FOUNDATION'S POLITICAL PRONOUNCEMENTS

While the maneuvering to control the blacks was taking place, the foundations, through their other front organizations, were busy undermining Locher. Plenty of ammunition was readily available. In February, 1967, ICAC openly broke with Locher, charging complete lack of faith particularly on the troublesome urban renewal program. The break earned the Besse committee banner headlines. Earlier, the Little Hoover Commission, staffed by the Government Research Institute, and heavily financed by the foundations, had turned out a damaging report on the city's urban renewal program. A similar report on the operations of the police - also a sensitive issue in the black community - hurt Locher. These public relations maneuvers were handled by Bill Silverman who later became campaign director for Seth Taft, a Little Hoover Commission member and former secretary of the Greater Cleveland Associated Foundation. Silverman, after Taft's defeat, became Stokes' image-maker with a $68,000 grant from the foundations routed through the Government Research Institute. This provides a good example of the ability of the foundations to provide "help" to politicians.

At the same time the Cleveland Development Foundation and the PATH Committee were making public and private statements that further undercut Locher. The ability to create a climate through the private utterances of civic leaders who run supposedly non-political civic groups cannot be underestimated. This is especially true since the civic leaders here spoken of have a ready mouthpiece through the decisions-makers in the media. Thus what they say is reflected to the entire citizenry by the media.

Meanwhile, in Cleveland a private fund of some $40,000 had been put together by Besse and ICAC to pay militants to keep peace in Cleveland ghettos. The project was headed by Baxter Hill. This project ended the weekend before the primary election in which Stokes defeated Locher. This suggests that the businessmen here were more interested in being rid of Locher than in electing a black mayor. Indeed, the top contributors to a third candidate, put in the race to split the white vote suggests the same. Among the top contributors were Reavis, $3,000; foundation trustees Kent Smith, $3,000, Frank Josephs, $1,000 and H. Stuart Harrison, $1,000.

The departure of Locher and eventual victory of Stokes may certainly have convinced both the Ford Foundation and the foundations here of the wiseness of their methods of buying urban peace. But a year later in a similar "cooling down" program, Ahmed Evans, a black militant who had kept the peace with Baxter Hill the summer before, had a gun battle followed by street rioting. Ironically, the study of the National

Commission on the Causes and Prevention of Violence, which wrongly blamed Evans and his men for the shootout, was written by the Civil Violence Research Center of Case Western Reserve University, which, as the reader might expect, was funded by the foundations. And when city officials, as is the custom, flew to Washington to ask for "riot relief", among the pleaders was Dolph Norton, president of the Cleveland and Greater Cleveland Associated Foundations.

The city paid his way this time.

CLEVELAND'S MEDICAL EMPIRE

Don't get sick in Cleveland. Once you do, the problems of getting adequate health care are often more troublesome than the illness itself.

The first problem is the physical problem of getting to a doctor. Even for people who can afford a private doctor, house calls are a thing of the past-- you have to get to the office yourself. And, for people who can't afford a private doctor, the logistics of getting to a clinic can be more overwhelming than the illness itself. Take the case of Mrs. S., who lives on the east side and is pregnant with her third child. For prenatal care, wh prefers Metropolitan General Hospital, on the west side, which is more lenient about billing than the east side private hospitals. But how to get there? The ride across town will cost at least $1.00 and will take about 45 minutes each way. If Mrs. S. takes her children with her, she'll have to pay another $2.00 for their fares, otherwise she'll have to pay a babysitter. So, like many other women, Mrs. S. never manages to trek across town for a prenatal visit. No less than one third of the women who give birth at Cleveland's four largest hospitals have never seen a doctor during their pregnancy, in many cases just because they couldn't afford the time, money and effort it takes to get to a doctor.

Once you arrive at a clinic in one of Cleveland's hospitals, you're still a long way from actually receiving medical care. Most clinics welcome the new patient with a lengthy intake procedure, featuring a detailed financial interrogation. Then there's a stint in the waiting room. University Hospitals, Cleveland's most prestigious medical complex, still operates on the archaic and inhuman "block appointment" system. That means that every patient for a given specialty clinic gets an appointment for the same time. For example, Mr. R. thought he could squeeze in a visit to a clinic, which opens at 1 PM, by taking a late lunch hour. When he arrived at one, he found that there were already 19 people ahead of him. It was 1:30 before any of the doctors showed up. Mr. R. finally saw a doctor at 2:30 and got out before 3-- at the cost of an afternoon's pay.

When you finally get to a doctor, your troubles are far from over. You may get no care, or worse, improper care. Mr. M., on the west side, went to Metropolital Hospital with a broken leg, and was put in a cast. The cast seemed tight, but he didn't complain. A few weeks later the doctors found that the cast was too tight-- circulation had been cut off,

and the leg had to be amputated. Mr. M. would like to sue the hospital but he can't afford the kind of legal talent the hospital has, especially since he's out of work now. Another case we know of is that of Mrs. C., who was told at University Hospitals to give her baby boiled skim milk for diarrhea. Weeks later Mrs. C. read in the paper that boiled skim milk can be fatal in infant diarrhea, and that doctors had known this for years. Fortunately, her baby was well, but how many other infants had succombed to this "treatment?"

If you're curious or skeptical about your treatment in a Cleveland hospital, it won't do you much good to show it. Especially in the big private hospitals, the doctors feel they're doing you a favor to see you at all-- and they certainly don't have time for questions. Too much curiosity can get you labeled a neurotic hypochondriac, or a troublemaker.

But it's essential to be alert. If you're too sick to challenge what is going on, you can be in real trouble. But for many people, the real problem begins only after they've receive medical care. This is the problem of paying. In Ohio, only welfare recipients are eligible for Medicaid. Everyone else (except those old enough to be on Medicare) is entirely on his own. In Cleveland, a visit to a hospital clinic can cost up to about $17; a one-day stay in a hospital, up to $123 (not counting special tests and procedures in either case). Many working people depend on Blue Cross to pay for their stays in hospitals (it doesn't cover clinic visits) but Blue Cross itself has become a financial burden. Blue Cross rates went up 60% this year, with more increases slated for the next few months. And when it comes to collecting for clinic visits, most hospitals drop all pretense of "mercy" and "charity." At Lutheran Hospital and several others, patients are required to sign a "cognovit note" before seeing a doctor. Then, in case the patient fails to pay the bill, he automatically faces a court judgement, with no possibilit of protest or a hearing. Mr. T. signed a cognovit note without knowing what it was. After letting several weeks go by without paying his bill which ran into hundreds of dollars, he found that his wages had been garnished.

