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PUBLIC HEALTH THEN AND NOW

The New Left and Public Health


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Soon after its founding in the politically tumultuous late 1960s, the Health Policy Advisory Center (Health/PAC) and its Health/PAC Bulletin became the strategic hub of an intense urban social movement around health care equality in New York City. I discuss its early formation, its intellectual influences, and the analytical framework that it devised to interpret power relations in municipal health care. I also describe Health/PAC’s interpretation of health activism, focusing in particular on a protracted struggle regarding Lincoln Hospital in the South Bronx. Over the years, the organization’s stance toward community-oriented health politics evolved considerably, from enthusiastically promoting its potential to later confronting its limits. I conclude with a discussion of Health/PAC’s major theoretical contributions, often taken for granted today, and its book American Health Empire. (Am J Public Health. 2011;101: 238–249. doi:10.2105/AJPH.2009.189985)

FOR ALMOST A DECADE after its founding in 1968, New York City’s Health Policy Advisory Center (Health/PAC) served as the strategic hub of a vibrant radical social movement around health care equality, one that paralleled (and sometimes conflicted with) more widely known liberal counterparts of the time. Its Health/PAC Bulletin became an established bimonthly that boasted a wide audience composed of radicalized medical students and physicians and neighborhood activists, on one side, and nervous health administrators at powerful medical centers pilloried in each issue, on the other.

In 1970, Health/PAC published a popular book, American Health Empire, predicting a movement that would “turn the medical system upside down, putting human care on top, placing research and education at its service, and putting profit-making aside.”1 Fueling these proclamations were a series of occupations at city health facilities, leading Health/PAC to ponder the possibility of “creating a wholly new American health care system.”2 Yet, by the mid-1970s, Health/PAC declared itself guilty of “intellectual euphoria” in its founding years as the political energy that had generated so much initial enthusiasm disappeared. In its place were emerging governance regimes that, in many ways, accelerated the concentration of private power in health care that spawned Health/PAC’s early analysis in the first place.

In this article, I explain these developments by first detailing the framework that Health/PAC devised to analyze inequality in municipal health care. Second, I turn to the political prescription that followed. Using Health/PAC’s analysis of events around the South Bronx’s Lincoln Hospital, I examine the organization’s invocation of “community” and the notion’s power at the time “as the source of political legitimation and its attendant rhetoric of authenticity,” to borrow Adolph Reed’s words for a parallel context.3 The potential (and limits) of community-oriented health politics for transformative ends would become the organization’s central strategic conundrum. I conclude by considering Health/PAC’s legacy and ramifications for public health analysis and practice today.4

ORIGINS

By the end of the 1950s, New York City’s public hospital system,
Burlage's report scathingly indicted the affiliation plan. It argued that the benefits of affiliation mostly flowed one way, in the direction of the private medical centers. In practice, he wrote, ceding operation to the latter (and paying for their services) resulted in little public accountability. One section of the report elaborated on this issue, charging regular misuse of money paid by the city through affiliations for administration of the municipal hospitals. Accusations included “diversion and use of equipment intended only for city hospitals,” “padding of payrolls and extravagant and uneven offering of professional salaries with city funds,” “use of city funds to provide luxuries and extras,” and “use of city laboratories and research space.

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Health/PAC emerged from a 1967 investigation conducted by Robb Burlage, a founding member of Students for a Democratic Society who had helped draft its Port Huron Statement. A few years after graduating from the University of Texas, he had begun work at the Institute for Policy Studies, a new think tank funded by left-wing perfume magnate Samuel Rubin (Faberge). Impressed by Burlage, Rubin asked whether he would be interested in investigating the affiliation plan's origins and consequences. Rubin had served on several medical center boards and grown critical of Ray Trussell, the commissioner of hospitals and formerly of Columbia University, one of the city's most powerful medical institutions and private affiliates.

