

2008

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Recommended Citation

Jin Hee Lee, *A Civic Republican View of Hospital Closures and Community Health Planning*, 35 Fordham Urb. L.J. 561 (2008).
Available at: <https://ir.lawnet.fordham.edu/ulj/vol35/iss3/3>

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A CIVIC REPUBLICAN VIEW OF HOSPITAL CLOSURES AND COMMUNITY HEALTH PLANNING

*Jin Hee Lee**

I. INTRODUCTION

Listening to today's news, it is impossible not to hear someone call for immediate health care reform. The uninsured, rising health care costs, the diabetes epidemic, the financial instability of health care facilities—these are just some of the issues that have contributed to what has become a health crisis of epic proportions. Presidential candidates,¹ former New York Governor Eliot Spitzer,² and even New York City Council Speaker Christine Quinn³ have presented various reform proposals to cover the uninsured and underinsured, expand primary care, and curb inflated health care costs in an effort to manage this crisis. What is missing from these proposals, however, is a crucial element that health care policymakers have overlooked for far too long: meaningful community participation in a deliberative process whereby community residents can influence decisions about their local health care resources.

The concept of community residents participating fully in a deliberative decisionmaking process is hardly new. Legal scholars

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1. See Editorial, *The Battle Over Health Care*, N.Y. TIMES, Sept. 23, 2007, at WK 11.

2. See Governor Eliot Spitzer, 2008 State of the State Address (Jan. 9, 2008), http://www.ny.gov/governor/keydocs/2008sos_speech.html.

3. See City Council Speaker Christine C. Quinn, 2007 State of the City Address (Feb. 19, 2007), <http://www.nycouncil.info/tempissues/SOCspeech.pdf>.

have discussed what has been called a “republican⁴ revival” for over two decades.⁵ The modern form of republicanism—what this Article refers to as “civic republicanism”—stresses the transformative nature of deliberation as people with diverse interests collectively seek the common good. Thus civic republicanism, with its emphasis on deliberation and community, is a counterpoint to liberal pluralism, which conceives of society as individuals with competing interests bargaining within the political process.

This Article utilizes the civic republicanism framework to call for a form of community health planning that incorporates the active participation of community members in the deliberative process of allocating health care resources. Like liberal pluralism, the current health policy model rests upon the competing interests of special interest groups, such as hospitals and labor unions, as they battle for leverage within the political process. Yet recent hospital closures in New York City communities have demonstrated the fallibility of excluding community input within this pluralist model. By failing to consult the people most affected by health policy decisions, the State, as well as health care administrators, makes uninformed choices that have proven to be costly for both the community’s health and the financial stability of the health care system. Thus, no health care reform proposal can succeed without engaging the public in a meaningful dialogue that learns from community members’ localized knowledge while at the same time empowers them to take control of their health care needs.

Part II of this Article provides some background on civic republicanism, drawing heavily from the work of Professor Cass Sunstein, whose conception of civic republicanism has four key principles: deliberation in the public sphere, equality within the deliberative process, group consensus towards a common good, and

4. This Article uses the term “republican” in reference to a public philosophy, not to a particular political affiliation. See Paul Brest, *Further Beyond the Republican Revival: Toward Radical Republicanism*, 97 *YALE L.J.* 1609, 1623 n.1 (1988) (noting “need to distinguish republican thought from the ideology of the party of Ronald Reagan”). Likewise, the terms “liberalism” and “pluralism” do not connote a political preference or a particular celebration of diversity. See, e.g., Frank Michelman, *Law’s Republic*, 97 *YALE L.J.* 1493, 1507-08 (1988) (“By ‘pluralism’ here I don’t mean the acceptance and celebration of diversity within a society.”). Rather, liberalism and pluralism are both political philosophies focused on the individual, as opposed to the more community-oriented emphasis of republicanism. These political philosophies will be discussed later in this Article.

5. Symposium, *Discovering the Republican Civic Tradition*, 97 *YALE L.J.* 1493 (1988).

the development of the civic virtues of active citizenship.⁶ These principles of civic republicanism are further discussed in the context of health care policymaking, particularly regarding the need for civic participation in community health planning. Part III of this Article moves the discussion of civic republicanism beyond just theory by telling the story of four communities in New York City—Central Brooklyn, Southeast Queens, the Northeast Bronx, and Southwest Brooklyn—that have endeavored to insert themselves in the public discourse regarding the possible closure of their respective neighborhood hospitals. By making their voices heard, these communities have demonstrated that localized knowledge and concerns are essential features of good government, especially in an area like health care that so greatly impacts the welfare of the community. Equally as important, these stories demonstrate the need for comprehensive, community-based health planning that incorporates genuine community participation as part of any successful health care reform.

II. CIVIC REPUBLICANISM AS A FRAMEWORK FOR HEALTH PLANNING

It is important to clarify what exactly “civic republicanism” means as the term is used in this Article. Like many forms of political theory, it is subject to various distinctions and possible disagreements among legal scholars.⁷ But there are general themes of community, deliberation and the common good which serve as the foundations of modern republicanism and inform our understanding of political processes as an analytical framework to critique the failures of the present health care system. Civic republicanism conceives of citizens as part of a larger political community and stresses the potential of reaching consensus for the common good through deliberation, rather than competition among independent and isolated actors within the political process.⁸ The contrast be-

6. See Cass R. Sunstein, *Beyond the Republican Revival*, 97 *YALE L.J.* 1539, 1549-56 (1988).

7. See, e.g., Richard H. Fallon, Jr., *What Is Republicanism, and Is It Worth Reviving?*, 102 *HARV. L. REV.* 1695, 1697 (1989) (“The republicanism that is currently being revived is also difficult to define.”); Cynthia Ward, *The Limits of ‘Liberal Republicanism’: Why Group-based Remedies and Republican Citizenship Don’t Mix*, 91 *COLUM. L. REV.* 581, 584 (1991) (“Republican theories have varied so widely that discussing republicanism in the contemporary context, without multiple qualifications, is a serious problem.”).

8. Stephen M. Feldman, *Republican Revival/Interpretive Turn*, 1992 *WIS. L. REV.* 679, 680 (1992).

tween the “community” and the “individual” is particularly helpful when discussing health care, which currently suffers from a more market-based emphasis on competition among individual self-interests. Indeed, it would be difficult to think of a more “common good” than a community’s health and health care, rendering civic republicanism especially apropos to this area of public decisionmaking.

A. Background on Civic Republicanism

What has been coined the “republican revival” is a response by some legal scholars to the over-emphasis of liberal and pluralist ideals in U.S. constitutional jurisprudence. Liberal theory considers the individual to be the “ultimate concern of moral and political justice,” and thus focuses on the individual’s desires as the engine of political activity.⁹ Drawing upon liberal theory, pluralism likewise emphasizes the primacy of the individual in the political sphere as conflicting interests compete with each other.¹⁰ As a consequence, pluralism has little faith in the capacity of people with diverse interests to deliberate collectively towards a common goal. Instead, pluralism conceives of individuals utilizing “deception, coercion, or other manipulation” in their interactions with each other within the political process.¹¹ As a consequence, pluralists consider politics to be nothing more than a “market-like medium” navigated by competing individuals who seek to satisfy their own private interests.¹²

Dissatisfied with the shortcomings of liberal pluralism’s individualistic and market-based approach towards political participation,¹³ republican theorists have challenged the “hegemony” of liberal assumptions and pluralist ideals in American political culture.¹⁴ The efficacy of connecting civic republicanism to the foundational principles of the U.S. Constitution or pronouncing republicanism’s superiority over the rights-based discourse of liberal pluralism is beyond the scope of this Article. Rather, this Article utilizes civic republicanism as a theoretical framework to critique the exclusion

9. Fallon, *supra* note 7, at 1700 (discussing Tushnet).

10. Feldman, *supra* note 8, at 679.

11. Michelman, *supra* note 4, at 1507-08; *see also* Feldman, *supra* note 8, at 685-86.

12. Michelman, *supra* note 4, at 1508; *see also* Sunstein, *supra* note 6, at 1542; Ward, *supra* note 7, at 591.

13. Feldman, *supra* note 8, at 680.

14. *Id.* at 680, 683. At least one scholar has commented that modern republicanism “often functions more as a counter-ideology to liberalism than as a philosophy that is fully developed in its own terms.” Fallon, *supra* note 7, at 1700-01.

of community participation in decisions concerning the allocation of health care resources. Of particular insight is Professor Sunstein's theory of republicanism and its four main principles: deliberation in politics, equality of political actors, universalism or a common good, and citizenship.¹⁵ Each of these principles supports the argument that community participation in political decision-making, in this case health care policy, is necessary for an effective democracy and the judicious allocation of health care resources.

Civic republicanism's emphasis on open dialogue and deliberation presupposes that policymakers cannot know what is best for the community.¹⁶ Thus, according to Professor Sunstein, the requirement for deliberation should not be "purely formal" nor should politically powerful groups be allowed to impose outcomes onto the deliberative process.¹⁷ Rather, in believing in the transformative potential of deliberation, civic republicanism requires exposure to as many diverse interests as possible, which are then subject to scrutiny and revision based on the multiple perspectives that contribute to and are borne from the interactive discussions.¹⁸ The ideal of civic republicanism, therefore, "is not initial agreement on substantive issues, but belief in the consensual possibilities of deliberative dialogue."¹⁹ Moreover, the potential for consensus is less dependent on "identical conceptions of the good," but instead depends on the faith that interaction that is truly open and free among individuals will eventually lead to a common understanding.²⁰ Consensus in this manner benefits from the process of vetting decisions through multiple perspectives, which is a "measure of the legitimacy of government action."²¹

15. Sunstein, *supra* note 6, at 1539. The term "citizenship" is not limited to its formal meaning under immigration law. Such a construction would, for example, exclude immigrants from a public dialogue on immigrant health, rendering it antithetical to the need for deliberation among diverse interests under republican theory. Instead, a "civic republican conception of citizenship supposes that people must be engaged in framing the rules and administering the institutions that govern all aspects of their communal lives." Brest, *supra* note 4, at 1626. Citizenship, therefore, is intimately connected to membership of a community and "does not occur solely through official organs." Sunstein, *supra* note 6, at 1573. Indeed, "[m]any organizations—including labor unions, religious associations, women's groups of various sorts, civil rights organizations, volunteer and charitable groups, and others . . . —serve as outlets for some of the principle functions of republican systems." *Id.*

16. See Fallon, *supra* note 7, at 1701; see also Sunstein, *supra* note 6, at 1574-75.

17. Sunstein, *supra* note 6, at 1551.

18. *Id.* at 1549; see also Michelman, *supra* note 4, at 1504.

19. Ward, *supra* note 7, at 584-85; see also Feldman, *supra* note 8, at 697.

20. Ward, *supra* note 7, at 585.

21. Fallon, *supra* note 7, at 1732 (discussing Sunstein).

A prerequisite for true deliberation—representing the wide array of interests demanded of civic republicanism—is equal participation in the deliberative process. Indeed, the integrity of the deliberative process, as well as the value of subsequent results, would be wholly undermined by the failure to ensure equal access to the political process due to disparities in wealth and power.²² Because civic republicanism values the opinions of everyone, regardless of status or power, unequal influences within the political sphere do not further its goals.²³ Thus, for Professor Sunstein, efforts to equalize political power, such as proportional representation, are more justified on republican bases because the deliberative process thrives on the inclusion of multiple voices, especially the voices of disadvantaged groups that may have less access to the process.²⁴ Furthermore, in contrast to a pluralist model where diverse interests are viewed as in competition with each other, republicanism seeks to ensure that certain groups have access to the deliberative process. Rather than giving these groups a “piece of the action,” the goal is to examine as many views as possible in search of the best outcome for everyone.²⁵

The importance of equal participation cannot be overestimated, especially in light of the United States’ history of excluding groups from civic life based on republican arguments.²⁶ Professor Derrick Bell, for example, has commented on the natural skepticism of African-Americans to revive a political theory that had defined the “common good” as the “common good of whites” and upheld the hypocrisy of civic participation in the context of the *de jure* and *de facto* exclusion of African-Americans from public life.²⁷ Even Professor Sunstein has noted the irony of invoking republicanism, which had “traditionally been allied with exclusionary practices,”

22. Sunstein, *supra* note 6, at 1552.

23. Brest, *supra* note 4, at 1626-27.

24. Sunstein, *supra* note 6, at 1588.

25. *Id.*

26. See Feldman, *supra* note 8, at 695 (“The concept of an objective common good led to elitist and conservative strains in the framers’ constitutional thought” whereby “certain individuals” are considered “more capable than others of perceiving the true interests of the people—the objective common good . . . [and that] some groups of people—namely, women and African-American slaves—are so incapable of perceiving the public good that they can be justifiably excluded from the deliberations within the political community.”); Ward, *supra* note 7, at 587 (“Historically, republicans relied on political exclusion—the restriction of citizenship to those sharing class, gender, and racial backgrounds—to ensure the kind of connectedness necessary to avoid divisive battles and secure general political agreement.”).