The safest thing to do is to stay well, and not risk health and livelihood in the search for medical care. But it's not easy to stay healthy in Cleveland:

-- Ghetto neighborhoods are rat-infested. In Glenville, 62% of the homes harbor rats, which carry a host of diseases from food poisoning to bubonic plague.

-- Malnutrition is rampant, especially in the poorest neighborhoods. One third of Cleveland's poor children suffer from vitamin C deficiency and one fourth are under-weight.

-- Air pollution blankets the city, intensifying and perhaps causing in some cases asthma, emphysema, and heart ailments.

-- Garbage collection is limited to a once-a-week pick-up. Because of recent city budget cutbacks, even the weekly pick-up is unreliable in many neighborhoods. Open piles of decaying garbage, covered with flies, line many streets in summer.

It used to be that Clevelanders could rely, more or less, on the city Health Department to ward off the dangers of contaminated food, epidemics, etc. But the 1971 budget cutbacks for the Department of Health have seriously undermined standard operations such as food and milk inspection, vaccinations, TB checks and monitoring of dangerous diseases. How long will it be before Cleveland suffers an epidemic of a disease we thought medical science had conquered years ago? And, given the state of the medical care system, what will we do when it happens?

There is no good reason why people's health needs should go unmet in Cleveland. The city has a higher-than-national ratio of doctors per capita; it has a medical school with a national reputation for excellent research and training; it has a host of major hospitals, all of which have undergone major expansion and modernization programs in the last five years. Why should there be such an enormous gap between resources and services in Cleveland? Who controls these resources and determines how, and in whose interests they will be used?

THE HOSPITAL SYSTEM: EAST SIDE ELITES

Cleveland's health resources are concentrated in hospitals, especially in private hospitals. Public institutions--hospitals and health clinics-- are too poorly financed to provide significant alternative services, thanks to Ohio's low corporate tax rates. Ohio ranks 37th in the nation in expenditures for medical assistance and lowest in the nation for corporate taxes!

The geographic distribution of Cleveland's hospitals is completely unbalanced. All the major private hospitals are on the east side. The one public general care hospital, Metropolitan General Hospital ("Metro"), a county hospital, is on the west side. Thus a west-sider who needs specialty care at a prestigious east side hospital faces at least an hour trip across town. An east-sider who has been rejected by the big east side hospitals for being unable to pay, "undesireable," or medically "uninteresting" must make an hour long trip to Metro.

For a poor person in Cleveland, it is no great advantage to live on the east side, near the "best" hospitals. The big private hospitals were built on the east side, not to serve

the poor people now living there, but to serve the rich people who once lived there. Now the rich have left for the suburbs, leaving their hospitals behind in what has become Cleveland's black ghetto-- an area ridden with disease and malnutrition. For any hospital truly committed to healing, this demographic change would mean a welcome opportunity for community service. But not for Cleveland's private hospitals.

St. Vincent Charity Hospital, the city's major catholic hospital, is known to be the worst offender when it comes to "dumping" poor patients who come in for emergency care across town to Metro. Many people in the public housing projects near St. Vincent prefer to take the two-bus ride across town anyway, rather than face what they consider to be slip-shod or racist treatment at St. Vincent.

Mt. Sinai, a 573 bed teaching hospital located in University Circle was founded by Jewish doctors who were discriminated against by Cleveland's Christian hospitals. Ironically, Mt. Sinai now probably has the most racist reputation in town, for its treatment of both patients and workers. In the mid-fifties, Mt. Sinai almost decided to pack up and move to the suburbs, but decided to stay because a hospital needs "the proximity of a source of medically indigent patients essential to the maintenance of a teaching program" and "a ready supply of unskilled and semiskilled personnel." (quoted in the Plain Dealer in 1955.) Mt. Sinai stayed not because the people needed the hospital, but because the hospital needed them, as cheap labor and as bodies to practice on.

Cleveland Clinic, a 600 bed voluntary hospital in the heart of the ghetto, likes to think of itself as Cleveland's equivalent of the Mayo Clinic. If you need and can afford a kidney transplant, open heart surgery or an intensive check-up, it's a great place to go. You can relax in well-appointed, wood-panelled waiting rooms; you have multi-course dinners and beautician service in your room; or you can stay in the plush Clinic Inn, the motel run by the clinic. But if you're an ordinary person with an ordinary problem, forget it. Cleveland Clinic has no outpatient department and no maternity service to put a drain on its finances. Only a third of the Clinic's patients come from the Cleveland area; the others, like a high Argentinian government official recently flown in for heart surgery, come from all over the world. The situation is so blatant that Mayor Stokes privately threatened to take the Clinic's tax-exempt status away unless it started serving the black community which surrounds it.

There is another side to the big east side hospitals: they are all major employers, and over 70% of their employees are women, many of them black. As employers, Cleveland's private hospitals are best known for their bitter opposition to workers'

efforts to organize unions. As recently as 1966, nurses' aides in Cleveland earned a mean wage of $58.50 a week; kitchen help (women) earned an average of $1.38 an hour; and porters (men) averaged $1.60 an hour-- hardly enough to support one person in a big city, much less a family.

When the nation-wide wave of hospital worker unionization hit Cleveland in the sixties, Cleveland hospitals fought back with weapons ranging from paternalistic propaganda to more overt repression. University Hospitals, in 1963 sent all its employees a letter saying, "University Hospitals, as your employer, is opposed to recognizing any union or organization which seeks to act for hospital employees. This has been our position for many years." The letter went on to explain that unions are inappropriate for hospital workers since a strike in a hospital is "unthinkable," and because hospitals are "non-profit" institutions. Cleveland Clinic made its position clear in a letter to all employees in 1968:

October 22, 1968

Dear Fellow Employee:

We are sure you are aware that for the past few months a "dues hungry" building service union has been pressuring Cleveland Clinic employees to sign cards. This union, which recently caused employees of another Cleveland hospital (St. Luke's) to lose more than $500,000 in wages in a strike, now claims to represent a majority of our employees.