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Structurally, there existed a "general looseness, wastefulness and lack of direction, of the affiliations program, not just individual cases," and "city officials were ultimately responsible for not getting sufficient improvements out of affiliation expenditures and arrangements." Rather than move increasing numbers of patients at municipal hospitals to less pressured voluntary (private) ones, many major medical centers in fact did the exact opposite and shuffled or "dumped" their "undesirable" patients from their voluntary hospitals into the municipal affiliates.14

Although shocking, Burlage’s empirical findings themselves were not news, as his own report indicated. A 1967 blue ribbon panel reporting to Governor Nelson Rockefeller wrote of "inadequate upkeep of physical facilities," "shortages and imbalance among the many essential categories of personnel," and "insufficient funds and rigidity in legal and administrative procedures," problems that affiliation promised to alleviate.15 A year after Burlage’s report, a state commission confirmed multiple fiscal abuses. Some were minor, others far more serious, such as directing affiliation contract funds into interest-accruing accounts benefiting the private medical centers rather than toward municipal hospital improvements.16

Burlage’s distinction rested not so much on the revelations about hospital conditions. Rather, it centered on Burlage’s interpretation of them and his discussion of where the city ought to go next. Many analysts characterized the problems with affiliation as blights on an otherwise sound idea, ones that could be eliminated with increased oversight. Burlage argued, however, that affiliations as currently practiced were inherently exploitative and unaccountable. His institutional critique denounced “too much uncontrolled domination by the scattered ‘private’ and ‘academic’ sectors of health services.”17 With respect to policy, it called for the creation of a centralized public Metropolitan Health Services Commission that would regulate the municipal hospitals.18

At the same time, Burlage advocated the creation of District and Neighborhood Health Planning and Review Councils composed of residents who would provide bottom-up policy input and devise neighborhood health plans.19 The proposal exemplified a tension in New Left thinking: a supportive but simultaneously uneasy view of post–New Deal centralized state power, which could in fact be put in service of varying ends, not always progressive.20 It reflected, too, the experimentation of the War on Poverty era, particularly its Community Action Program, funds from which were directed to decentralized neighborhood-level projects that mandated public participation.21 And it applied ideas of the New Left political milieu, especially the “participatory democracy” that the Port Huron Statement had introduced into the political lexicon.

Two important themes emerged from Burlage’s report: its concern that private incursion into public health domains deprioritized patient care in favor of private medical interests and its contention that patients should have an increased influence on the policies of the medical facilities they used. His work earned significant mainstream press coverage.22 Most importantly, it pleased Samuel Rubin, who shortly afterward suggested creating a permanent center, Health/PAC, that would offer health care analysis in the same vein as the 1967 report. Soon thereafter, Burlage received seed funds from the Samuel Rubin Foundation and the Institute for Policy Studies and appointed as an assistant Maxine Kenny, who had worked previously as an aide to Vermont governor Philip Hoff and with the Committee of Responsibility and Committee of the Professions, two local peace groups opposed to the Vietnam War.23

A year later, in June 1968, Health/PAC released the first Health/PAC Bulletin. It critiqued in detail an official city commission headed by Scientific American publisher Gerald Piel that had also issued a report on the hospitals. Although critical overall, Piel’s report took a more favorable view of the affiliations and declared that they had “largely accomplished” one short-term goal, alleviation of the medical staff shortage. It tended to focus more on bureaucratic shortcomings, such as the “divided management” that resulted from an affiliation, and much less on democratizing city health administration.24

After this inaugural issue, Health/PAC continued its withering examination of affiliation,
post–World War II era. The sixth issue, published in November 1968, marked a turning point. Although maintaining the Burlage report’s analysis, it theorized much more forcefully, likening the relationship between private medical centers and municipal hospitals to colonialism. This comparison was, of course, a byproduct of the time, when many left analysts, especially the journal *Monthly Review*, debated the geopolitical consequences of near-monopolistic economic concentrations in the post–World War II era.

Many also sought to explain the dynamics of internal inequality by drawing analogies to colonialism and the underdevelopment that it sustained. In 1962, Burlage himself had written *The South as an Underdeveloped Country*, which highlighted economic underdevelopment both within the region and in comparison with the North. Andre Gunder Frank’s work on the “development of underdevelopment” famously characterized the internal dynamics of Brazil and Chile as a “chain of interlinked metropolitan-satellite relationships,” with the aﬄuence of metropoles predicated on the exploitation of satellites. And most inﬂuentially, Stokely Carmichael and Charles Hamilton, in their *Black Power*, used the language to describe the relationship of the Black ghetto to American society, characterizing it as internal “colonialism.”