27. Derrick Bell & Preeta Bansal, *The Republican Revival and Racial Politics*, 97 YALE L.J. 1609, 1610-12 (1988).

in order to reject those very same practices.²⁸ Nevertheless, Sunstein argues that the value of republican theory is its ability to critique its own implementation.²⁹ The key, however, is the foundational principles of civic republicanism that require the equality of political actors during the deliberative process. In order to foster true diversity of perspectives, there must be more than mere formal equality; there must be an affirmative effort to include voices that are more likely to be silenced due to racial, economic, or other forms of injustice.³⁰ For this purpose, Professor Mari Matsuda's method of "looking to the bottom" is particularly instructive. According to Professor Matsuda, the "technique of imagining oneself black and poor in some hypothetical world is less effective than studying the actual experience of black poverty and listening to those who have done so."³¹ Likewise, it is imperative for policymakers, especially health policymakers, to listen to the voices of those most marginalized within the political system and ensure that their concerns inform policy decisions in a meaningful way.

Deliberation is only productive if it will lead to some form of consensus. As a consequence, the "common good"—or what Professor Sunstein calls "universalism"—is an underlying supposition of what can be achieved through civic republicanism. The concept of "universalism" is simply a belief in the power of discussion and dialogue in mediating differences, including different notions of the common good.³² The common good, therefore, is an unknowable concept that can only be revealed to a certain extent at the end of an inclusive and functional deliberative process.³³ Consequently, the mutual respect necessary for successful mediation is intimately connected to civic republicanism's view of individuals as members of a larger community. The community is "consciously and jointly

28. Sunstein, *supra* note 6, at 1581.

29. *Id.* ("[T]he premises of republican thought furnish an aspiration that turns out to provide the basis for criticism of republican traditions.")

30. On this issue, I disagree with Ward's contention that civic republicanism is inconsistent with group-based remedies. See Ward, *supra* note 7, at 583. In her analysis of Professor Sunstein's version of civic republicanism, she does not sufficiently address his "equality principle" and the need for group-based remedies if that group is excluded from the deliberative process due to systemic reasons, such as institutionalized racism.

31. Mari J. Matsuda, *Looking to the Bottom: Critical Legal Studies and Reparations*, 22 *HARV. C.R.-C.L. L. REV.* 323, 325 (1987); see also Stephen M. Feldman, *Whose Common Good? Racism in the Political Community*, 80 *Geo. L.J.* 1835 (1992) (arguing that civic republicanism is the best approach to reduce racism).

32. Sunstein, *supra* note 6, at 1554.

33. *Id.*

shaping its polity [and] its way of life”³⁴ as members interact with and learn from each other through their deliberation in the public sphere.³⁵

During the course of deliberation, participants seek what is best for the community at large, not the satisfaction of their own personal interests.³⁶ Thus, the very act of deliberating for the common good, as opposed to one’s self-interest, promotes citizenship and helps develop the civic virtues of empathy and community.³⁷ By placing a “high premium on citizenship and participation,” civic republicanism also facilitates “decentralization, local control, and local self-determination,”³⁸ and advances an active self-government that cultivates “knowledge of public affairs, a sense of belonging, a concern for the whole, and a moral bond with the community whose fate is at stake.”³⁹ In essence, civic republicanism is a “commitment to self-government by citizens conceived of as equals” as they control their own political fate and the well-being of their community.⁴⁰ Active participation in the political community, therefore, results in both good government and good citizens, for the benefit of everyone.

B. Civic Participation in Community Health Planning

The civic republican principles of deliberation, equality, the common good, and citizenship all support the active participation of community members in community health planning. Indeed, health policy experts and legal scholars have long advocated greater community participation in health care decisionmaking. The key, however, is the form of that community participation and whether it truly entails equal access to meaningful deliberation.

Much of the literature discussing community involvement in health policymaking uses language strikingly similar to that of civic republicanism. Equal access to and participation in the deliberative process, a key feature of civic republicanism, is considered an essential component of health policymaking because it legitimizes

34. Michelman, *supra* note 4, at 1504.

35. See Brest, *supra* note 4, at 1623; Fallon, *supra* note 7, at 1700.

36. Sunstein, *supra* note 6, at 1550; see also Feldman, *supra* note 8, at 679.

37. Sunstein, *supra* note 6, at 1556.

38. *Id.* at 1555-56.

39. Michael Sandel, *Keynote Address: Democracy’s Discontent: America in Search of a Public Philosophy*, 85 GEO. L.J. 2074 (1997).

40. Fallon, *supra* note 7, at 1725. Professor Michelman calls this a “jurisgenerative” political process, or one that is “capable of imbuing its legislative product with a ‘sense of validity’ as ‘our’ law.” Michelman, *supra* note 4, at 1502.

decisions, rendering them more acceptable to the public.⁴¹ This legitimacy is especially important in the area of health care, which “is deeply ingrained in the American consciousness” as a fundamental right.⁴² Because the allocation, or rationing, of health care resources is “fundamentally a moral and political problem,” the government must play a role in protecting the public interests at stake in health care policy, especially for the more vulnerable members in the community.⁴³ As a consequence, what may seem to be “objective approaches to health care cost containment,” such as the closure or downsizing of hospitals, necessarily invoke questions of morality and justice that must be resolved in the public sphere by all those affected.⁴⁴ The enormity of the public interest at stake when health care resources are allocated or rationed demands that decisions be “publicly assessed through a democratic consensus mechanism” in order to achieve legitimacy as a community driven decision.⁴⁵

Broad-based deliberation, moreover, produces more valuable results because such deliberation incorporates the diverse interests

41. This has been called the “participation hypothesis”—“the generalization that people are more likely to accept change if the persons who are expected to change take part in deciding what the change will be and how it will be made.” Jack H. Nagel, *Combining Deliberation and Fair Representation in Community Health Decisions*, 140 U. PA. L. REV. 1965, 1973 (1992).

42. In a recent poll conducted by the Opportunity Agenda and Harvard University researchers, eighty-nine percent of New York State residents believed that health care should be a right for everyone, and seventy percent thought that government should be “mainly responsible for ensuring that everyone in New York gets the health care that they need.” Press Release, Opportunity Agenda, NEW POLL: 77% of New Yorkers AGREE Hospital Closures would be BAD for New York’s Health Care System (Nov. 20, 2006), http://www.opportunityagenda.org/site/c.mwL5KkN0LvH/b.2265835/k.6558/NYC_Health_Poll_Release.htm; see also Ezekial J. Emanuel & Linda L. Emanuel, *Preserving Community in Health Care*, 22 J. HEALTH POL. POL’Y & L. 147, 166 (1997).

A 1938 Gallup poll reported that 81 percent of adults nationwide believed that “government should be responsible for medical care for people who can’t afford it.” Fifty-three years later the number was 80%—a remarkably stable conviction. [And an] annual trend study also shows that more than three-quarters of the public consistently express the conviction that “access to health care should be a fundamental right.”

Id. (quoting Daniel Yankelovich, *The Debate That Wasn’t: The Public and the Clinton Plan*, 14 HEALTH AFF. 7-23 (1995)).

43. Leonard M. Fleck, *Health Care Rationing: A Democratic Decisionmaking Approach*, 140 U. PA. L. REV. 1597, 1599, 1603 (1992). Professor Fleck argues that the distribution of health care is both a moral matter and a matter of social justice, and rejects the “claim that health care is simply another commodity properly distributed in accord with ability to pay.” *Id.* at 1601.

44. *Id.* at 1611.

45. *Id.* at 1611, 1617.

and concerns of people within the health care system. The shift away from relying primarily on the medical profession in the decisionmaking process reflects a new understanding that technical expertise is no more valuable in health resource allocation than information that lay people can provide.⁴⁶ Even at the treatment level, providers are recognizing the importance of incorporating the particular cultural, moral, and lifestyle preferences of a given patient when determining treatment options.⁴⁷ Without the active participation of communities in the deliberative process, health care allocation decisions would be “beyond the pale of public scrutiny or accountability” and subject to the possibility of “capricious, unreasonable, or dangerous” decisionmaking that lacks the imprimatur of widespread legitimacy.⁴⁸

Like civic republicans, health advocates and scholars recognize deliberation as the “key to consensus,” because various stakeholders actively learn about a given situation, listen to others, and share multiple perspectives.⁴⁹ Incorporation of a broad range of community input from the very beginning, through a structured and institutionalized process, allows health care to develop into a political issue for individuals from all walks of life, as it should be.⁵⁰ Institutionalized support for community engagement in public discourse is, in essence, an *affirmation of community*, which has a “self-reinforcing effect when the benefits are produced.”⁵¹ This is particularly important in low-income communities, immigrant communities, and communities of color, which often have experienced numerous forms of exclusion and disempowerment.

46. Cathy Charles & Suzanne DeMaio, *Lay Participation in Health Care Decision Making: A Conceptual Framework*, 18 J. HEALTH POL. POL'Y & L. 881, 883-84 (1993).

47. *Id.*

48. Fleck, *supra* note 43, at 1612.

49. Nagel, *supra* note 41, at 1972.

50. SYDNEY J. SOCOLAR, VICTOR W. SIDEL, ANNETTE RAMIREZ DE ARELLANO & FRANK GOLDSMITH, PUB. HEALTH ASS'N OF N.Y. CITY, STRENGTHENING NEW YORK CITY'S PUBLIC HEALTH INFRASTRUCTURE 13-14 (2001), available at <http://www.phanyc.org/pdfs/NYCphiW2.pdf>.

51. Emanuel & Emanuel, *supra* note 42, at 174. The “affirmation of community” parallels civic republicanism’s “momentum toward community in order to overcome separatist drives,” as opposed to the pluralist system that “encourages the citizenry to divide itself into groups in order to win politically controlled benefits.” Ward, *supra* note 7, at 593, 595-96; see also James Morone & Elizabeth Kilbreth, *Power to the People? Restoring Citizen Participation*, 28 J. HEALTH POL. POL'Y & L. 271, 281 (2003) (“Give communities real responsibility over their lives—over the social programs that directly affect them—and intense, ideological minorities will tend to be muted by serious democratic deliberations.”).

Through the process of addressing their local health problems, these communities can develop a grassroots political infrastructure to engage actively in the improvement of their local health care system.⁵²

Ultimately, meaningful deliberation in the health care decision-making process can foster self-government and community empowerment—the same objectives advanced by civic republicanism’s emphasis on the civic virtues of active citizenship. Communities become empowered when they gain “information, skills, and resources” that facilitate and improve their participation in public deliberation.⁵³ As new groups become introduced to health care politics through their involvement in the deliberative process, the locus of power within the health care system shifts towards the grassroots level, resulting in a system that is more responsive to the local health care needs of the community.⁵⁴ Thus, once community empowerment is identified as a priority in health care policymaking, the mechanics of the health care system immediately *require* input from community members and rely upon the diversity of their views through a process that is accessible and understandable with limitless possibilities of local leadership development.⁵⁵ Of course, participation does not necessarily produce community empowerment; there must be a fundamental shift in the power dynamics within the health care system for true empowerment to take place.⁵⁶

Unfortunately, however, our current health care system makes little effort to ensure community participation, and instead bears similarities to the competitive pluralist model that had spurred the republican revival. Federal deregulation of the health care industry has produced a “mushrooming of for-profit activities in the health field,” evident in insurance companies, HMOs, nursing

52. Morone & Kilbreth, *supra* note 51, at 287.

53. Pauline Vaillancort Rosenau, *Health Politics Meets Post-Modernism: Its Meaning and Implications for Community Health Organizing*, 19 J. HEALTH POL. POL’Y & L. 303, 310 (1994).