THIS ISN'T THE TRUTH.

Many of our employees have asked the administration to do everything in its power to prevent these outside professional unionists from succeeding in this attempted power grab.

We feel that the best way to get rid of this union is to arrange for an election by secret ballot in which our employees can tell these outsiders, in an unmistakable way, that THEY ARE NOT WANTED HERE.

Therefore, we will seek to work out the details for an election as soon as possible. You may be assured, however, that we do not intend to be stampeded into a premature election by anyone, but will insist that proper, timely, and precise procedures be taken to insure the right of ALL employees.

You should be warned that in an attempt to win an election and take over all Cleveland Clinic employees, this union will say anything and promise anything which it thinks

will persuade you into voting it into power. When you read this slick propaganda, always keep in mind that employees in another hospital who fell for the union found themselves out on the sidewalk without a job, without pay, in a strike that lasted for nearly one year.

It is extremely important that you know all the truth, all the facts, and how the "takeover" by this union could affect you, your job, and your future. THEREFORE, WE PROMISE YOU that the Cleveland Clinic does not intend to stand idly by and permit the union propaganda professionals to weave a web of deceit. We intend to campaign vigorously and with the most powerful weapon in the world - THE TRUTH.

Sincerely yours,
signed James G. Harding
Hospital Administrator

According to workers at Mt. Sinai, Cleveland Clinic and University Hospitals, these institutions also use concrete methods of preventing workers' organizing. Personal favors and selective pay raises have been used to cultivate the loyalty of long-term workers who, in return, are expected to keep an eye on the short-term workers.

Despite such techniques of intimidation and cooptation, Cleveland hospital workers have been organizing and sometimes winning union recognition. In 1967, Local 47 of the Building Service and Maintenance Workers led a bitter, year-long strike at St. Luke's Hospital. Maintenance workers, almost all black people, struck for higher wages, better working conditions, and the right to organize hospital workers in Cleveland. Organizers were able to point out the connections between St. Luke's Board of Trustees and Cleveland industry and other "non-profit" groups such as Blue Cross. During the strike, racial and class tensions ran high. Several Trustees'homes were firebombed and striking employees were arrested. For the first six months, the board refused to negotiate at all with the workers. An arbiter was called in but was unable to work out a settlement. After about ten months, City Council decided it had to intervene, and threatened the hospital with a labor relations law which would require all employers, including hospitals, to recognize the organization of its workers. Rather than tolerate such a law, St. Luke's gave in to the workers, and Local 47 secured a good contract for its members. Local 47 subsequently led a successful fight for maintenance workers at Forest City and Woman's Hospitals, and has cases in court with Lutheran Medical Center and Fairview General Hospital.

In 1969, the nurses at St. Vincent Charity Hospital struck for two months to gain recognition for the Ohio Nurses' Association as their bargaining agent. Most of their demands

centered around working conditions and "dignity" rather than wages. Nevertheless, the administration adamantly rejected their demands until City Council stepped in and, this time, did pass the Cleveland Labor Relations Law. St. Vincent was forced to recognize the Ohio Nurses' Association.

Cleveland Clinic, Mt. Sinai and University Hospitals are still unorganized. But with hospital workers unionization on the upswing throughout the country, including traditionally anti-labor Southern cities, it won't be long before these elite institutions are also forced to recognize the rights of their workers.

THE HOSPITAL SYSTEM: A MEDICAL EMPIRE

The pattern of control in the Cleveland hospital system centers on the Case Western Reserve University Medical Center, the city's largest and most prestigious medical complex. It consists of the CWRU medical school and its affiliated University Hospitals, a seven-hospital, 965-bed complex under a single administration. The University Medical Center (UMC) is the kingpin medical institution of the entire northeast Ohio region:

* It is rich. University Hospitals alone has an endowment of $24 million and an operating budget of $24 million. In 1958 the Medical School and the University Hospitals embarked on a joint development program estimated to cost $54.8 million. The UMC is now completing Phase I of this program, with expenditures having already exceeded $64.6 million.

* Its trustees include some of the most powerful men and wealthy aristocrats in Cleveland. Old Cleveland families such as the Humphreys, the Hannas and the Prentisses poured money into UMC in the early days. Today their descendants and top officers of the family companies still dominate the boards of the University Hospitals and of Case Western Reserve University. For example, University Hospitals 50-member board collectively holds 40 directorships in Cleveland's top industries, banks and utilities. (Many of the board members sit on the boards of several corporations.) The University Hospitals board is really a family affair among Cleveland's aristocracy - no less than 23 members are related to at least one other board member! One of the coziest family groupings on the board is that of the Hanna/Humphrey/Ireland dynasty (see NACLA Newsletter, Vol II #4, July-August 1968). There's Gilbert Humphrey (chairman of Hanna Mining), his father-in-law, R.L. Ireland (retired director of Hanna Mining), his sister and her husband Mr. and Mrs. Royal Firman, Jr., (the latter until 1969) and (until his death in 1970) Humphrey's father George M. Humphrey (former Secretary of the Treasury under Eisenhower). The CWRU board is less

incestuous, but just as impressive in terms of economic power. There are two personal interlocks and numerous corporate and family interlocks between the University Hospitals and the CWRU boards.

* It has a regional monoply on medical education. CWRU has the only medical school in northern Ohio, and lesser institutions have been consistently rebuffed in their efforts to create medical schools of their own. In the 60s, Metro, in a grab for independence from its affiliated medical school, CWRU, made a bid for state funds for a medical school, but was turned down; and Cleveland State University's request of the Ohio Board of Regents has been stalled for over a year.

UMC's medical resources, combined with its wealth and powerful connections, are more than enough to make it the city's most influential medical institution in an informal sense. It plays a dominant role on the local Regional Medical Program (federal Heart, Cancer and Stroke program), and, according to one local health planner, "Nothing happens in the health area here without [UMC's] OK." But UMC's formal influence over the Cleveland health system is even more impressive. The CWRU Medical School is affiliated with six major Cleveland hospitals: three county hospitals (Metro, Highland View and Sunny Acres), the VA hospital and two voluntary hospitals, St. Lukes and Mt. Sinai. UMC's medical empire of affiliated institutions includes a total of 4100 beds, out of 6500 in the city and 9000 in the entire county.