Critics would later identify shortcomings in this formulation and its elision of critical differences between European colonization and ghetto formation in the United States. But might health be different? Given the appalling state of the city’s municipal hospitals at the hands of the private medical centers and the dependence of the city’s poor racial minorities on them, the colonial metaphor proved apt for the health sector speciﬁcally. The sixth issue of the *Bulletin* captured the power relationship with one word: empire. The accompanying article, “Medical Empires: Who Controls?” declared that:

> medical research, teaching and specialized services empires, based primarily in seven loose medical school-hospital afﬁliation networks, are increasingly the centers of power in New York’s medical establishment, with mammoth institutional control of the major medical resources in the City.

A map of the empires showed linkages between the public hospitals and the private medical centers to which they were ceded.

As an antidote, the *Bulletin* proposed a “De-colonization Program for Health,” word choice inﬂuenced by revolutionary “Third Worldism” and swelling anti-imperialist sentiment around the world toward American military aggression in Vietnam and European powers’ retreat from former colonies. This proposal extended the Burlage report’s 1967 recommendations, calling for an “accountable City government agency based in citizen-representative health boards and conferated regional boards” that would oversee a “publicly-approved comprehensive health services plan.” These boards needed to replace top-down medical centers, in other words, as key instruments of health planning.

Devising strategies for overthrowing the medical empires became Health/PAC’s chief goal. In this aim, Health/PAC was often counseled by Harry Becker, a sympathetic professor of community health at Albert Einstein College of Medicine (hereafter referred to as Einstein) and a health policy veteran with decades of government and labor union experience. It began an internship program while its staff expanded to include, at various points over the next few years, Vicki Cooper, Ruth Glick, John Ehrenreicht, Barbara Ehrenreicht, Oli Fein, Leslie Cagan, Susan Reverby, Connie Bloom- field, Marsha Handelman, Ken Kimmencing, Ronda Kotelchuck, Des Callan, and Howard Levy.

All had participated in civil rights, women’s, antipoverty, or student struggles of the decade. However, other than the physicians in the group—Callan, Fein, and Levy—they came to the world of health care as outsiders. Health/PAC’s popularity kept growing as its staff continued engaging media outlets, universities, and political groups through its busy speakers’ program. Its oﬃce became a go-to place for people to ask questions about health care, and activists made frequent use of Health/PAC’s discussions of esoteric municipal health policy. Links between analysis and action became apparent at the Lower East Side’s Gouverneur Health Services, one of the ﬁrst community health centers funded by the Oﬃce of Economic Opportunity (OEO). Activists of the Lower East Side Health Council-South, a government-mandated watchdog, increasingly believed that Beth Israel Medical Center, a private aﬃliate of Gouverneur that actually received the OEO...
funds, viewed it as a dismissible token. Beth Israel’s seemingly arbitrary employee reassignments and cancellations of Gouverneur neighborhood health programs brought these tensions to a pitch. Soon after Health/PAC’s appearance, Council members began challenging Beth Israel administrators on arcane policy points. A Bulletin article summarized one episode:

When Beth Israel (the affiliating hospital for the Gouverneur Health Services) turned over its 173-page plus proposal for OEO funds to the Health Council, as mandated by OEO regulations, few thought the Health Council would be able to master the document. To Beth Israel’s surprise and consternation, the Health Council’s review of the proposal included a thorough analysis and some severe criticism of the hospital’s program priorities with an explicit statement of the Council’s own priorities and appropriate justification.37

Terry Mizrahi, a Lower East Side community organizer, recalled later that the relationship between the Council and Health/PAC “was one of reciprocity and exchange . . . each of us learning from and educating the other,” the organization a provider of “advice and direction as we [the Council] discussed political and technical strategies, conducted open community meetings, and held behind-the-scenes negotiations.”38

When discussing political transformation, however, Health/PAC focused most extensively on Einstein Medical College, the affiliate of Lincoln Hospital in the economically devastated South Bronx.39 From the agitation around Lincoln, Health/PAC generated (and constantly revised) new ideas about the transformation of the health sector.

