin Gansberg, "Thaler Says City Hospitals Lost \$100-Million Because of Abuses," *New York Times*, 8 December 1966.
- ¹⁴ 1963-1966, RG 15 (NAR-Governor) Microfilm, Rockefeller Family Archives.
- ¹⁵ 6 October 1966, Hollis S. Ingraham to NAR, Rockefeller Family Archives, RG 15, Series 25, Box 68, Folder 1496, RAC; see also, "Report of Blue Ribbon Panel to Governor Nelson A. Rockefeller on Municipal Hospitals of New York City," New York State Department of Health, 1967.
- ¹⁶ HHC Press Release, 12 March 1970, Health and Hospitals Corporation, 125 Worth Street, New York City.
- ¹⁷ Box 164, Folder 1492, Medical Sciences, RG 1.2, Series 200, RF.
- ¹⁸ Box 164, Folders 1492 and 1493, Medical Sciences, RG 1.2, Series 200, RF; for Cherkasky see oral history interview, 17 September 1992, Rare Books and Manuscripts, Columbia University.
- ¹⁹ Box 213, Folder 200, Box 215, Folder 2015, Series 18: Grants, Commonwealth Fund.
- ²⁰ Bonnie Lefkowitz, *Community Health Centers: A Movement and the People Who Made it Happen*. New Brunswick, New Jersey: Rutgers University Press, 2007, pp. 52-54.
- ²¹ Box 40, Folder 362, Series 18: Grants, Commonwealth Fund.
- ²² Box 73, Folder 670, Series 18: Grants, Commonwealth Fund.
- ²³ T. Keenan to Dr. Glaser and Mr. Newton, 4 August 1971, Box 73, Folder 670, Commonwealth Fund, RAC.
- ²⁴ For Harlem Drug Fighters see Les Matthews, "Will Not Desert Drug Addicts," 1 August 1970, *New York Amsterdam News*; for Holloman and the Medical Committee for Human Rights, see John Dittmer, *The Good Doctors* [xx]; for the civil rights claim against Columbia University, see Adele Oltman, [xx].