54. Morone & Kilbreth, *supra* note 51, at 272. One study cites to an effort by an African-American community in Arkansas to assert control over their local health care: “In overcoming the opposition of local physicians, the county judge, white citizens, county health departments, and pharmacists, the black community has developed a sense of strength and participation in the political process. Outstanding leaders and spokes [sic] people for the community have emerged.” Emanuel & Emanuel, *supra* note 42, at 161.

55. Emanuel & Emanuel, *supra* note 42, at 175 (citing STEPHEN M. SHORTELL ET. AL., *REMAKING HEALTH CARE IN AMERICA: BUILDING ORGANIZED DELIVERY SYSTEMS* 6 (1996)).

56. Charles & DeMaio, *supra* note 46, at 900.

homes, ambulatory surgery centers, and the like.⁵⁷ At the same time, uninsured, underinsured, and low-income families suffer from Medicaid cutbacks and the deterioration of their health care safety net. With the current emphasis on profit comes a “corporate style of planning” that focuses on maximizing profitable services regardless of actual health needs.⁵⁸ As a result, the health care system has replaced community health planning, which focused on the needs of the community regardless of profit, with corporate “strategic planning,” which focuses on the market potential of health services determined primarily by profit.⁵⁹

Likewise, the limited amount of health planning in New York City primarily takes place in the private sector, where each health care institution has a separate goal of “maximizing profits and averting risks.”⁶⁰ Instead, New York City needs a “uniform, transparent, participatory process” for allocating health care resources, including the termination of services from hospital closures.⁶¹ In the aftermath of health care deregulation, public intervention in health planning and coordination is needed now more than ever in order to ensure equal access to quality services.⁶² The rationale behind health planning has always been the effective use of resources—in other words, health planning seeks to “do *more* with *less*.”⁶³ An equally important rationale, however, is the provision of sufficient and quality health services in underserved areas pursuant to “equitable principles of distributive justice.”⁶⁴ This understanding comports with traditional beliefs that health care should not be a “market commodity” or “part of a business transaction,”

57. Herbert H. Hyman, *Reagan's Impact on Health Planning*, 4 J. PLAN. LITERATURE 259, 265 (1989).

58. *Id.* at 266.

59. *Id.* In her analysis of Health Systems Agencies, which will be discussed later in this Article, Professor Sofaer notes the “substantial purchasing power” of “major institutions such as business, labor unions, and government.” Shoshanna Sofaer, *Community Health Planning in the United States: A Postmortem*, FAM. CMTY. HEALTH, Feb. 1988, at 1, 10. She also cautions, however, that “[p]urchasers are concerned, ultimately, with the ‘bottom line.’ Many care about quality and health status, both as values in themselves and because poor quality and poor health status can be costly. But their primary concern is not overall community health but the health status and health care utilization of the defined population for whom they are buying health benefits.” *Id.* at 10-11.

60. SOCOLAR ET AL., *supra* note 50, at 9.

61. *Id.*

62. *Id.* at 7.

63. Bruce C. Vladeck, *Interest-group Representation and the HSAs: Health Planning and Political Theory*, 67 AM. J. PUB. HEALTH. 23, 26 (1977) (emphasis added).

64. James F. Blumstein & Frank A. Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3, 6 (1978).

but rather made available to everyone as a necessary component of a productive and successful life.⁶⁵

Health planning, therefore, has two complementary goals: to allocate health resources in a more efficient manner and to improve the delivery of health services in underserved areas.⁶⁶ Yet in order to achieve both purposes jointly, health planning must include equal access to a meaningful, deliberative, and consensus building process that is independent from market-based, competitive influences, amounting to an explicit rejection of the pluralist model. Indeed, civic republicanism's critique of pluralism is insightful on this point: while pluralism conceives of government's role as facilitating the "satisfaction of private interests," such as increased profits in health care, republicanism believes government should aid the "pursuit of the common good," such as health services to underserved and disadvantaged groups.⁶⁷ Moreover, because civic republicanism deals directly with "economic and political inequality," it recognizes the need for government to play an active role in ensuring the successful implementation of a truly participatory deliberative process.⁶⁸

The Federal Government's most recent effort to promote participatory democracy in the health care arena took the form of the Health Systems Agencies ("HSAs"), which were created by the Federal National Health Planning and Resources Development Act of 1974⁶⁹ ("Planning Act") and subsequent state law.⁷⁰ Under the Planning Act, HSAs could serve as a "public regional planning body" or a "unit of general local government" charged with the responsibility of developing and implementing system-wide health plans.⁷¹ An innovative and controversial feature of the Planning Act was the requirement that a majority of the HSA governing body consist of "consumers of health care and who are not . . . providers of health care and who are broadly representative of the social economic, linguistic and racial populations, geographic areas

65. Emanuel & Emanuel, *supra* note 42, at 165.

66. Blumstein & Sloan, *supra* note 64, at 7.

67. Feldman, *supra* note 8, at 697.

68. Brest, *supra* note 4, at 1623; *see also* Sunstein, *supra* note 6, at 1574 ("[M]ultiple threats are posed by private power, including that wielded by intermediate organizations, which are themselves a source of oppression. Government must therefore play a role in limiting the powers of such organizations without denying the importance of their continued existence.").

69. National Health Planning & Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975).

70. N.Y. PUB. HEALTH LAW § 2904-b (Consol. 2007).

71. National Health Planning & Resources Development Act § 1512.

of the health service area, and major purchasers of health care.”⁷² According to at least one scholar, this requirement “finally eclipsed the role of physicians as the unchallenged leaders of the [health care] system.”⁷³

The functions of the HSA included collecting and analyzing data, developing and implementing health plans, reviewing health care facility expansions, and reviewing applications for certain federal funds.⁷⁴ The HSA’s only real authority over health care institutions like hospitals, however, was the approval or disapproval of certain federally funded projects that made up only about ten percent of federal health expenditures.⁷⁵ Thus, although HSAs had a “quasi-regulatory” role in reviewing certain health-related projects, they mostly served as advisors to state and federal agencies, which had the ultimate authority to make policy decisions.⁷⁶ As one scholar commented, “planning without authority to implement goals is merely an exercise in fantasy land decision-making.”⁷⁷

Another criticism of the HSAs was the actual functioning of the governing board that was supposed to represent a broad range of community interests. Though this may have been an initial attempt at participatory democracy in the same vein as civic republicanism, the reality was quite different. Despite the statutory requirement for a consumer majority, HSAs were often still controlled by providers that traditionally held power in health policy.⁷⁸ Moreover, the mandate for broad representation on the HSAs’ governing

72. *Id.* § 1512(b)(3)(C)(i). New York’s statute required that a “majority of members . . . be residents of the health service region served by the agency who are consumers of health care and major purchasers of health care, including labor organizations and business corporations, in the region.” N.Y. PUB. HEALTH LAW § 2904-b(4)(a). The state regulations, however, required that the majority be:

(i) residents of the health service area served by the agency who are consumers of health care, and (ii) broadly representative of the health service area and shall include individuals representing the principal social, linguistic, handicapped, ethnic and racial populations and geographic areas of the health service area and major purchasers of health care, including labor organizations and business corporations, in the area.

N.Y. COMP. CODES R. & REGS. tit 10, § 82-1.5(c)(1) (2007).

73. Mark A. Peterson, *Introduction: Who Shall Lead?*, 28 J. HEALTH POL. POL’Y & L. 181, 183 (2003).

74. Sofaer, *supra* note 59, at 4.

75. Vladeck, *supra* note 63, at 24.

76. Sofaer, *supra* note 59, at 4; *see also* Blumstein & Sloan, *supra* note 64, at 17 n.108 (“With respect to the roles of the Health Systems Agencies in achieving their established targets, it is clear that their current authority is limited.” (quoting 43 Fed. Reg. 3056, 3058 (Jan. 20, 1978))).

77. Hyman, *supra* note 57, at 263.

78. *Id.* at 262.

boards was often reduced to a superficial effort to maintain quotas in satisfaction of the statutory requirements.⁷⁹ By specifying the formal composition of an HSA's governing body, rather than ensuring equal access to the deliberative process, Congress failed to ensure that HSAs would be accountable to the public-at-large instead of "more narrowly-based interest groups."⁸⁰ The New York City HSA, for example, was dominated by the interests of private medical care institutions, which in turn relied upon the market to determine health needs that were not reflective of the larger community.⁸¹ Unless HSAs gain credibility through responsiveness to local concerns, they can never have the legitimacy to enact the sometimes controversial changes required by comprehensive planning.⁸²

Nevertheless, when New York City lost its HSA in 1996, it also experienced a total collapse of health planning.⁸³ Currently, New York City has no long-term vision for the city's health care system that includes the planning elements of "goals, priorities, time frame, strategies and resource commitment."⁸⁴ Despite its flaws, the loss of the New York City HSA took with it some very important functions, such as vetting hospitals' capital projects and proposed service changes and serving as a repository for health data and analysis.⁸⁵ There is also presently no collection or analysis of "health indicators broken down by ethnicity, gender, age group, geography, disease category, and type of services used" that would identify disparities and inequities, which is a necessary first step before attempting to remedy them.⁸⁶ In the republican tradition, this type of data had previously been used by community groups to support their positions during deliberations on health care policy. In effect, the data facilitated their participation in policymaking, thereby engendering a demand for access to even more information.⁸⁷

One could argue that the failure of the HSAs goes hand-in-hand with their nonconformity with civic republican principles. A republican approach would have demanded that community mem-

79. Sofaer, *supra* note 59, at 5-6.

80. Vladeck, *supra* note 63, at 28.

81. SOCOLAR ET AL., *supra* note 50, at 1.

82. Sofaer, *supra* note 59, at 9.

83. SOCOLAR ET AL., *supra* note 50, at 1.

84. *Id.* at 8.

85. *Id.*

86. *Id.*

87. *Id.*

bers have more authority over and participation in the deliberative process. Such an approach would have also emphasized consensus building for the good of the entire community rather than competition among special interest groups. Without broad-based deliberation and consensus, there can be no broad-based community support for potentially controversial decisions regarding health care allocation. This lack of support undermines the credibility of the decisions and the decisionmaking process themselves. In order for any community health planning to succeed, all of these issues—deliberation, participation, community, and accountability—must be taken seriously.