**BATTLE IN THE SOUTH BRONX**

Prior to Health/PAC, most health activists directed their energies toward conservative organizations such as the American Medical Association.40 By contrast, Health/PAC directed its wrath toward what it perceived as liberal hypocrisy couched in the language of progressive social medicine. One Bulletin editorial stated that liberal “promoters” such as Einstein have tended to direct their energies for “reform” in the most arrogant, dogmatic and unaccountable fashion. Even while rhetorically espousing “progressive” principles of medical system reorganization, they have engaged in wasteful inter-institution competition, hustling scarce manpower on a fee-basis, and scrapping over “teaching material.” . . . The irony is that these corporate liberals of the medical establishment have begun to imitate the competitiveness and self-interest of the solo, fee-for-service systems of which they are often so critical.41

An internal Einstein document seemed to substantiate such an analysis. On reasons why Einstein ought to continue its Lincoln affiliation, the document listed “needed for teaching,” “needed for financial support of school,” and “needed for health care research.” At the bottom (perhaps tellingly so) was “needed so School can meet its obligation to help with contemporary problems, to heal the sick poor etc.”42

Einstein showcased the contradictions of the affiliation plan like few other institutions. Under affiliation, Lincoln Hospital remained one of the country’s worst urban hospitals. An internal Einstein report described Lincoln as a hopelessly inefficient and inadequate building which would be useless for the running of a modern hospital for a population of 350,000 even if it were in brand new condition. As it is, the dirt and grime and general dilapidation make it a completely improper place to care for the sick or even run the complex administrative machinery that is required to do this.43

It was a “constant daily reminder to all who are in it of their futility and impotence: to the patient who gets sick in a dirty slum and enters a dirty slum for treatment it must mean that ‘they’ do not really care or try.”44

During 1969 and 1970, neighborhood residents, hospital service workers, and young physicians expressed anger over conditions at Lincoln. In 1969, politicized workers in its mental health unit seized control of the facility. They administered it by themselves for weeks, arguing that their day-to-day contact from actually living in patients’ neighborhoods gave them unique insight on how to run it, knowledge that typical medical administrators did not possess.

In July 1970, the Young Lords, a radical Puerto Rican nationalist group, occupied Lincoln Hospital for one day, drawing considerable public attention.45 An adjunct organization called the Health Revolutionary Union Movement (HRUM), composed mostly of Young Lords and Lincoln health workers (almost all members of racial minority groups), had demanded “total self-determination of all health services through a community-worker board to operate Lincoln Hospital.”46 On top of this was a group of radical residents and interns who called themselves the Lincoln Collective. Centered in the hospital’s pediatric ward, they advocated for many
had “made some steps toward emancipation” and could serve as a model for “institutional organizing,” a New Left formulation that predicted changes in more and more institutions would accumulate into subsequent total change in a given sector and the society writ large.54

Within the hospital, the Lincoln groups were able to introduce some significant internal reforms: a continuity-of-care system, a certain degree of parental decision making in the hiring of pediatric staff, and Lawrence Weed’s much more rigorous “problem-oriented” system of patient record keeping.55 One year, the pediatrics department’s infant care program received a rating nearly 30 points higher than that of PAC’s Susan Reverby and Marsha Handelman. It differed considerably from the organization’s prior assessments of health activism, such as the excited articles after the 1969 and 1970 events and Health/PAC’s American Health Empire book, published in late 1970, that included a final chapter titled “The Community Revolt: Rising Up Angry.” Reverby and Handelman, by contrast, were much more cautious as they dissected the community-worker control idea. They argued that radical health workers, represented by HRUM, were far more reliable catalysts for change than an elastically and vaguely defined “community,” writing that “the community residents’ relationship to the hospital is episodic; people only come when they are ill.” “In contrast,” they continued, “the non-professional and professional workers are at Lincoln every day; it is a focus and a definition for their lives. From this base changes at Lincoln have come.”52 Their piece decidedly favored HRUM over the Collective as a key source of transformation. Reverby and Handelman described the Collective’s difficulties with devising a coherent political program and charged that the group’s support of HRUM and the Young Lords resulted from “the politics of guilt and the politics of adventurism.” The Collective’s commitment to “the community” arose “out of a romantic notion about the medical savior who leads other people’s struggles; or the voyeuristic tendency that defines a ‘total political’ as ‘rapping with the Lords.’ ”53

Still, they argued that Lincoln represented “one of the first thin threads of a sustained struggle to achieve worker-community control within a health institution.” It had “made some steps toward emancipation” and could serve as a model for “institutional organizing,” a New Left formulation that predicted changes in more and more institutions would accumulate into subsequent total change in a given sector and the society writ large.54

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New York City, moreover, became embroiled in a protracted fiscal crisis resulting in an austerity regime that led to medical facility closures, service cutbacks, and layoffs.62 From 1975 to 1980, Charles Brecher recounts, Health and Hospitals Corporation spending growth was “virtually frozen,” in contrast to the previous five years, when expenditures had risen 54%.63