What's behind the creation of this impressive hospital empire? What drives UMC, and the medical school in particular, to affiliate with so many institutions, and why do they in turn wish to affiliate with the medical school? The answer lies in the nature of medical education. Young doctors must have patients to practice on-- poor patients who have no private doctors of their own-- and they must be exposed to a large population of such patients to provide a variety of learning experiences. UMC's own University Hospitals simply do not have enough poor patients to meet the medical school's needs. Affiliations with the public hospitals which serve the poor almost exclusively, allow the medical school to send its students, interns and residents to these hospitals for their practical training. In return, the public hospitals get the cheap labor of the medical school's students. The medical school's recent affiliations with Mt. Sinai and St. Lukes add still more variety to the medical school's teaching programs. From their point of view, as hospitals with their own teaching programs for interns and residents, Mt. Sinai and St. Lukes gain prestige from their affiliations with the only medical school in town.

All these affiliations give real power to UMC, and to the medical school in particular. At Metro, the medical school appoints all the heads of departments, which insures that the Metro staff is in accordance with the staff at UMC. And the affiliations with the two voluntary hospitals-- Mt. Sinai and St. Lukes-- give the medical school effective control over the teaching programs and over the care of poor people at these two hospitals.

As center of a giant medical empire and as informal leader of the Cleveland hospital system, what kind of an example does UMC set for other Cleveland hospitals? How does it use its tremendous influence? A few quick facts suggest an answer:

1. UMC has no outreach programs to meet the massive health needs of the ghetto-- no community health or mental health centers, no preventive care programs in the community. Although the medical school boasts of the community orientation in its training programs (which means only that medical students are exposed to poor patients very early in their training), UMC has provided no leadership in health care.

2. UMC is as racist as any of the east side hospitals. In the 1968 Glenville shoot-out between cops and blacks including Ahmed Evans, UMC suppressed the fact that several cops received at the University Hospitals' emergency room were drunk on arrival-- a fact which might do alot to clear up the Ahmed Evans "murder" case. Speaking of present-day care in the wards and outpatient department, an orderly who is a member of the newly formed Black Workers' Committee for Human Rights told us, "They treat our people like animals here. We had to organize to defend them ourselves."

3. Metro Hospital, Clevelands only public, general care hospital, under the tutelege of UMC has become known nationally for its research program. The 1970 Metro annual report boasts, with dubious logic:

> Metropolitan General has a large scale research program. Research belongs in a public tax-supported institution, for the benefits it promises will be of value to the entire population. This argument for Metropolitan General finds its greatest support in the number of projects assigned here. There are nearly 100 separate grants for research presently in force at the hospital. Their annual value is more than $2,000,000.

There's nothing wrong with doing research, but is research on subjects like antibody formation and neurovascular surgery what Cleveland's poor need most, first?

4. In 1969 UMC spent $500,000 for teaching equipment that was seldom used and that is already obsolete. UMC is planning to spend tens of millions on a new pavilion for private patients. With money like this to throw around, not to mention the endowment, or the personal and corporate fortunes of the trustees, University Hospitals somehow can't afford clinic care for the poor. In the spring of 1971, University Hospitals announced what will amount to a 48% cutback in clinic services. University Hospitals' public relations magazine Archways (who pays for it?) regretfully reported in February that "something must be done to meet the needs of the ever-increasing number of indigent patients. The losses we are sustaining make it impossible for the hospital to continue to meet these needs." There is no doubt that Mt. Sinai and St. Lukes are waiting to see if University Hospitals can carry this off without protest from the community, so that they can go ahead with similar cutbacks of their own.

In short, the leadership UMC provides is reactionary and elitest. UMC's priorities are not health care for the general public, but teaching, research and the lucrative care of private patients.

THE HEALTH ESTABLISHMENT

Who are the people who make decisions about health care in Cleveland? To answer this question, we began by studying the trustees of the leading health institutions, since the trustees are legally responsible for everything that happens in their hospitals. We took the lists of all the trustees of the large (400 or more beds) hospitals, social service agencies related to health, foundations which fund hospitals, health planning bodies, temporary health-related commissions and the local hospital association (a branch of the American Hospital Association). Combing through these lists of trustees for duplications, we found that certain names occurred again and again-- suggesting that there is a definite "establishment" presiding over health policy in Cleveland. We found that these holders of multiple health trusteeships seemed to fall into two categories-- what we called "business oligarchs" and "high society." The distinction between oligarch and socialite is somewhat artificial but has been done for purposes of clarity. Oligarch and socialite groupings overlap since they both control enormous wealth and ultimately make decisions based on their own political and economic interests.

In addition, through interviews and newspaper stories on health institutions, we distinguished two other prominent, if not really dominant, categories of health leaders-- what we called "promoters" and "front men." These are a handful of men employed in top positions by health agencies or institutions. They lack the ultimate authority of the trustees, but have

considerable discretion in making day-to-day decisions or, at least in representing these decisions to the public. Below, we describe these four categories-- naming the names and attempting to identify their interests in the health system.

BUSINESS OLIGARCHS

Cleveland is not a democracy. The city is dominated by a group of 29 men, the men who direct Cleveland's top corporations. (See Chapter I on Oligarchy.) It was no surprise to us that so many business oligarchs turned up in our list of the city's health leaders. Take a few examples:

Willis Boyer, the president of Republic Steel, until recently Cleveland's largest company, sits on the boards of University Hospitals, CWRU, the Health Fund, the Commission on Health and Social Services (sponsored by the United Appeal) and the Cleveland Development Foundation. He has sat on the boards of the United Appeal and the Regional Hospital Planning Board (now replaced by the Metropolitan Health Planning Commission). In his business life, he is a director of Sherwin Williams paint and chemical company, National City Bank of Cleveland and the Marathon Oil Company, as well as Republic Steel. (Republic and Sherwin Williams are among Cleveland's top polluters.)

George Karch, the chairman of Cleveland Trust Bank, sits on the boards of CWRU, Cleveland Clinic, Health Hill (a private pediatric hospital), the Cleveland Foundation and the Cleveland Development Foundation. He is a director of Oglebay Norton (iron ore mining), Reliance Electric Company, Cleveland Twist Drill Co., Medusa Portland Cement, Warner and Swasey (machine tools), White Motor Co., North American Rockwell Corp., and over 10 smaller firms.