III. HOSPITAL DISINVESTMENT IN THE ABSENCE OF HEALTH PLANNING

In the decade since New York City lost its HSA, there has been no comprehensive, long-term health planning to determine the allocation of health care resources and no form of meaningful community participation in health policy decisionmaking. The results have been disastrous, causing further retrenchment of alarming levels of health disparities and the costly and inefficient use of vital health care dollars. As members of the New York City Council aptly noted:

The health care system in the United States has reached a crisis point, and nowhere more so than in New York City. . . . [T]he health care infrastructure in the City fails to work effectively as a whole. A system-wide lack of planning has led to tremendous inequities in service delivery. Services offered by different providers are poorly coordinated and far too many New Yorkers do not have access to appropriate services. Additionally, while many communities are significantly underserved, other communities have too many facilities.⁸⁸

There is no better example of the failures of New York City's health care system—both in terms of the lack of health planning and the exclusion of community participation—than the closure of hospitals in New York City's medically underserved areas, which are often immigrant communities or communities of color. Without comprehensive health planning, hospitals have been left to their own devices in a competitive, profit-seeking mode consistent with the pluralist model. Instead of working with community

88. N.Y. CITY COUNCIL, A PRESCRIPTION FOR NEW YORK CITY'S HEALTH CARE CRISIS: RECOMMENDATIONS OF THE NEW YORK CITY COUNCIL HOSPITAL CLOSING TASK FORCE 1 (Nov. 2006).

members to serve their neighborhoods better, hospitals have been forced to fight for their own financial survival.⁸⁹ In the meantime, New York City has witnessed the closure of twelve hospitals in the past decade—two-thirds of which predominantly served people of color.⁹⁰ For some of these closed hospitals, more than ninety percent of their patients were African-American, Latino, and Asian.⁹¹

In order to illustrate the disconnect between health care resources and health care needs in the absence of health planning, this Article discusses two major events that have negatively impacted New York City's health care system: the bankruptcy of the St. Vincent's Catholic Medical Centers ("St. Vincent's") and the hospital closing recommendations of the Commission on Health Care Facilities in the 21st Century ("Berger Commission").⁹² Both events resulted in the disinvestment of health care resources in medically underserved areas and, just as importantly, excluded affected community members from the decisionmaking process. This is a story of four communities in Central Brooklyn, Southeast Queens, the Northeast Bronx, and Southwest Brooklyn, and their battle with government officials and health care institutions to preserve their local health care.

A. St. Vincent's' Bankruptcy

The St. Vincent's network claimed to be "one of the New York metropolitan area's most comprehensive healthcare system" and "the largest provider of emergency medical services in the New

89. According to the Healthcare Association of New York State, "New York hospitals lost money providing patient care . . . every year in the seven-year period 1998 through 2004," amounting to losses of \$127 million in 2004 and cumulative losses of up to \$2.3 billion since 1998. HEALTHCARE ASS'N OF N.Y. STATE, *HOSPITALS ON LIFE SUPPORT: SEVEN STRAIGHT YEARS OF LOSSES* 2 (Jan. 2006).

90. THE OPPORTUNITY AGENDA, DANGEROUS AND UNLAWFUL: WHY OUR HEALTH CARE SYSTEM IS FAILING NEW YORK COMMUNITIES AND HOW TO FIX IT 6 (2007) [hereinafter DANGEROUS AND UNLAWFUL]. The disproportionate impact of these hospital closures on communities of color potentially violates regulations promulgated under Title VI of the Civil Rights Act of 1964, which prohibit hospitals from utilizing "criteria or methods of administration that would have the effect of subjecting individuals to discrimination because of their race, color, or national origin . . ." 45 C.F.R. § 80.3(b)(2) (2005) (emphasis added). Unfortunately, this claim cannot be tested in court because the U.S. Supreme Court has found no private right of action to enforce these regulations. See *Alexander v. Sandoval*, 532 U.S. 275 (2001).

91. DANGEROUS AND UNLAWFUL, *supra* note 90, at 3.

92. COMM'N ON HEALTH CARE FACILITIES IN THE 21ST CENTURY, A PLAN TO STABILIZE AND STRENGTHEN NEW YORK'S HEALTH CARE SYSTEM (Dec. 2006) [hereinafter BERGER COMMISSION REPORT], available at <http://www.nyhealthcarecommission.org/docs/final/commissionfinalreport.pdf>. The term "Berger Commission" is derived from the name of the commission's chair, Stephen Berger.

York City's Fire Department's 911 service"⁹³ When it filed for bankruptcy in July 2005, St. Vincent's had seven hospitals with 2500 affiliated physicians and employed 12,500 full or part-time employees in the New York City area.⁹⁴ In 2004 alone, the network had "600,000 outpatient visits, 640,000 home care visits and 92,000 inpatient discharges."⁹⁵ Needless to say, any decisions to close or downsize the network's hospitals would have a tremendous impact on New York City's health care system.

Yet, despite the obvious connection between the health services provided by St. Vincent's and the health of the communities that relied on those services, there was no formal process by which community members could voice their concerns and inform health administrators and public officials about how best to handle St. Vincent's financial constraints. Over the course of its bankruptcy, St. Vincent's divested itself of all its acute-care hospitals, except its flagship hospital in Greenwich Village.⁹⁶ St. Vincent's reasons for closing or selling its hospitals were never based on the health needs of the community, but rather the hospitals' profitability.⁹⁷ Meanwhile, St. Vincent's incurred over \$14 million in legal fees during its two and a half years in bankruptcy⁹⁸ and currently plans on under-

93. Debtor's Motion for (A) an Order Approving (i) Bidding Procedures with Respect to the Sale of Mary Immaculate Hospital and St. John's Queens Hospital, and Related Assets, (ii) the Time, Date, Place, and Form of Notice for Each of the Auction and Sale Hearing, and (iii) a Break-Up Fee and Expense Reimbursement and (B) an Order Approving (i) the Sale of the Hospitals and Related Assets Free and Clear of Liens, Claims, Encumbrances, and Other Interests, and (ii) the Assumption and Assignment of Executory Contracts and Unexpired Leases ¶ 2, *In re Saint Vincent's Catholic Med. Ctrs. of New York et al.*, No. 05-14945 (ASH) (Bankr. S.D.N.Y. May 9, 2006).

94. *Id.* ¶¶ 2-3.

95. *Id.* ¶ 2.

96. Richard Pérez-Peña, *Hospital to Exit Bankruptcy, Promising to Pay Back Debts*, N.Y. TIMES, Feb. 12, 2007, at B2.

97. In one of its bankruptcy submissions, St. Vincent's stated that:

Several of [St. Vincent's] hospitals have been unprofitable for many years Because [St. Vincent's] cannot afford to operate [these hospitals], have been unable to improve significantly the operating performance of these hospitals, and do not have the financial resources to fund the required capital improvements at these hospitals, [St. Vincent's] determined that they must divest themselves of these hospitals in order to reorganize successfully and continue as a going concern.

MIH Bidding Motion, *supra* note 94, ¶¶ 5-6; see also Richard Pérez-Peña, *Chain of Catholic Hospitals Puts Three Units on the Market*, N.Y. TIMES, Dec. 19, 2005, at B3 ("These hospitals need major investments to modernize and stay competitive, and we don't have the resources to make those investments," said Bernadette Kingham-Bez, a senior vice president of the St. Vincent network.").

98. Elizabeth Solomont, *St. Vincent's Emerging from "Daunting" Bankruptcy*, N.Y. SUN, July 31, 2007, at 4.

going an \$800 million reconstruction of its Greenwich Village hospital.⁹⁹

Two communities of color, Central Brooklyn and Southeast Queens (Jamaica), were especially impacted by St. Vincent's divestment plan. Both communities suffer from some of the worst health care outcomes in the city, and both have been designated by the Federal Government as a "Medically Underserved Area"¹⁰⁰ and a "Health Professional Shortage Area" since 1993.¹⁰¹ A comparison of the health and racial demographics, in Table 1 below, of Greenwich Village against Central Brooklyn and Southeast Queens, further illustrates how St. Vincent's decisions were driven by finances, not community health needs. For example, Central Brooklyn—with a population that is eighty percent black, compared to three percent in Greenwich Village—has an infant mortality rate that is more than quadruple the rate in Greenwich Village. Additionally, the percentage of adults with diabetes in both Central Brooklyn and Jamaica, Queens is more than double the percentage in Greenwich Village. These are just some of the examples of the health disparities among these communities.

99. John Freeman Gill, *On Vigilant Streets, a Closely Watched Plan*, N.Y. TIMES, Dec. 16, 2007, at 14CY.

100. This designation requires the consideration of four variables: (i) "ratio of primary care medical physicians per 1,000 population;" (ii) "infant mortality rate;" (iii) "percentage of the population with incomes below the poverty level;" and (iv) "percentage of population age 65 or over." Bureau of Health Professions, U.S. Dep't of Health & Human Servs., Guidelines for Medically Underserved Area and Population Designation, <http://bhpr.hrsa.gov/shortage/muaguide.htm> (last visited Apr. 1, 2008). The Central Brooklyn neighborhoods of Crown Heights and Bedford-Stuyvesant and South Jamaica in Southeast Queens have all been designated "Medically Underserved Areas" since 1993. Health Res. & Servs. Admin., U.S. Dep't of Health & Human Servs., Medically Underserved Areas / Medically Underserved Populations (MUA/MUP), <http://muafind.hrsa.gov> (choose "NY" from state drop down menu, control click "Kings County" and "Queens County," then click "Find MVA/MVPs" hyperlink) (last visited Apr. 1, 2008).

101. In making such a designation, the U.S. Department of Health and Human Services looks at (i) whether the "area is a rational area for the delivery of primary medical care services;" (ii) the ratio of full-time, primary care physicians to the population; and (iii) whether "[p]rimary medical care professionals in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration." U.S. Dep't of Health & Human Servs., Bureau of Health Professions, Health Professional Shortage Area Primary Medical Care Designation Criteria, <http://bhpr.hrsa.gov/shortage/hpsacritpcm.htm> (last visited Apr. 1, 2008). Other than the Central Brooklyn neighborhoods of East New York, Crown Heights, Bushwick, and Bedford-Stuyvesant and South Jamaica in Queens, the only other "Health Professional Shortage Areas" in New York City are Port Richmond and St. George in Staten Island, Long Island City in Queens, Washington Heights-Inwood and West Central Harlem in Manhattan, Williamsburg in Brooklyn, and Hunts Point-Mott Haven and Highbridge in the Bronx. DANGEROUS AND UNLAWFUL, *supra* note 90, at 5.

TABLE 1

	GREENWICH VILLAGE & SoHo ¹⁰²	CENTRAL BROOKLYN ¹⁰³	JAMAICA, QUEENS ¹⁰⁴	NYC
WHITE RESIDENTS	67%	5%	33%	35%
BLACK RESIDENTS	3%	80%	60%	24%
HISPANIC RESIDENTS	6%	11%	15%	27%
RESIDENTS LIVING BELOW POVERTY LEVEL	13%	31%	16%	21%
INFANT MORTALITY RATE ¹⁰⁵	2	9	7	6
ADULTS USING ER FOR HEALTH CARE	1%	13%	9%	8%
ADULTS WITH DIABETES	5%	12%	11%	9%

Due to their reliance on hospital emergency rooms, residents of Central Brooklyn and Jamaica, Queens are particularly vulnerable to the loss of hospital services, which are often their only source of health care. Nevertheless, St. Vincent's cost-benefit analysis clearly persuaded the network to get out of the unprofitable business of providing health care to poor, medically underserved communities of color.¹⁰⁶

102. NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE, COMMUNITY HEALTH PROFILES: GREENWICH VILLAGE AND SoHo (2d ed. 2006).

103. NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE, COMMUNITY HEALTH PROFILES: CENTRAL BROOKLYN (2d ed. 2006).

104. NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE, COMMUNITY HEALTH PROFILES: JAMAICA (2d ed. 2006).

105. "Infant mortality rate" is the number of babies who die in the first year per 1,000 live births.

106. One news article made a pointed comparison between St. Mary's Hospital in Central Brooklyn and St. Vincent's flagship hospital in Greenwich Village:

St. Mary's . . . which in its 123-year history has cared for the uninsured, poor and working class of Crown Heights and its surrounding neighborhoods, is in need of state aid or it faces closure come September. A borough away in Manhattan, St. Vincent's on West 12th Street is on the verge of opening a new, state-of-the-art trauma center next month. Both hospitals are traveling in opposite directions despite being owned and managed by the embattled Saint Vincent Catholic Medical Centers

Curtis L. Taylor, *Same Hospital System, Different Paths*, NEWSDAY, July 7, 2005, at A49.