The New Deal–New Left tension that always existed in Health/PAC came to the fore. Health/PAC had spent its early years attacking a state apparatus that it argued served as a handmaiden to the city’s powerful and concentrated private medical interests. Now, it (along with much of the political left) ironically found itself defending that very apparatus as it came under attack from banking interests and the political right.64

A simultaneous tension between centrally and locally oriented politics also surfaced. Amid these macroeconomic woes, the overall political potential of highly local actions around health care seemed much smaller. In the larger political picture, how much did local nodes of political power really matter when stacked against these macrostructural changes and the decisions of powerful centralized political bodies? The question had always lurked quietly in

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Nevertheless, racialized class tensions developed and persisted between politicized hospital workers and the Lincoln Collective’s young White radical physicians. One manifestation occurred during a dispute over meal tickets. At Lincoln, the physicians were entitled to free meals, but workers and nurses were not. HRUM proposed that the physicians, to show solidarity, start paying for meals like everybody else, but the Lincoln Collective failed to reach consensus. The real problem was not the minor surface issue of meal tickets. Rather, it was whether the Collective’s members could ever conceive of themselves not as professionals but as a “proletariat” like any other and put that conception into real practice, as HRUM demanded.

One Collective member objected to such proletarianization of professionals and declared that he did not think revolution would “be led by workers in a traditionally Marxian concept.”57 At another meeting, members noted a “lack of unity” and expressed frustration over their “failure . . . to relate” to “other health struggles throughout the city and country.”58 Activism around Lincoln and the South Bronx—and other city sites with more moderate conflict—was indeed declining dramatically, along with political morale.

And whatever forms of community control were won, long-standing structural problems endured. Across the city, the affiliation program had yet to undergo overhaul even with the 1970 creation of the New Health and Hospitals Corporation, a public benefit corporation somewhat resembling what Burlage had advocated in his initial report but lacking many of his suggested structures for public participation. Lincoln’s physical plant seemed, at times, irreversibly deteriorated. In mid-1973, Lincoln physicians Peter Schnall and Al Ross identified more than 40 hospital inadequacies, including a lack of basic supplies, 2-hour average waiting times in the pharmacy, and poor patient privacy in examination rooms.59

In late 1974, Lincoln briefly lost accreditation from the Joint Commission on Accreditation of Hospitals.60 Some Lincoln activists began to see the limits of single-institution organizing, although small doubts had always existed. As early as 1972, Mike Steinberg, an ardent advocate of such an approach at Lincoln, lamented:

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Health/PAC’s thinking. In a speech several years earlier, for example, Oli Fein mentioned the possibility that community control in fact “deflect[ed] challenges, particularly about the allocation of resources, from the national level where they should be.”65 For many activists, mounting structural economic woes threw this dilemma into relief: whether, in historian Thomas Sugrue’s words, “the problem was not one of governance” but ultimately “one of resources.”66

In one of the final pieces that discussed the Lincoln events extensively, published in 1975, Health/PAC staffers Howard Levy and Ronda Kotelchuck reexamined their organization’s valorization of community politics and its insurgent potential. They suggested that “the romanticization of these early institutional struggles, while intending to move health workers elsewhere to join the struggle, ultimately had the opposite effect—the blocking of a process of thought that might lend clarity, direction, vision and strength to strategic options and implications of institutional organizing.”67 “The end result of such unreflective and unwarranted positivity,” they concluded, “was epidemic disillusionment, divorce from reality and fostering of false premises, all of which were without doubt self-defeating.”68 The article served as critical self-recognition of the organization’s tendency to equate political synecdoches—in Health/PAC’s case, “community” or “community-worker” and their purported spokespeople—with larger foment that turned out to be much more tenuous than earlier militancy had suggested.69

With the parallel decline and demobilization of the political left more generally, Health/PAC confronted a crisis of purpose. In the latter half of the 1970s, low spirits surfaced in staff meetings characterized by one office memo as “abominable, interminable, intolerable and ineffective.”70 Many staffers described the post-1960s political landscape as one of “isolation.”71 Others noted that their career goals (and the mundane pressures of every day life) potentially conflicted with their political ones.72 The problem of funding loomed, sparking impassioned debates about whether Health/PAC ought to suspend the Bulletin, affiliate with a university, convert to a volunteer organization, or raise money from more traditional foundations.73 Some of these proposals signaled changing times. Health/PAC, after all, had begun by spotlighting the powerful influence that large, well-funded, and impersonal organizations—universities and establishment foundations among them—exerted over the health sector. It now found itself in the odd position of considering whether its existence might well depend much more heavily on them.