J.D. Wright, chairman of TRW Corp. (auto and airplane parts), sits on the boards of University Hospitals, the Cleveland Foundation and, formerly, the United Appeal. He is a director of Republic Steel, Goodyear Tire, National City Bank, Sherwin Williams and Eastman Kodak.

H. Stuart Harrison, chairman of Cleveland Cliffs Iron Co., is on the boards of University Hospitals, the Cleveland Foundation and the Cleveland Development Foundation. He directs over 19 companies including Jones and Laughlin Steel, Medusa Portland Cement, Cleveland Trust Bank, White Motor Co., Weatherhead (ordnance), Midland Ross and LTV (a conglomerate).

These men, plus others not listed, hold ultimate power over long-range planning for health institutions. As hospital and medical school trustees, as members of important city-wide

health funding and planning bodies, they control hospitals' long-term construction and expansion programs and set the overall tone of health policy in Cleveland. But the interests of these men are contrary to the health interests of the people of Cleveland: They direct the companies which have poisoned Lake Erie and made Cleveland's air a health hazard. They direct the banks which refuse to finance decent homes for poor people. They are members of the Chamber of Commerce which consistently lobbies for lower corporate taxes, hence inadequate Medicaid and underfinanced public health services. They direct companies whose indifference about workers' safety leads to hundreds of industrial accidents per year in Cleveland. To them, hospitals do not represent health care institutions so much as they represent concentrations of great wealth and real estate holdings. Control over the city's medical expenditures is just one more way that these men control the entire economic life of the city.

HIGH SOCIETY

The power of the business oligarchs in the city is economic, and is based on their institutional positions as top officers and directors of leading corporations. Our "high society" members of the health establishment do not derive their civic importance from any institutional positions, but simply from who they are-- their family and social connections, their membership in exclusive clubs. Their names appear, not in the business section of the newspaper, but in the "society" section, in Cleveland's Blue Book and the Social Register. They are not dictators of the city's economic and political life; they are its cultural and social arbiters, whose influence extends from the symphony and the garden club to the hospitals, social service agencies and foundations.

Many of the high society health leaders are descendents of the old families of Cleveland who originally founded the hospitals and the university. Families such as the Boltons, the Oglebays, the Hannas, the Severances and the Mathers, after making their fortunes in iron ore, oil or shipping, set out to make Cleveland a great cultural and medical capital in the mid-west. In the high society of the turn of the century, contributions to the community's civic development became a measure or one's social status. Their concern was not to serve the poor, but to build the city's image, hence their own national presitge. In many cases, their current descendents have sold-out their shares in the family corporation, but retain their control over the family foundation, e.g., the Bolton Foundation, the Elizabeth Severance Prentiss Foundation, or the various Mather and Hanna Trusts, all of which help fund the top private hospitals. They also sit on hospital and health agency boards, having "inherited" these positions along with the family wealth and social position.

In the area of health, the old-family members of high society cluster not surprisingly around the University Hospitals board. We've mentioned the Humphrey/Hanna/Ireland family grouping. Another example is Severance Milliken who sits on the Boards of University Hospitals, St. Lukes Hospital, and the Cleveland Development Foundation. Then there are the Boltons, for whom CWRU's nursing and dental schools are named. Mrs. C.C. Bolton was on the board of University Hospitals until her death last year, while Mr. C.B. Bolton (board chairman of the exclusive Hawken School, a prep school) served on CWRU's board.

Other high society health leaders are not descended from such venerable families, but are equally "in." For example, Mr. and Mrs. Herman Vail, parents of the publisher of the Plain Dealer, have, between them, seats on the boards of St. Lukes and the Cleveland Foundation, on the advisory board of Metro Hospital and membership in the Welfare Federation's Health Goals Committee. Mrs. Clark E. Bruner, of the CWRU board (one of three women on the 34 member board, incidentally), of the Lakewood Hospital board, of the Welfare Federation's Health Planning and Development Committee and of the Health Fund (an annual drive). She has served as president for the Society for the Blind and the Junior League, is currently President of the Garden Center and the Day Nursery Association, and is a perennial organizer of charity balls.

Today's high society health leaders do not sit on the boards of health institutions out of some basic social commitment to improving the health of the general populace. For the scions of old Cleveland families, service on health boards is a matter of noblesse oblige; for the more recent arrivals in high society, it is a means of increasing one's personal prestige. Having one's family name on the cornerstone of a hospital or medical school building, being associated with a health institution nationally famous for research and education and hence at the forefront of medical knowledge-- these are the rewards for our high society health leaders.

Are the health leaders we have listed, both businessmen and socialites, just a random collection of names, or do they comprise a coherent health establishment? We have, of course, no reason to believe that they sit down together periodically to hammer out health policy for the city of Cleveland. But it is certainly true that they have ample opportunities to meet together, and at least to develop common approaches. They may sit on separate hospital boards, but they come together on city-wide health planning bodies, foundations and fund-raising groups. Outside of the health area, their connections are numerous: many of the businessmen sit on the boards of the same corporations such as National City Bank, or Republic Steel, and many of their corporations were originally connected to the interests of

the Hanna, Mather or Ireland families, whose scions are now among our "high society" representatives. For example, Republic Steel Corporation was assembled in the 30's out of several small steel companies by Cyrus Eaton and the Mather family. The banks also have close historical ties to the Hannas, Mathers and other leading families. Almost all of our "business oligarchs" are members of the elite Union Club and, of course, the Chamber of Commerce. Along with the "high society" types, they are members of the top suburban country clubs, such as the Tavern Club, the Kirtland Club or the Chagrin Valley Hunt Club.

What we can assert with considerable confidence is that our "health leaders," selected solely on the basis of the number of their health agency board positions, are all members of the same class, and that class is Cleveland's ruling class. While they may not consciously operate as a leadership clique setting Cleveland's health policy, we can be sure that they consistently represent the interests of their class. There is no reason to believe that the interests of our health "leaders" or of their class in general coincide with the interests of the majority of Cleveland health consumers. To a man, and to a woman, Cleveland's ruling class does not live in Cleveland but in the eastern suburbs, and of course, none of them has to use the hospital clinics and wards that the average Clevelander depends on. In fact, we have given reasons to believe that the interests of the ruling class health leaders actually conflict with those of the average Cleveland health consumer. The former look to a health institution as a source of prestige or as a block of capital; the latter looks to it as a source of basic survival services. Thus, in Cleveland, the traditional economic conflict between corporate directors, shareholders and workers carries over to the field of health, because in Cleveland the health elites are all members of the city's ruling class.