1. Closure of St. Mary's Hospital in Central Brooklyn

The New York City HSA's last report in 1993 designated the Central Brooklyn neighborhoods of Crown Heights, Bedford-Stuyvesant, and East New York/Brownsville as three of only ten "Priority 1" neighborhoods, defined as areas "with the most severe health-related problems" that should have the "highest priority for the funding of resource development programs"¹⁰⁷ Over a decade later, Central Brooklyn's health has become even worse.¹⁰⁸ Compared to New York City overall, adults in Central Brooklyn have a twenty percent higher rate of heart disease hospitalizations, more than twice the rate of HIV-related deaths, a thirty-five percent higher rate of mental illness hospitalizations, a more than seventy percent higher rate of alcohol-related hospitalizations, a sixty percent higher rate of drug-related deaths, a twenty-five percent higher rate of deaths from cancer, and a sixty-six percent higher rate of asthma-related hospitalizations.¹⁰⁹ Among all of New York City's neighborhoods, "Central Brooklyn had the highest rate of newly diagnosed chlamydia in 2004, more than twice the New York City overall rate. This community also had the second highest rate of newly diagnosed gonorrhea, almost triple the NYC rate."¹¹⁰

This was the backdrop of St. Vincent's plan to close St. Mary's Hospital in Central Brooklyn in 2005. New York Lawyers for the Public Interest ("NYLPI") represented a coalition of local residents, churches, and community-based organizations, called the Committee to Save Our Hospitals ("CSOH"),¹¹¹ in an effort to

107. HEALTH SYSTEMS AGENCY (HSA) OF N.Y. CITY, A FRAMEWORK FOR PRIMARY CARE NEEDS ANALYSIS IN NEW YORK CITY ii, iv (Sept. 1993).

108. According to the City Department of Health, the hospitalization rate for heart disease increased by over twenty-five percent in the past decade. HEALTH PROFILES: CENTRAL BROOKLYN, *supra* note 103, at 6.

109. *Id.* at 6, 8-11, 13.

110. *Id.* at 14.

111. Members of the CSOH included the Brooklyn Council of Churches, Berean Community and Family Life Center, Greater Rugged Cross Baptist Church, Greater Friendship Baptist Church, Flatbush Reformed Church, Revival Hour Baptist Church, Church of God Seventh Day Pentecostal Church, Universal Church of God, Bethel Evangelical Church, St. Mark's Baptist Church, St. George's Episcopal Church, Shiloh Baptist Church, Concord Baptist Church, Mt. Paran Baptist Church, Mt. Sinai Baptist Church, United Baptist Church, Brooklyn Perinatal Network, Ocean-Hill Brownsville Tenants Association, Community Action Project, Caribbean Women's Health Association, Riggins Cultural Oasis, and the Task Force on Infant and Maternal Mortality and Family Health. See Press Release, Committee to Save Our Hospitals, Enough is Enough! Community Residents, Religious and Community Leaders and Hospital Employees Voice Concerns at City Council Hearing; Central Brooklyn Losing Vital Medical Services (June 15, 2005) (on file with the author).

prevent what would amount to a health care catastrophe. Although the closure of St. Mary's required the approval of the State Department of Health, there was no formal mechanism for concerned residents and organizations to participate in the process of determining St. Mary's' future. As a consequence, CSOH had to take an activist stance and insert itself into the public debate by convening a "Call to Action Forum,"¹¹² organizing a rally to protest the hospital closure,¹¹³ and testifying at a City Council Health Committee hearing.¹¹⁴

Despite overwhelming community protest and public knowledge of Central Brooklyn's health status, St. Vincent's decided to close St. Mary's Hospital when the State refused to provide the funds necessary for a sale to an interested buyer.¹¹⁵ In a final effort to stop the hospital closure, NYLPI filed a lawsuit on behalf of CSOH member, Harriet McCloud. McCloud was a fifty-six-year old woman with multiple disabilities and illnesses including diabetes, hypertension, kidney failure, poor circulation, and heart disease, who relied on St. Mary's for all of her health care needs.¹¹⁶ McCloud based her claim on the New York Public Health Law, which requires the State Department of Health to conduct a needs assessment, determine whether patients would have alternative sites for health services, and allow the public to participate in the decision-making process before closing a hospital.¹¹⁷

The state court initially granted a temporary restraining order,¹¹⁸ but eventually ruled that the matter was stayed by St. Vincent's'

112. Press Release, Committee to Save Our Hospitals, Community Forum Draws Angry Brooklynites Concerned about Threatened Hospital Closures; New Broad-Based Coalition Fights to Stop Dramatic Loss of Health and Medical Services; Committee to Save Our Hospitals Targets St. Mary's Hospital and Interfaith Medical Center (Jan. 20, 2005), <http://www.nylpi.org/pub/hospcomm.pdf>.

113. Press Release, Committee to Save Our Hospitals, Enough is Enough! Committee to Save Our Hospitals Demands, Stop Stripping Medical Services to Low Income Communities of Color (May 23, 2005), <http://nylpi.org/pub/csphrallypressreleasemay232005.pdf>.

114. Press Release, Committee to Save Our Hospitals, *supra* note 111.

115. See Marc Santora, *St. Mary's Hospital in Brooklyn Is to Close After Years of Losses*, N.Y. TIMES, June 4, 2005, at B1; Joyce Shelby, *St. Mary's Rescue Bid Is Scuttled*, N.Y. DAILY NEWS, May 24, 2005, at S1.

116. Verified Petition ¶¶ 8-9, *McCloud v. Novello*, Index No. 22406/05 (N.Y. Sup. Ct. Kings County July 22, 2005).

117. *Id.* ¶¶ 7-10.

118. Order To Show Cause ¶ 1, *McCloud v. Novello*, Index No. 22406/05 (N.Y. Sup. Ct. Kings County July 22, 2005); see also Joyce Shelby, *Reprieve for Hospital*, N.Y. DAILY NEWS, July 23, 2005.

bankruptcy.¹¹⁹ The state court proceedings, however, were insightful in that it highlighted both the State's and St. Vincent's interpretation of section 2806(6) of the New York Public Health Law, which requires the State Department of Health to find whether it "would be within the public interest" to "suspend, limit, modify, or revoke a hospital operating certificate" after considering, inter alia, the public need, the presence of alternative or substitute services, and the level of care and type of services needed by patients seeking care at the hospital in question.¹²⁰ Section 2806(6) further requires the State to inform the public that any finding is under consideration for at least thirty days before making that finding and, most importantly, to "take all public comments into consideration in making such a finding."¹²¹ Because the closure of a hospital would necessarily "modify" a hospital's operating certificate, McCloud argued that section 2806(6) clearly called for community input before the State approved a hospital closure.¹²²

According to the State, however, "[n]either the Public Health Law nor state regulations require the extensive review process . . . for a voluntary surrender."¹²³ In other words, the State believes that if a hospital chose to *voluntarily* close—as opposed to an involuntary, state-mandated closure—there is no need to comply with section 2806(6), including the requirement for public comment.¹²⁴ Likewise, St. Vincent's argued that section 2806(6) "does not apply to a voluntary closing of a hospital and surrender of its operating certificate," and that it was only subject to the requirement that it "provide information to patients regarding their ability to obtain future health services and establish a plan for the storage and safekeeping of its patients' medical records."¹²⁵ Under this analysis, St. Mary's' closure was not subject to "a public needs

119. Order, McCloud v. Novello, No. 22406/05, (N.Y. Sup. Ct. Kings County July 27, 2005).

120. N.Y. PUB. HEALTH LAW § 2806(6)(a) (Consol. 2007).

121. *Id.* § 2806(6)(b).

122. Petitioner's Memorandum of Law at 11, McCloud v. Novello, Index No. 22406/05 (N.Y. Sup. Ct. Kings County July 26, 2005).

123. Affidavit in Support of Respondent's Cross-Motion To Dismiss the Petition at 7-8, McCloud v. Novello, Index No. 22406/05 (N.Y. Sup. Ct. Kings County July 26, 2005).

124. *Id.*

125. Affirmation of Lawrence J. Slattery in Support of Motion To Intervene and Motion To Dismiss the Petition for a Temporary Restraining Order and Permanent Injunction ¶¶ 25-26, McCloud v. Novello, Index No. 22406/05 (N.Y. Sup. Ct. Kings County July 25, 2005).

analysis or any other 'factors' to be examined by the State before approving the closure."¹²⁶

The state court never resolved these conflicting interpretations of section 2806(6) due to the bankruptcy stay, but the intention of both the State and St. Vincent's was clear: neither wanted any community participation in the State Department of Health's deliberations about whether or not to approve St. Mary's' closure. Indeed, St. Vincent's went so far as to file its own lawsuit against McCloud, claiming "willful" violation of the bankruptcy stay and seeking *punitive damages*, in addition to actual damages and declaratory and injunctive relief.¹²⁷ Seen through the lens of civic republicanism, the State and St. Vincent's' construction of section 2806(6) is patently inconsistent with the democratic principles of self-government and open participation in the deliberative process. With no opportunity for public scrutiny, decisions of such immense public importance as the closure of a community hospital could not benefit from the concerns and expertise of the people most affected by those decisions.

St. Vincent's eventually closed St. Mary's in October 2005,¹²⁸ and over a year later sold the main building to a Manhattan-based firm for \$22 million.¹²⁹ Although more than two years have passed, there has still been no investment in health care in the Central Brooklyn area to replace services lost from the closure. To the contrary, Central Brooklyn continues to experience a series of health care *disinvestments*, but each loss has been met with community activism and unrest as residents battle for control over their local health care. For example, after the State Department of Health approved the closure of five centers in the Women, Infants and Children Program ("WIC"),¹³⁰ CSOH was able to save three of these centers by mobilizing the community and pressuring their

126. *Id.*

127. Adversary Complaint at 7, Saint Vincent's Catholic Med. Ctrs of N.Y. v. McCloud, (*In re* Saint Vincents Catholic Med. Ctrs of New York), No. 05-14945 (Bankr. S.D.N.Y. July 29, 2005). The parties later stipulated to an order dismissing this adversary proceeding. Stipulation and Order Dismissing Adversary Proceeding, Saint Vincent's Catholic Med. Ctrs of N.Y. v. McCloud (*In re* Saint Vincents Catholic Med. Ctrs of New York), Case No. 05-2351A (Bankr. S.D.N.Y. Jan. 19, 2006).

128. Jeff Vandam, *Lights Out*, N.Y. TIMES, Oct. 16, 2005, §14, at 1.

129. Rachel Monahan, *St. Mary's Hospital Sold for \$22M*, N.Y. DAILY NEWS, Jan. 31, 2007, at S8.

130. "WIC is a special supplemental food program that provides nutritious foods, milk, juice, formula and other items to low income pregnant or breastfeeding women, infants and children up to age 5." N.Y. State Dep't of Health, WIC Program, Women, Infants, Children (July 2007), <http://www.health.state.ny.us/prevention/nutrition/wic/>.

local elected officials.¹³¹ More recently, a new coalition called the Central Brooklyn Health Crisis Coalition (“CBHCC”) fought desperately to save St. Mary’s’ former outpatient clinics that had been transferred to another hospital just two years earlier to escape closure.¹³² By October 2007, four of St. Mary’s’ outpatient clinics and the WIC center in a fifth clinic were closed. Yet, the battle is far from over; NYLPI is currently working with CBHCC in additional efforts to bring health care resources into Central Brooklyn.