Eventually, the organization survived with small-foundation support (including a recommitment from Rubin), its subscriber base, and later, well-known parties at the American Public Health Association’s annual meetings.74 In 1978, it changed from an organization with a full-time staff to one run by a volunteer editorial board and increasingly relied on submissions and solicited pieces.75 Until eventually folding in 1994, the Bulletin took the form of a left-liberal health policy journal in both style and substance. But it by no means abandoned coverage of on-the-ground struggles entirely, publishing issues on activism around HIV/AIDS, environmental justice, and occupational and women’s health.

HEALTH/PAC’S SYSTEMIC ANALYSIS

Although focused mainly on New York City events and agitation in these early years, Health/PAC soon developed a national-level analysis of political economy and health care. The November 1969 Bulletin introduced “medical industrial complex,” a key term for which Health/PAC became known.76 One article in the issue argued that although billions flowed into the medical industry each year, the money rarely made its way into qualitative improvements for primary patient care and instead flowed to a myriad of profiteers:

This year the nation will spend over $62 billion on medical care, up more than 11 percent over last year and twice the 1960 level. $6 billion of this will flow into the hands of the drug companies, almost $10 billion will go to the companies that sell doctors and hospitals everything from bed linen to electrocardiographs, $35 billion will be spent on “proprietary” (profit-making) hospitals and nursing homes. The nation will purchase $6 billion worth of commercial health insurance and construction companies will build about $2 billion worth of hospitals.77

The issue depicted webs of privately owned drug companies, insurance firms, stockholders, financial interests, and hospital and nursing home proprietors transferring enormous profits among themselves, with patient care a second thought. Health providers themselves were but a small component—“little more than a front for the industry”—in this bleak national picture.78 Although supporting
more federal spending on health, the issue cautioned that the increase would be “wasted” unless “developmental programs and spending priorities” within the system changed drastically.79

These lines were aimed at Medicare and Medicaid, two reforms of the Lyndon Johnson administration initiated in 1965 that expanded federal dollars for health expenditures of senior citizens and the poor. Ehrenreich and Ehrenreich interpreted them as a boon for private health profiteers who saw the new programs as a new source of money.80 “For years,” they wrote, “the government has directly or indirectly fed dollars into the gaping pockets of the dealers in human disease.”

This position underpinned Health/PAC’s interpretation of liberal proposals for national health insurance, which it attacked for being too conservative and again saw as “a special interest” where “survival depended on a steady and copious stream of research dollars,” and “hype and self-justification became inevitable,” often resulting in overwhelming analysis.83 It is thus unsurprising to see regular calls for more sophistication in public health thinking.84

In municipal health care, the lax regulatory climate that first spurred Health/PAC is gone.95 But in actual practice, the fundamental conflict between private interests and the public’s health remains. In recent years, for example, reports of illegal dumping have come out of Los Angeles, leading to investigation and prosecution by the city attorney against several hospitals. One cannot help but recall Lincoln Hospital and Einstein when reading about the travails of Los Angeles’ King-Drew Medical Center (restructured and renamed in 2007) and its private affiliate, Charles Drew University of Medicine and Sciences.

We continue wrestling with the politics of “community”—a term invoked frequently (and often mystically) yet imprecisely in public health—and the associated search for sources of transformation in health provision. Historical and present efforts...
related to government health insurance have been propelled mainly by middle-class reformers, not more popular constituencies.85 With some exceptions, mass organizing around health equality remains difficult.

Health/PAC’s crowning achievement was situating health care politics in a wider political-economic context and bringing intellectual rigor to activism.86 It struggled constantly with identifying the most promising methods for change in the health sector, but it must be credited, too, with revisiting that question, often in a ruthlessly self-critical way. Class medicine and obscene health inequalities remain stark.

Forty years after American Health Empire, we would all do well to recall Health/PAC’s political spirit and analytic totality and to revive the ambitious parameters of debate that it set.