PROMOTERS AND FRONT MEN

As we said above, there are two other categories of health leaders in the city, both subordinate to the business oligarch and high society-dominated boards of trustees. These are men who lack economic or social leverage of their own, and are important only because of the staff positions they occupy in health institutions or agencies. They are "professionals"-- doctors and administrators. They cannot make long-term decisions, but they have a certain amount of day-to-day responsibility.

The best representatives of Promoters are Sid Lewine, administrator of Mt. Sinai Hospital, and Fred Robbins, Dean of the CWRU Medical School. They are the most visible day-to-day operators in the health establishment-- participating in the doings of the hospital association, consulting to the Welfare Federation and Cleveland Foundation, lobbying at the State capitol for favorable legislation. Their primary concern is their own personal careers which they may see extending to broader horizons than Cleveland has to offer. (Former CWRU med school Dean Ebert is now med school dean at Harvard.) But for the meantime their objectives coincide with those of the powerful trustees to whom they are beholden, i.e., to build prestigious

medical complexes.

The front men are not truly health leaders at all, but they are easily mistaken for leaders. Best examples are the directors of the City Health Department and of the Metropolitan Health Planning Commission (MHPC). Both take flack from health consumers for unpopular health policies, although both belong to essentially powerless agencies. For example, Dr. Ellis of the City Health Department is often blamed for the city's failure to staff the newly built west side health clinic, but it's not his fault the city hasn't the funds to occupy the expensive new buildings - witness his impotence last winter when the mayor submitted the Health Department to a disastrous 50% cutback. When Dr. Lee Podelin, director of the MHPC, was urged by local activists to take a strong stand against UMC's clinic cutbacks, he answered that that "isn't how things are done around here" and remained silent. Of cource, even his loudest protests wouldn't have moved UMC. As a MHPC staff member told us, "MHPC is a nothing organization. It can't do anything."

In the case of the front men, it is hard to see their interests in the health system. They are the fall-guys, the immediate targets for community protests against decisions they have no power to change even if they wanted to. The wonder is that they haven't figured this out yet, and made public exposees of the health establishment they indirectly cater to.

COMMUNITY HEALTH FOUNDATION

A prime example of how health leaders have tried to stimy even moderate change in the health delivery system is seen in the development of the Community Health Foundation. It was founded in 1962 by the steelworkers', painters', plumbers', retail clerks', meatcutters', machinists', and automobile workers' unions. It was conceived as a traditional prepaid, group practice program providing doctor's office and home visits, hospitalization and limited psychiatric care. Membership in a group, usually a union, was prerequisite for joining.

For the average Clevelander, prepaid group practice represented a real improvement in health care delivery. It meant that medical care could be obtained without regard to its cost and that preventive check-ups were encouraged. The entire family could be cared for under one roof, with a continuous medical record from doctor's office to the hospital, and an end to fragmented health services. CHF was designed to make minimal reforms in health care for middle class people but not to solve the major shortcomings of the American health system, such as the availability of health care for the poor. Nonetheless Cleveland's "health establishment" resisted its development.

The first sign of resistance occurred in June, 1962. After eleven months of negotiations between consultants hired by the unions and UMC, the word came down: UMC would not affiliate with CHF. This came as a shock to those associated with CHF. The negotiations had proceeded well, with considerable support from most of the chiefs of service at University Hospital, including Dr. Robert Ebert, then chief of medicine, now dean of Harvard Medical School. Although there was some dissension among the doctors, none wished to block the program. The proposal was novel. CWRU was to be the site of the first prepaid group practice program affiliated directly to a medical school. A prepaid group practice meant a convenient "captive" population for teaching, as well as the opportunity to shift the focus of medical student and house staff training from purely hospital-based medicine to out-patient medicine.

For CHF the benefits of a medical school affiliation were clear. First, it would guarantee high quality medical practice, at least as defined by the medical school. Second, perhaps more important, it would assure adequate physician manpower for the program. And third, it would guarantee a back-up hospital for CHF admissions.

Why then did UMC turn CHF down? Apparently the issue reached University Hospitals' Board of Trustees. Two reasons are commonly given to explain the Board's negative response. The first revolves around George M. Humphrey, one of the most prominent members of the Board. Humphrey had drawn up the constitution and by-laws of University Hospitals in 1920. Shortly thereafter he became President of the M.A. Hanna Company and in this capacity, developed a strong anti-labor bias, which he often expressed while later serving as Eisenhower's Secretary of the Treasury. CHF had been initiated and funded by labor unions. Humphrey wasn't about to let "his" medical center affiliate with a union-dominated health plan.

The clincher, however, was the drop in donations to UMC's $54 million expansion program. In April, 1962, UMC announced a dramatic building program which included new nursing, dental and medical school buildings. Shortly thereafter, news about the potential UMC-CHF affiliation was leaked to the press. Conservative alumni and other potential funders apparently withdrew their support from UMC's expansion drive. When it was over, CHF was told by one UMC spokesman, "You've cost us over $2 million already without even affiliating."

UMC's refusal to affiliate with CHF was a severe blow to the newly-incorporated organization. Planning and operating goals were set back by one year at least. The whole project appeared in jeopardy. Despite the risks, the labor unions backing CHF insisted that plans move forward.

On July 4, 1964 CHF opened the doors of its new outpatient building located on the east side. Capital for construction had been raised through loans amounting to $500,000 from the unions and $650,000 from Central National Bank. The health plan grew rapidly. Within four years, membership passed 30,000. A second out-paitent facility was opened in Parma, a southwestern suburb of Cleveland.