2. *Sale of Mary Immaculate Hospital in Southeast Queens*

After closing St. Mary’s Hospital, St. Vincent’s prepared to divest itself of another hospital in a community of color—Mary Immaculate Hospital, located in the Jamaica neighborhood of Southeast Queens. Like Central Brooklyn, Jamaica is a predominately African-American community with significant health disparities. According to the City Department of Health, Jamaica’s “hospitalization rates for both long-term diabetes complications and lower-extremity amputation among people with diabetes are higher than the rates in NYC overall, suggesting inadequate access to health care among people with diabetes in this community.”¹³³ For all neighborhoods in Queens, Jamaica had the second highest asthma hospitalization rate for children up to age fourteen, and had by far the highest rate of current self-reported asthma prevalence for adults ages eighteen and older.¹³⁴ Additionally, the infant mortality rate for the Jamaica East health district was 10.1 in 2004, compared to the city average of 6.1, nearly doubling in just two years.¹³⁵

Also like Central Brooklyn, numerous community groups in Jamaica were concerned about the fate of their local hospital during the St. Vincent’s bankruptcy. Although potential buyers had been identified, there was a fear that a deal would fall through, as it had with St. Mary’s. Harking back to the problems with the pluralist

131. Joyce Shelby, *Good News for Moms & Kids as 3 WIC Centers Are Saved*, N.Y. DAILY NEWS, Apr. 25, 2006, at 51.

132. See Joyce Shelby, *Fight Gears up to Keep Two Health Clinics from Closing*, N.Y. DAILY NEWS, July 5, 2007 at S1; Joyce Shelby, *Gloves Off in Fight to Keep Clinics Open*, N.Y. DAILY NEWS, July 25, 2007, at S1; Joyce Shelby, *Brownsville Clinics May See New Life*, N.Y. DAILY NEWS, Aug. 28, 2007, at 1.

133. HEALTH PROFILES: JAMAICA, *supra* note 104, at 14.

134. N.Y. CITY DEP’T OF HEALTH & MENTAL HYGIENE, ASTHMA FACTS: NEW YORK CITY CHILDHOOD ASTHMA INITIATIVE 16, 30 (2d ed. 2003).

135. Compare N.Y. CITY DEP’T OF HEALTH & MENTAL HYGIENE, SUMMARY OF VITAL STATISTICS 2004 46 (2005) with N.Y. CITY DEP’T OF HEALTH & MENTAL HYGIENE, SUMMARY OF VITAL STATISTICS 2002 36 (2003).

model, community members were also concerned that a competing hospital would see Mary Immaculate as a threat and thus seek to purchase the hospital only to shut it down shortly thereafter.¹³⁶ Amidst all of the negotiations among St. Vincent's, interested hospitals, and the State Department of Health, the community was left completely in the dark—unable to either access information or provide their own information about the future of Mary Immaculate. In order to become an organized voice representing community interests, local groups formed a coalition called Southeast Queens in Support of Health Services (“SQUISH”).¹³⁷

As with CSOH, NYLPI represented SQUISH in a multi-pronged approach to save the hospital from closure. In accordance with civic republicanism, the goal of SQUISH's efforts was the inclusion of diverse community interests and concerns in any deliberation about Mary Immaculate.¹³⁸ For example, SQUISH submitted information about the community's health disparities and health needs through affidavits of local residents and community letters to demonstrate why non-economic factors, such as the continued operation of the hospital, should be considered when deliberating on the appropriate buyer during bankruptcy court proceedings.¹³⁹ SQUISH provided similar information to the State Department of Health, the State Hospital Review and Planning Council, and the Public Health Council through both a written submission and oral testimony.¹⁴⁰

136. This concern was realized in a *New York Times* article that reported Jamaica Hospital's interest in purchasing Mary Immaculate. Jamaica Hospital's president was quoted as saying that “if Mary Immaculate becomes a strong competitor, that could ‘put us over the edge.’” Richard Pérez-Peña, *2 Small Queens Hospitals in a Struggle for Survival*, N.Y. TIMES, May 12, 2006, at B5. This consideration led “[l]ocal officials and St. Vincent executives [to] contend that Jamaica would cut services at Mary Immaculate.” *Id.*

137. Members of SQUISH included Grace Episcopal Church, Federation of Civic Associations, Centro Hispano Cuzcatlán, Brinkerhoff Action Association, Jamaica YMCA, Haitian Americans United for Progress, Inc., Jamaica Neighborhood Center, and St. Pascal Babylon Parish.

138. Rick Archer, *Wyckoff Hts. Purchases Are Approved By Court*, QUEENS CHRON., June 29, 2006 (“[SQUISH's] goal has been to make the court and state authorities aware of the health needs in Jamaica.”).

139. Statement of SQUISH in Furtherance of the Debtors' Bidding Procedures with Respect to the Sale of Mary Immaculate Hospital and St. John's Queens Hospital, and Related Assets, and in Response to the Official Creditors' Committee's Statement and Reservation of Rights with Respect Thereto ¶¶ 8-9, *In re Saint Vincent's Catholic Med. Ctrs. of N.Y.*, No. 05-14945 (Bankr. S.D.N.Y. June 16, 2006).

140. See Letter from Jin Hee Lee, Staff Attorney, N.Y. Lawyers for the Pub. Interest, to Julia G. Richards, N.Y. State Dep't of Health (Sept. 18, 2006) (on file with author); Testimony of Jin Hee Lee before Project Review Committee of State Hospi-

Without this information, neither the bankruptcy court nor the state executive bodies would have known, for example, that: within walking distance of the hospital, the Jamaica YMCA runs a transitional housing program for homeless men and women living with AIDS, who rely upon Mary Immaculate for treatment of their mental illness, substance abuse, and AIDS-related illnesses;¹⁴¹ a neighborhood near Mary Immaculate was found to be a toxic site due to contamination from a former dry cleaning storage and distribution center;¹⁴² and a large Latino community living near Mary Immaculate would face significant transportation barriers if forced to seek care at other hospitals.¹⁴³ These are just a few examples of significant, localized knowledge that community members bring to bear in decisions concerning their local health care needs.¹⁴⁴

Consistent with the civic republican tradition, SQUISH held a community forum so that local residents could speak directly with an executive from the purchasing hospital and engage in a dialogue about how the hospital and the community could work together for the benefit of everyone.¹⁴⁵ In the absence of any formal mechanism for community participation, this forum was the only opportunity for community members to ask questions and voice their concerns—in other words, to participate in some form of deliberative process. Yet, history has shown that this informal mode of deliberation is not enough—there must also be genuine accountability to the community in order to ensure that mere words are supported with results. As one SQUISH member commented, “the proof will be in the pudding,” and the community will need to “watch[] that pudding very closely for some time.”¹⁴⁶ Just a few months later, that proved to be true. Although the successful sale of Mary Immaculate Hospital prevented its closure, the new

tal Review and Planning Council, Sept. 21, 2006 [hereinafter Lee Testimony]; Rick Archer, *Going, Going, Gone: Wyckoff Gets Hospitals*, QUEENS CHRON., Sept. 22, 2006 (noting that SQUISH had “spoken with Health Department officials, and plans to weigh in on the state approval process”).

141. Lee Testimony, *supra* note 140.

142. Declaration of Irving Hicks ¶ 7, *In re Saint Vincent’s Catholic Med. Ctrs.* of N.Y., No. 05-14945 (Bankr. S.D.N.Y. June 16, 2006).

143. Declaration of Eduardo Barahona ¶ 14, *In re Saint Vincent’s Catholic Med. Ctrs.* of N.Y., No. 05-14945 (Bankr. S.D.N.Y. June 15, 2006).

144. Craig Giammona, *Mary Immac, St. John’s Sold*, JAMAICA TIMES LEDGER, June 29, 2006 (“[W]hile the Department of Health has access to statistics, it often lacks specific information about the communities hospitals serve.”).

145. Karen Clements, *Community Weighs in on Sale of Hospitals*, QUEENS CHRON., Oct. 5, 2006.

146. Colin Gustafson, *Hospitals’ Sale Approved, but Concerns Linger*, QUEENS CHRON., Nov. 16, 2006.

owner inherited substantial financial constraints, which resulted in unexpected staff cuts, problems with cash flow, and questions about possible mismanagement.¹⁴⁷ Despite the receipt of approximately \$6 million in state funds,¹⁴⁸ Mary Immaculate remains at risk of closure, and the community continues to seek possible avenues to influence the hospital's future.

B. Berger Commission "Recommendations"

In what is perhaps the antithesis of deliberative democracy, the New York State Legislature created the Berger Commission in 2005, "charged with examining the supply of general hospital and nursing home facilities,¹⁴⁹ and recommending changes that will result in a more coherent, streamlined health care system in the state of New York."¹⁵⁰ The term "recommendations" is a misnomer: in actuality, the Berger Commission's so-called recommendations automatically became law on January 1, 2007, without any action on the part of the Legislature.¹⁵¹ By the terms of the legislation creating the Berger Commission, both houses of the State Legislature had only a one month window to review the Berger Commission's 231 page report¹⁵² and reach a majority resolution rejecting the "recommendations" in totality—all during the winter holiday season when the Legislature was not in general session.¹⁵³ Clearly, the Legislature created the Berger Commission to make potentially controversial decisions without having any accountability to their own constituency. Thus, a state legislator could honestly say that she or he never approved or voted for any of the Berger Commission's "recommendations."

In addition to its unprecedented lawmaking authority, the Berger Commission had several other fundamental flaws: none of the

147. See Pete Davis, *Hospital Facing Staff Cuts*, QUEENS COURIER, Mar. 1, 2007; Craig Giammona, *Mary Immac Cash Flow Problems Could Force Layoffs, Budget Cuts*, JAMAICA TIMES LEDGER, Mar. 1, 2007.

148. See Donald Bertrand, *2 Hosps Get 6M State Loan at Last Minute*, N.Y. DAILY NEWS, Mar. 26, 2007, at 52; Craig Giammona, *Ailing Mary Immac Receives State Bailout*, JAMAICA TIMES LEDGER, Mar. 29, 2007.

149. Although the Berger Commission addressed the supply of both hospitals and nursing homes, this Article discusses the "recommendations" for hospital closures only.

150. Commission on Health Care Facilities in the 21st Century, *Enabling Legislation*, pt. K, sec. 31, § 1, 2005 N.Y. Sess. Laws 193-202 (McKinney) [hereinafter *Enabling Legislation*].

151. *Id.* § 9.

152. BERGER COMMISSION REPORT, *supra* note 92.

153. *Enabling Legislation*, *supra* note 150, § 9.

eighteen commission members were elected and, thus, not accountable to the public—in fact, twelve of the eighteen were appointed by former Governor George Pataki even though he left office when the recommendations went into effect;¹⁵⁴ the state was divided into six separate regions, and New York City was considered one, single region despite having almost one-half of the state's population;¹⁵⁵ although the Legislature provided a list of factors for consideration, it gave no guidance as to the weight of each factor and even authorized the Berger Commission to devise its own factors for consideration;¹⁵⁶ the only opportunity for public comment was in public hearings held before Regional Advisory Committees (“RACs”)¹⁵⁷—not members of the Berger Commission—and the hearings were not transcribed or taped in any manner;¹⁵⁸ and the Berger Commission was not subject to New York's “Open Meetings Law”¹⁵⁹ and, therefore, conducted most of its deliberations in executive session beyond the purview of the public.¹⁶⁰

Until the recommendations were released on November 28, 2006,¹⁶¹ the general public could only speculate on which hospitals were at risk of closure since the Berger Commission's discussions

154. *Id.* § 2. The Berger Commission's recommendations went into effect on January 1, 2007, the same time Governor Pataki left office.

155. *Id.* § 7. David Sandman, Executive Director of the Berger Commission, noted that New York City made up forty-two percent of New York State's population. *SEE COMM'N ON HEALTH CARE FACILITIES IN THE 21ST CENTURY, LONG ISLAND, NEW YORK CITY AND NORTHERN REGIONAL OVERVIEWS 4* (May 11, 2006), http://www.ny.healthcarecommission.org/docs/2006-05-11_regional_overviews_presentation.pdf [hereinafter REGIONAL OVERVIEW].

156. Enabling Legislation, *supra* note 150, § 5.

157. A “Regional Advisory Committee” consisted of appointed members who were charged with the development of “recommendations for reconfiguring its region's general hospital and nursing home bed supply to align bed supply with regional and local needs.” *Id.* § 7(d). Although each RAC was required to submit recommendations to the entire Berger Commission, there was no equivalent requirement for the Berger Commission to consider those recommendations or explain its rejection of them. *Id.*

158. This is based on my personal observations at the RAC public hearings held in New York City and my office's effort to obtain a transcript of the proceedings. I was informed that no such transcript exists. The Berger Commission itself was not required to receive public comment from community members about its work. *Id.* §§ 7(d), 8(a).