Endnotes
2. Ibid.
16. The American Planned Economy: Liberalism, Christianity, and the New Left in America (New York: Columbia University Press, 2002), 34–36. The tension is also visible in Burlage, “The American Planned Economy,” in which he critiques the lack of post—World War II American economy planning and surveys varieties of planning without conclusively favoring one over the other. For example: “All prescriptions for social change in our society must have at least an implicit notion of the nature of ‘planning’ and decision-making in the ‘political economy’ in which we live: from Gunnar Myrdal’s urging for more public national planning (in Beyond the Welfare State); to those of the pundits of the Center for the Study of Democratic Institutions for ‘democratization’ of and social responsibility in the ‘metrocoporation’; to Paul Goodman’s pleas for new models of decentralization (see People and Personnel, New York: Random House, 1965).”
17. On the Office of Economic Opportunity and the Community Action Program, see Alice O’Connor, Poverty Knowledge: Social Science, Social Policy, and the Poor in Twentieth-Century U.S.


44. Ibid.

45. For a thorough introduction to the Young Lords, see Johanna Fernández, “The Young Lords and the Postwar City: Notes on the Geographical and Structural Reconfigurations of Contemporary Urban Life,” in African American Urban History Since World War II, ed. Kenneth L. Susmer and Joe William Trotter (Chicago: University of Chicago Press, 2009), which also analyzes the Lincoln events but from the vantage point of the group.


47. “Purposes of a Program in Community Pediatrics at Lincoln Hospital,” September 11, 1969, Part II (subject files), Box E-1, “Lincoln Hospital/HRUM folder, Health/PAC papers,” Albert Einstein College of Medicine Lincoln Hospital House Officer Program in Community Pediatrics, circa 1970, Part II (subject files), Box E-1, “Lincoln Hospital/HRUM” folder, Health/PAC papers; “Lincoln Hospital—Albert Einstein College of Medicine House Officer Program 1972–73,” in personal papers of Michael McGarvey. See also Fitzhugh Mullan, White Coat, Clenched Fist (New York: Macmillan, 1976), a memoir of one Lincoln resident’s experience in these events. My summary here is a greatly compressed version of Lincoln events, which I will explore further in a separate future article.


53. Ibid., 16.

54. Ibid., 1, 16.

55. Helen Rodriguez-Trias, “The Medical Staff and the Hospital,” Bulletin of the New York Academy of Medicine 48


57. “Collective Meeting Minutes,” February 7, 1972, Box 2, Folder 1, Mullan papers.

58. “Collective Meeting Minutes,” February 7, 1972, Box 2, Folder 1, Mullan papers.


68. Ibid., 22.


70. Ronda Kotelchuck to staff, circa 1976, Part I, Box 18, “HPAC STAFF MTGS” folder, Health/PAC papers.


76. Fortune magazine, of all places, used the term in a special issue on health care in January 1970.


79. Ibid.


85. Ehrenreich and Ehrenreich, Ameri- can Health Empire, 7.

86. Ibid., 11.

87. This phrase, or ones like it, was fre- quently used in the 1960s and earlier to describe patients studied by medical students, interns, and residents.

88. Ehrenreich and Ehrenreich, Ameri- can Health Empire, 17.

89. Ibid., 21, 23, 25.

90. Ibid., 26.

91. For a more recent analysis of these forces, particularly racism in urban planning and fire policy, during this time period that includes discussion of the South Bronx, see Deborah Wallace and Rodrick Wallace, A Plague on Your Houses: How New York Was Burned Down and National Public Health Cram- bled (New York: Verso, 1998).

92. See, for example, Marcia Angell, The Truth About the Drug Companies: How They Deceive Us and What to Do About It (New York: Random House, 2004).


95. My view of gradual policy reform is thus more upbeat than the bleak assess- ment of Alford, Health Care Politics, al- though I share many of his brilliant in- sights on the limited and often myopic character of reforms.


97. Health/PAC differed from 2 other strands of health critique: one exempli- fied by Ivan Illich’s 1970s writings, which criticized the very content of health science itself (as opposed to its political–economic distribution and manner of administration, as Health/ PAC did), and another related one an- chored in individualist, “self-help” ideas that emphasized self-maintenance of personal wellness. See Ivan Illich, Medi- cal Nemesis: The Expropriation of Health (New York: Pantheon, 1976), and, for an intellectual history of these varying strands, see David Rosner, “From Doc- tor Shortage to Doctor Surplus—The Shifting Debate over the Health Care ‘Crisis’ During the 1970s” (unpublished draft manuscript, 2004).