But CHF was plagued with economic problems. Many of these stemmed from the lack of a CHF-owned hospital. As hospital costs leaped upward in the post-Medicare era, CHF was unable to negotiate the same reduced hospitalization rates as Blue Cross. CHF ended up paying as much as $176/day for patients hospitalized at University Hospitals. Furthermore, Blue Cross lagged in raising its premiums so that, to remain competitive with Blue Cross, CHF had to postpone needed increases in its own subscriber premiums. The final economic straw was the purchase of a proposed new hospital site in Independence, Ohio (south of Cleveland) for $400,000. After buying the land, the town unexpectedly denied CHF the necessary zoning clearances.

Rising economic problems threatened CHF with extinction. Cleveland's business and society "health leaders" now had the opportunity to rescue the program. Its dramatic growth had demonstrated CHF's vitality and usefulness for middle class health consumers. But the banks closed their doors. Even Central National, which had advanced the original loan to build the east side center, reneged on its promises to help finance the new hospital. CHF was forced to turn outside the Cleveland community for help.

In 1968, CHF sought the aid of the multi-million dollar west coast Kaiser Foundation Health Plan (with 1970 revenues of $313 million). After several months of negotiation, an agreement was reached. Kaiser offered $3.5 million to construct a CHF hospital in Cleveland, in return for virtually complete control of the program. CHF became the Kaiser Community Health Foundation (KCHF) and Kaiser demanded that of the new nine member board six seats be reserved for Kaiser. Until the merger with Kaiser, CHF had a decidedly local flavor. Although it had been established with the aid of nationwide consultants, CHF had been initiated and controlled by local Cleveland labor unions. This had given CHF a measure of subscriber control. With the entry of Kaiser, and its persistent opposition to any form of subscriber control, CHF lost its independence. Industry now controlled KCHF and would operate it like the "business" that most prepaid group practice is about (see Health-Pac BULLETIN, November, 1970.)

The case of the Community Health Foundation illustrates how Cleveland's "health leadership" has thwarted the development of improved forms of health care delivery through prepaid group

practice. These same forces have collaborated in using hospitals for their own ends, Cleveland urban renewal. For it is here that Cleveland's major hospitals became pawns in a larger enterprise- black removal by white institutional real estate interests.

HOSPITALS AND URBAN RENEWAL

Cleveland's major hospitals are not just medical empires, or would-be medical empires; many are expanding real estate empires. Hospitals in Cleveland are major land holders with the largest parcels belonging to the UMC and to Cleveland Clinic. To hospital management, real estate acquisition serves two purposes: (1) it provides space for institutional expansion including new buildings and parking lots, (2) it can be a means for clearing away "undesireable" neighborhoods around the hospital, such as the east side ghettos near the university and Cleveland Clinic. Both functions coincide with the needs of the top hospitals' elite trustees and the local power structure to which they belong. Gleaming modern buildings-- usually named after the trustee who contributed the most to their construction-- are as prestigious to the trustees as the hospital's research reputation. And slum clearance, to the hospitals' immediate trustees and their friends, helps make the whole city "safer" for existing industry and hopefully more attractive to outside industry.

Starting in the late fifties, Cleveland medical institutions entered a boom period of real estate growth and institutional expansion. St. Vincent added a $4 million wing in the early 60's. University Hospitals and CWRU Medical School have almost completed a $54 million building program begun in 1960. CSU plans to expand its campus to a length of one half mile, in part to make room for a new medical school for which it still does not have state approval. Cleveland Clinic, which has been buying up neighboring lots since it opened in 1921, is now embarking on a building program whose cost will run into the tens of millions of dollars. Many of these institutional building programs are associated with slum clearance projects many acres beyond the institution itself. St. Vincent, for example, was the center of a 118 acre urban renewal project. The UMC along with the museums and other cultural institutions in the University Circle area, launched a 1600 acre urban renewal project covering much of the Hough area in 1961. CSU is still waiting for Federal approval for its proposed urban renewal project, which would cover the southeast corner of downtown.

It is not a coincidence that these hospitals and universities, all on the east side of Cleveland, all launched major expansionary drives in the same period of time. The plans of the individual institutions were not made independently but, in most cases, were made as part of a larger plan to ensure white business and institutional domination of the east side of

Cleveland. Since the mid-fifties, the central part of the east side has been almost entirely black. Blocked from settling in the better neighborhoods, blacks coming to Cleveland from the south were forced to crowd into already deteriorated areas like Hough and Central on the east side. Rising black unemployment in the late fifties led to more crowding, and further deterioration. The slums extended from the heavy industrial area of the Cuyahoga valley (the Flats) and the downtown commercial area on the west, to the university and the upper class suburbs on the east. Logistically, it was an untenable situation for the city's white ruling class. The growing black belt had cut off the white cultural and residential areas from the industrial sources of wealth.

In 1954, Cleveland's top business leaders-- the heads of Republic Steel and the top utilities and banks-- decided to take action to save the city from "blight," as they called it. As was mentioned in the Oligarchy chapter, they formed a nonprofit organization, the Cleveland Development Foundation (CDF) to promote urban renewal in Cleveland. With over $1 million in contributions from Cleveland's top 83 firms and a $5 million grant from the Hanna Fund, CDF was supposed to provide "seed money" and planning assistance to the city government's urban renewal agency. Actually, CDF quickly supplanted the city and became a kind of private "government" for urban renewal. Closely connected with CDF was another new private foundation, the University Circle Development Foundation, concerned with redevelopment of University Circle and its environs. Trusteed by top board members from the universities and University Hospitals, and initiated by a grant from the Mather family, UCDF represented the same interests as did CDF.

The pattern of urban renewal undertaken by the two development foundations strongly suggests that they shared a common strategy to reclaim the east side from the blacks. First, urban renewal on the east side has been primarily used to create land for industrial, commercial and institutional re-use, not low income housing. The two housing projects CDF did build were, from the start, too expensive for low income families and too barrack-like to attract middle income families. They have never been more than two-thirds full. Second, if you look at a map, you see that the urban renewal projects add up to a sort of dumbbell shaped area: at one end is Erieview, the CDF sponsored downtown renewal project, slated for office buildings, luxury apartments, malls and fountains; at the other end is University Circle, developed over the last ten years into a gleaming island of cultural institutions. Along the bar of the dumbbell down Euclid Avenue lie the University-Euclid renewal project, CSU and its proposed extension, and the Cleveland Clinic. Just south of the bar is St. Vincent urban renewal area.