159. The Open Meetings Law, N.Y. PUB. OFF. LAW § 100 *et seq.*, includes stringent requirements to ensure that the activities of public bodies are transparent and open to the public. For example, the public must be notified of meetings, which can go into executive session only under limited circumstances. *Id.* § 105.

160. Enabling Legislation, *supra* note 150, § 6.

161. *See generally* BERGER COMMISSION REPORT, *supra* note 92.

about hospitals took place behind closed doors.¹⁶² Thus local residents and community groups were not able to prepare beforehand for an announcement that their neighborhood hospital was subject to mandatory closure. Overall, the Berger Commission recommended the closure of nine hospitals throughout New York State—five of them were in New York City even though the occupancy rates of New York City's hospitals were higher than the state average.¹⁶³ Moreover, New York City's projected population growth far exceeded the state average. Indeed, it is the only region in the state where population is *increasing*, which raises questions of whether *more* hospitals would be needed in the future.¹⁶⁴ By the Berger Commission's own estimate, it would cost the health care system \$1.2 billion to implement its recommendations.¹⁶⁵

The structure of the Berger Commission's work made it impossible to scrutinize the accuracy of its findings before they attained the force of law. Shortly after the release of the Berger Commission's recommendations, the New York City Comptroller raised concerns about the availability of emergency rooms should those five hospitals close—an issue that was never openly addressed by the Berger Commission.¹⁶⁶ At least one hospital has argued that

162. See Jacob Gershman, *Closing Six Hospitals to Be Sought in the City*, N.Y. SUN, Nov. 22, 2006 at 1; Jordan Lite, *Hospitals on Critical List*, N.Y. DAILY NEWS, Nov. 20, 2006, at 10; Owen Moritz & Jordan Lite, *Hospitals on Dead List*, N.Y. DAILY NEWS, Nov. 23, 2006 at 46; Richard Pérez-Peña, *No Clues Yet as Health Industry Awaits a Report on Downsizing*, N.Y. TIMES, Nov. 27, 2006, at B1; Gail Scott, *A Dozen City Hospitals May Have to Close*, CRAIN'S N.Y. BUS., Nov. 20, 2006, at 1.

163. According to the Berger Commission, the occupancy rate of New York City's hospitals was 68.6% (compared to the state average of 65.3%) for licensed beds and 83.5% (compared to the state average of 77.6%) for available beds. BERGER COMMISSION REPORT, *supra* note 92, at 50.

164. REGIONAL OVERVIEW, *supra* note 155, at 6. In fact, the New York City Regional Advisory Committee, which made non-binding recommendations to the Berger Commission regarding New York City's hospital capacity, found that the "bed capacity is about right for current utilization in New York City" and recommended the reduction of only "paper"—or unstaffed—beds. COMM'N ON HEALTH CARE FACILITIES IN THE 21ST CENTURY, NEW YORK CITY REGIONAL ADVISORY COMMITTEE RECOMMENDATIONS 9 (2006) [hereinafter RAC REPORT], available at <http://www.nyhealthcarecommission.org/docs/final/appendix2-newyorkcityrac.pdf> (capitalizations modified).

165. BERGER COMMISSION REPORT, *supra* note 92, at 17.

166. WILLIAM C. THOMPSON, JR., OFFICE OF THE N.Y. CITY COMPTROLLER, EMERGENCY CARE: WILL IT BE THERE? ASSESSING THE IMPACT OF CLOSING FIVE EMERGENCY ROOMS IN NEW YORK CITY (Dec. 2006). A subsequent study by the Cambridge Health Alliance and Harvard Medical School proves that these concerns are well founded. Emergency room visits nationwide increased by 18-26% between 1994 and 2004 while the number of emergency departments decreased by 9-12% during the same time period. Andrew P. Wilper et al., *Waits to See an Emergency Department Physician: U.S. Trends and Predictors, 1997-2004*, 27 HEALTH AFF. w84 (2008).

the Berger Commission relied on inaccurate data, which it never had the opportunity to correct because there was no process to vet the findings.¹⁶⁷ Moreover, prominent public health scholars have discredited the underlying principle behind the Berger Commission's drive to close hospitals.¹⁶⁸ This principle called "Roemer's law" claims that unnecessary hospital admissions increase if there are more available beds.¹⁶⁹ Perhaps most disturbingly, the Berger Commission cited to a single study for the proposition that "hospital closures have a modest effect on access to care in urban areas."¹⁷⁰ That study actually found that "[i]ncreased distance to the closest hospital increases deaths from heart attacks and unintentional injuries"¹⁷¹ and that "the effect of closures [are expected] to be greatest on seniors and low-income patients."¹⁷²

This Article has no intention of debating whether the Berger Commission was correct in its analysis and recommendations. Rather, the key issue is the complete absence of an open, delibera-

As a consequence, the wait time to see a physician in the emergency department increased from a median of 22 minutes in 1997 to 30 minutes in 2004. *Id.* at w87-w88. These wait times were disproportionately longer for black and Hispanic patients (31 minutes for black patients and 33 minutes for Hispanic patients, compared to only 24 minutes for white patients). *Id.*

167. This hospital claimed that the Berger Commission underestimated its outpatient visits by 25% and overestimated its long-term debt by 39%. *See* Complaint at 10, *Albert Lindley Lee Mem'l Hosp. v. Comm'r of the N.Y. State Dep't of Health et al.*, No. 07-0509 (N.Y. Sup. Ct. Oswego County Mar. 8, 2007).

168. Professors Alan Sager and Deborah Socolar, Directors of the Health Reform Program at Boston University School of Public Health, cite to a study by the United States General Accounting Office that found "only a weak relation between bed capacity and volume of use of hospital care." ALAN SAGER & DEBORAH SOCOLAR, HEALTH REFORM PROGRAM, BOSTON UNIV. SCHOOL OF PUB. HEALTH, CLOSING HOSPITALS WON'T SAVE MONEY BUT WILL HARM ACCESS TO HEALTH CARE (2006).

169. BERGER COMMISSION REPORT, *supra* note 92, at 56.

170. *Id.* at 61.

171. Thomas C. Buchmueller et al., *How Far to the Hospital? The Effect of Hospital Closures on Access to Care*, 25 J. HEALTH ECON. 740, 740 (2005).

172. *Id.* at 743. Just prior to the release of the Berger Commission's final recommendations, the Primary Care Development Corporation and the New York City Health and Hospitals Corporation predicted that hospital closures would have a similar impact on low-income New Yorkers because of their greater reliance on hospitals for their primary care services. NANCY LAGER ET AL., PRIMARY CARE DEV. CORP. & THE N.Y. CITY HEALTH & HOSPS. CORPS., A PRIMARY CARE CAPACITY SHORTAGE IN NEW YORK CITY AND THE POTENTIAL IMPACT OF HOSPITAL CLOSURES 2 (2006). In fact, they found that "[l]ow-income New Yorkers are twice as reliant as New Yorkers as a whole on hospitals as their source for primary care." *Id.* at 10. Another report issued more recently by the Cambridge Health Alliance and Harvard Medical School has found wait times in urban emergency departments to be double the wait times in non-urban areas, further evidencing the vulnerabilities of urban communities to hospital closures, particularly for emergency conditions such as accidents and heart attacks. Wilper et al., *supra* note 166, at w88.

tive process by which individuals could challenge the commission's findings and ensure that they are, in fact, the best determinations. Essentially, the Berger Commission's structure and process were inherently antithetical to the civic republican principles of deliberation, equality, universalism, and citizenship. This is particularly troubling in the area of health care, where decisions—such as the closure of a neighborhood hospital—can have a tremendous impact on the lives of thousands of individuals.

Despite being shut out of the decisionmaking process, some communities have challenged the Berger Commission's recommendations. This Article discusses the efforts of two such communities: residents in the Northeast Bronx and Southwest Brooklyn, who are battling to preserve the services of two hospitals slated for closure by the Berger Commission. Yet again, community members are taking action as they fight to insert themselves into the public debate about their local health care in an effort to make the principles of civic republicanism a part of the State's health care policymaking.

1. *Mandated Closure of New York Westchester Square Medical Center in the Northeast Bronx*

The announcement that the Berger Commission had chosen to close New York Westchester Square Medical Center came as something of a surprise. The New York City Regional Advisory Committee, the local body that made non-binding recommendations to the Berger Commission, found that Westchester Square is “financially sound” and the “lowest cost hospital in the Bronx.”¹⁷³ The Regional Advisory Committee further found that the hospital is “a high quality provider” and the “number one choice of [neighboring] community residents,” serving a “primary service area [that] includes parts of . . . neighborhoods which are ‘stressed’ and ‘serious shortage areas’ for primary care.”¹⁷⁴ When making its final determinations, the Berger Commission made no effort to explain why it decided to reject the Regional Advisory Committee's recommendations and close Westchester Square, instead of other more financially distressed hospitals.

In essence, the Berger Commission members, who had no particular ties or accountability to the Northeast Bronx community served by Westchester Square, were authorized by the State to

173. RAC REPORT, *supra* note 164, at 12.

174. *Id.*

make an important decision about the community's health care without consulting the people affected by those decisions. Had the Commission sought information from community members themselves, it may have reached a different and far better conclusion. For example, the next closest hospital has wait times of up to nine to twelve hours in its emergency room for patients with serious illnesses, such as cancer and kidney failure.¹⁷⁵ Several area nursing homes relied upon Westchester Square for emergency medical care, which was crucial for elderly residents with life threatening conditions, such as strokes and pneumonia.¹⁷⁶ Furthermore, the hospital's patients and staff truly thought of Westchester Square as a "community hospital." Many of the nurses, in fact, had been born at Westchester Square and spent their entire nursing careers (up to thirty-three years) working there.¹⁷⁷

On January 3, 2007, NYLPI, in conjunction with pro bono counsel Chadbourne & Parke, filed a lawsuit on behalf of some of the community members who were concerned about the imminent closure of Westchester Square.¹⁷⁸ The clients, Mary McKinney and the members of Mechler Hall Senior Center, used Westchester Square for decades and were concerned about their access to care, especially emergency medical care, should the hospital be forced to shut down. Mary McKinney, a sixty-four-year old cancer survivor, suffered from severe asthma, erratic blood pressure, and debilitating arthritis.¹⁷⁹ In the prior ten years, McKinney had gone to Westchester Square more than four times due to asthma attacks, blood

175. See Affidavit of Hannah Acampora ¶¶ 3-7, 9-10, *McKinney v. Comm'r of N.Y. State Dep't of Health*, No. 6034/07 (N.Y. Sup. Ct. Bronx County Jan. 24, 2007); Affidavit of Winifred Kirby, R.N., ¶ 78, *McKinney v. Comm'r of N.Y. State Dep't of Health*, No. 6034/07 (N.Y. Sup. Ct. Bronx County Jan. 25, 2007).

176. See Affidavit of George Stops ¶¶ 5-6, *McKinney v. Comm'r of N.Y. State Dep't of Health*, No. 6034/07 (N.Y. Sup. Ct. Bronx County Jan. 23, 2007); Affidavit of Alexander Stern (Kings Harbor Multicare Center) ¶ 7, *McKinney v. Comm'r of N.Y. State Dep't of Health*, No. 6034/07 (N.Y. Sup. Ct. Bronx County Jan. 23, 2007).

177. See Affidavit of Mary McNulty ¶ 2, *McKinney v. Comm'r of N.Y. State Dep't of Health*, No. 6034/07 (N.Y. Sup. Ct. Bronx County Jan. 24, 2007); Affidavit of Colleen Molloy ¶ 2, *McKinney v. Comm'r of N.Y. State Dep't of Health*, No. 6034/07 (N.Y. Sup. Ct. Bronx County Jan. 24, 2007); Affidavit of Jeanette Torres ¶ 2, *McKinney v. Comm'r of N.Y. State Dep't of Health*, No. 6034/07 (N.Y. Sup. Ct. Bronx County Jan. 25, 2007).