A former top staff member of CDF told us that this arrangement of projects was not accidental, but the result of a conscious strategy (a "planning concept," as he put it). That strategy was first, to build up two white-dominated enclaves at either end of the east side, Erieview on the northwest and University Circle on the southeast, and connect these enclaves by a sort of "white corridor" of cleared areas running through the ghetto. CDF took responsibility for the western end, Erieview-- financing the initial planning, finding the developers, and even the tenants for the projected office building. UCDF, of course, handled the redevelopment of University Circle itself. They both worked on the white corridor (the bar of the "dumbbell"). CDF worked the western end, financed the planning for CSU's urban renewal project (CDF had previously sponsored the formation of CSU from a small private college) and UCDF worked the eastern end, instigated the University-Euclid renewal project with some seed money from CDF, of course. In tribute to the close cooperation between these two elite planning agencies, the CDF annual report lists all of these projects, including the redevelopment of University Circle, as CDF accomplishments.

Hospitals were willing instruments in the implementation of this stretegy:

St. Vincent, with planning funds from CDF, displaced over 1200 families, 95% of them black, to make room for luxury high rise apartment buildings. Then no developers could be found for the high-rises, the land was sold, at reduced rates, to Cuyahoga Community College, to the Boy Scouts and the Salvation Army for new headquarters, and to some lesser voluntary agencies. In 1954, at the outset of the project, St. Vincent's board chairman described the project's relation to CDF's overall plans with touching humility: "We admit that Charity Hospital [St. Vincent] represents but a small part of this broad development picture. The hospital is but a tiny plot of ground, 10% of the area involved in the entire plan [the entire St. Vincent plan]. But in our small way we wanted to be a part of this movement to reawaken the heart of Cleveland."

Cleveland Clinic is sufficiently wealthy that it has not depended on the Federal urban renewal program to subsidize its expansion. In the early sixties, the Clinic revealed plans to expand four blocks along Euclid Avenue and cover a total of seven square blocks. By 1965, it had acquired all but 25% of the needed land, and began to look to urban renewal as a way of getting the rest. The clinic proceeded to hire a full-time "urban renewal coordinator" and arranged with UCDF to get a piece of the University-Euclid project pie. In imitation of UCDF, the Clinic set up its own multi-institutional development foundation including the Health Museum, Women's Hospital (a small voluntary hospital) and the Harshaw Chemical Company, which was planning

to build a research lab in the area. Since then, the Clinic has decided that urban renewal meant "too much red tape," and returned to its private land-grabbing operations. This meant that, instead of having right of eminent domain to displace die-hard landowners, the Clinic has, according to residents of the area, had to resort to intimidation to secure the last little lots. Even though the Clinic has broken off its plans to work directly with UCDF on the University-Euclid project, it retains ties to UCDF through the present director of Cleveland Clinic's expansion program, Neil Carothers, who is the former president of UCDF. (Prior to that he was an executive of the construction firm which did most of the re-building of the University Circle for UCDF.)

University Hospitals and the Western Reserve Medical School were not simply instruments of the overall strategy-- as key institutional members of UCDF they were, in effect, co-conspirators. The boards of University Hospitals and the university are closely interlocked with those of CDF, and, of course, UCDF. University Hospitals and the medical school, which together garnered over half the funds spent on University Circle redevelopment, must be considered chief beneficiaries of UCDF's racist policies. When UCDF went into business in 1960, then-president Neil Carothers, explained:

> On several sides University Circle has fine stable neighborhoods, but on other sides are badly deteriorated sections where crime and disease are skyrocketing. And no apple stays good when there are bad apples around it.... Something had to be done. The [UCDF's] 20 year development plan is the answer. (Emphasis added)

UCDF's short-term answer was to hire a private police force to keep the "crime and disease" out of University Circle proper. It's long term answer was the University-Euclid urban renewal project. Ostensibly designed to rehabilitate slum housing the project actually worked to force out the slum dwellers. By 1966, only 11% of the homes slated for rehabilitation had had even perfunctory repairs. Hundreds more homes were destroyed to make room for commercial and institutional building, forcing people to crowd even more tightly into the remaining dilapidated structures. Then, because the area was slated for urban renewal, the city suspended enforcement of housing codes and cut back on garbage and police services; landlords cut back on home maintenance. Rats multiplied, garbage piled up, and disease spread-- right on the doorstep on Cleveland's most prestigious medical complex. It was UCDF's "gift" of urban renewal to the people of Hough that set the stage for the week long riots of 1966.

The net results of Cleveland's east side urban renewal projects, for which the medical institutions deserve so much credit, can be summarized quickly:

> Twice as many housing units were destroyed by urban renewal as were built, leaving Cleveland with a severe housing shortage. Cleveland now has 55,000 substandard housing units and the number is growing every year, but the city's vacancy rate is a dangerously low 1.5%,
>
> Over 4500 families, almost all black, were displaced by urban renewal. Only 40% of these were relocated by government agencies, the other 60% had to fend for themselves. Of those who were "lucky" enough to be relocated by the city, 56% were sent to areas which were already over 90% black; 89% to areas which were over 50% black. The St. Vincent and University-Euclid projects were responsible for most of the displacement.

In Cleveland we see the classic case of urban renewal as black removal. Reader's Digest, for example, ran an article in 1968 entitled "Cleveland in Crisis: An Urban-Renewal Tragedy" blaming the Hough riots on urban renewal. And Thomas Westropp, president of a minor Cleveland bank, said in 1970:

> For some, the urban renewal program has worked very well indeed. Hospitals and educational institutions have been constructed and enlarged. So have commercial and industrial interests and many service organizarions-- all with the help of urban renewal dollars. With respect to housing, however, the urban renewal program has been a disaster. . . I wish I could believe that all of this was accidental and brought about by the inefficiency of well-meaning people-- but I just can't. The truth, it seems to me, is that it was planned that way.

* * *

What do we gain from this description of the Cleveland health system? Maybe a sense of how the system works and to whose benefit. We can see that there are systemic reasons why so many people suffer from bad health care-- it is not due to one individual's accidental incompetence. The health care system operates not for our needs but for a small number of businessmen and health professionals by giving them power, prestige and profit. We see that their interests are in conflict with the health care needs of the average Clevelander. A health institution to an elite is a block of real estate or a source of prestige but to most of us health care delivery is a matter of survival. This piece of research is a