178. See Michael Clancy, *Hospitals Get Judge's Reprieve*, *NEWSDAY*, Jan. 4, 2007, at A18; Dean Meminger, *Judge Signs Temporary Restraining Order on Hospital Closing*, *NY1 NEWS*, Jan. 3, 2007, http://www.ny1.com/ny1/content/index.jsp?&aid=65613&search_result=1&stid=19.

179. Affidavit of Mary McKinney in Support of Motion for a Preliminary Injunction and Application for a Temporary Restraining Order ¶ 1, *McKinney v. Comm'r of N.Y. State Dep't of Health*, No. 6034/07 (N.Y. Sup. Ct. Bronx County Dec. 30, 2006).

clots requiring surgery, and dangerously high blood pressure.¹⁸⁰ Her travel time to the next nearest hospitals would have doubled, causing particular concern since time is of the essence during an asthma attack.¹⁸¹ Likewise, several of the members of Mechler Hall Senior Center would suffer from the loss of Westchester Square's services. One member, Anthony Ortiz, was becoming progressively blind in addition to other numerous health problems.¹⁸² In 2006 alone, Ortiz had been hospitalized four times at Westchester Square, his preferred hospital.¹⁸³ One hospital that the Berger Commission found to be an adequate substitute for Westchester Square was not an option for him. Ortiz had previously been left on a stretcher for three days in that hospital because it was so overcrowded and he refused to go there again.¹⁸⁴ The Berger Commission, of course, had none of this information when it reached its decision to close Westchester Square.

The legal basis of the lawsuit was that the legislature delegated its lawmaking authority to an unelected commission in violation of the New York State Constitution's separation of powers.¹⁸⁵ What that meant in real terms is that the Legislature removed the closure of hospitals from the democratic process so that citizens, like McKinney and Ortiz, had no one to turn to with their concerns. This outcome is contrary to the state constitutional mandate that only the Legislature, which is politically accountable to its electorate, could actually *make law*. Our clients could not go to the State Department of Health because it was statutorily required to follow the law, nor could they go to their state elected officials, who played no part in the hospital closing decisions. They could not even go to the Berger Commission because it dissolved after the completion of its work. The entire decisionmaking process under the Berger Commission was fashioned specifically to ensure that there would be no accountability to local residents for decisions of great importance in their lives.

180. *Id.* ¶ 9.

181. *Id.* ¶¶ 13-14.

182. Affidavit of Deacon Dhoel Canals in Support of Motion for a Preliminary Injunction and Application for a Temporary Restraining Order ¶ 10, *McKinney v. Comm'r of N.Y. State Dep't of Health*, No. 6034/07 (N.Y. Sup. Ct. Bronx County Jan. 2, 2007).

183. *Id.* ¶ 11.

184. *Id.* ¶ 12.

185. Verified Complaint ¶ 1, *McKinney v. Comm'r of N.Y. State Dep't of Health*, No. 6034/07 (N.Y. Sup. Ct. Bronx County Jan. 3, 2007).

Although our clients initially obtained a Temporary Restraining Order to stop the closure of Westchester Square, their case was eventually dismissed because the court found that the Legislature delegated a “reasonable amount of discretion” with sufficient guidelines that had been necessarily general “due to the complexity” of streamlining New York’s health care system.¹⁸⁶ Leaving aside the state constitutional question of whether the Berger Commission’s unfettered discretion to pick and choose hospitals for closure—based on considerations of its own making—can properly be called “sufficient” legislative guidelines, the court’s reasoning has tremendous implications with respect to the community’s ability to influence public policy and hold their elected officials accountable. The court made the explicit point that the “complexity of the task involved” required the Berger Commission to be “accorded greater flexibility in resolving” the issues with its “specialized expertise.”¹⁸⁷ Yet, the court’s reasoning negates the value of a different sort of expertise—localized knowledge and experiences—that are equally important to issues of public concern. Furthermore, the logic of the court’s decision inescapably leads to the disempowerment of communities as their lives become more “complex” and therefore vulnerable to the discretions and greater “flexibility” of the so-called “experts” in unelected bodies.

2. *Mandated Closure of Victory Memorial Hospital in Southwest Brooklyn*

Victory Memorial Hospital filed for bankruptcy approximately two weeks before the Berger Commission issued its recommendations.¹⁸⁸ Thus, it came as no surprise when the hospital, located in the Southwest area of Brooklyn, was ultimately slated for closure.¹⁸⁹ As with Westchester Square, the Berger Commission reached its decisions without fully understanding the repercussions to the neighboring community, especially the large immigrant communities that relied on Victory Memorial’s culturally competent care. Also similar to Westchester Square was the recommendation of the New York City Regional Advisory Committee that Victory Memorial remain open, in this case because of its linguistic and

186. *McKinney v. Comm’r of N.Y. State Dep’t of Health*, 836 N.Y.S.2d 794, 805 (Sup. Ct. 2007), *aff’d*, 840 N.Y.S.2d 6 (App. Div. 2007), *appeal denied*, 848 N.Y.S.2d 26 (2007) (table decision).

187. *Id.* at 14.

188. Matthew Chayes, *Hospital’s Bankruptcy Filing Precedes Report on Closure*, N.Y. SUN, Nov. 17, 2006 at 3.

189. BERGER COMMISSION REPORT, *supra* note 92, at 151.

culturally competent care for the Muslim and Chinese communities and its service to the Bensonhurst-Bay Ridge community that faces “serious shortages in primary care.”¹⁹⁰ Cultural competency was of particular importance for the larger Arab community that lives near Victory Memorial, which hired an Arab community outreach coordinator, set up a *masjit* (prayer area) for its Muslim patients, and had contracts with several Arab-American physicians.¹⁹¹

The neighborhood of Bay Ridge-Bensonhurst in Southwest Brooklyn is the largest immigrant neighborhood in Brooklyn and the fourth largest citywide, with a population of 78,600 immigrants.¹⁹² Over forty percent of the residents in Southwest Brooklyn are foreign-born, and one-half of all residents speak a language other than English at home.¹⁹³ Additionally, 34,000 residents—one out of every six—are sixty-five years or older, a population that is particularly susceptible to health conditions requiring hospital care.¹⁹⁴ The New York City Regional Advisory Committee further noted that Victory Memorial was “one of the major providers in Bensonhurst-Bay Ridge,” accounting for half of all hospital admissions for this community.¹⁹⁵ These facts indicate that the loss of Victory Memorial could be devastating to the communities that it serves, especially when that care is culturally competent and neighboring hospitals have wait times of seven to eight hours due to overcapacity.¹⁹⁶

With the looming threat of Victory Memorial’s closure, the Arab and Muslim community in Southwest Brooklyn organized to form the Concerned Residents of Southwest Brooklyn (“CRSB”).¹⁹⁷

190. RAC REPORT, *supra* note 164, at 14, 36.

191. Letter from Nisha Agarwal, Staff Attorney, N.Y. Lawyers for the Pub. Interest, to Richard F. Daines, Comm’r, N.Y. State Dep’t of Health, app. C (Oct. 17, 2007) (Statement of Habib Joudeh) [hereinafter Joudeh Statement] (on file with author).

192. NEW YORK CITY DEPARTMENT OF CITY PLANNING, THE NEWEST NEW YORKERS 2000: BRIEFING BOOKLET 15 (2004).

193. These percentages were taken from the 2000 census for zip codes 11209, 11228, and 11214 that comprise Southwest Brooklyn. This information can be found in the “Population Finder” at <http://www.census.gov/>.

194. This information was taken from the 2000 census for zip codes 11209, 11228, and 11214 in the “Population Finder” at <http://www.census.gov/>.

195. RAC REPORT, *supra* note 164, at 14.

196. Letter from Nisha Agarwal, Staff Attorney, N.Y. Lawyers for the Pub. Interest, to Richard F. Daines, Comm’r, N.Y. State Dep’t of Health, app. B (Oct. 17, 2007) (Statement of Dr. Faiz Alzoobae) (on file with author).

197. The Concerned Residents of Southwest Brooklyn include Sakibeh Mustafa, Victory Memorial’s Community Outreach Coordinator, Salam Arabic Church, the Arab American Association of New York, the United American Muslim Association of New York, the Council of People’s Organizations, and the Arab Muslim American Federation. *Id.*

Having experienced retaliations from the September 11th terrorist attacks, many of CRSB's members had already engaged in community activism and became leaders of their community.¹⁹⁸ When CRSB members learned of Victory Memorial's mandated closure, they took a similar activist stance through participation in vigils and rallies and meeting with public officials and Victory Memorial's executives to ensure their concerns were heard.¹⁹⁹ CRSB also submitted information to the State Department of Health in support of a proposal to sell Victory Memorial to another Brooklyn hospital that planned on preserving critical health services in the Southwest Brooklyn community.²⁰⁰

In the civic republican tradition, CRSB's goal was to influence key decisionmakers in the State Department of Health and Victory Memorial with information that had been gathered from the community. CRSB's participation in the deliberative process, however, resulted from its own initiative despite resistance from both the State and the hospital. Victory Memorial repeatedly failed to share timely information with community members, and most recently terminated its labor and delivery services just four days before Christmas and nearly two weeks ahead of schedule.²⁰¹ Additionally, the State Department of Health rejected the proposal to sell Victory Memorial, and then placed the burden on CRSB, a coalition of local residents, to come up with a financial plan to save the hospital. Rather than calling upon the community for the expertise that they had (for example, the utilization of Victory Memorial's services, the specific cultural competency needs, and the barriers to seek care elsewhere), the State asked the community to devise a plan to preserve critical services where they were needed, a task that the State itself should be required to perform.

The campaign to save Victory Memorial is emblematic of the larger problem of "burdens" caused by the exclusion of community members from the deliberative process. Despite the activism of CRSB, the coalition faced an uphill battle in mobilizing a community that was already disheartened by the announcement of Victory Memorial's imminent closure. The burden of reversing a decision

198. Joudeh Statement, *supra* note 191.

199. Letter from Nisha Agarwal, Staff Attorney, N.Y. Lawyers for the Pub. Interest, to Richard F. Daines, Comm'r, N.Y. State Dep't of Health (Oct. 17, 2007) (on file with author).

200. *Id.*

201. See Harold Egel, *After 107 Years, Victory Hospital's Maternity Ward Heads to Fort Greene*, BROOKLYN DAILY EAGLE, Dec. 28, 2007; Joyce Shelby & Rachel Monahan, *Bay Ridge Hospital Shuts Baby Unit*, N.Y. DAILY NEWS, Dec. 21, 2007.

to close a hospital is far greater than participating in a process where a decision has yet to be made. Likewise, influencing the Berger Commission's recommendations would necessarily be less taxing and burdensome than attempting to fashion a way to save some of the hospital's services within the constraints of the commission-mandated closure. CRSB had the additional burden of coming up with a financial plan for Victory Memorial and navigating the complex landscape of bankruptcy law and health care financing—subject areas far beyond their expertise—because they were more committed than either the hospital or the State in preserving vital health services in the community.

CRSB's campaign to save Victory Memorial also illustrates the crucial nature of the "equality principle" of civic republicanism. Ironically, the community members of Southwest Brooklyn, which had the greatest stake in Victory Memorial's health services, had to force themselves into negotiations between the hospital and the State Department of Health, which considered themselves the only real decisionmakers. CRSB and other Southwest Brooklyn residents should instead be seen as equal partners in deciding what health care resources are needed in their community. The guarantee of such equality is especially important for groups like CRSB's members, which are often silenced by the prejudice and discrimination that continues to pervade public discourse. The rampant anti-Arab and anti-Muslim sentiments following the September 11th terrorist attacks, for example, should be taken into consideration when ensuring the equal participation of community members in the deliberative process.²⁰² As Professor Matsuda so eloquently stated, the inequities faced by CRSB's members, as well as the other community groups and residents discussed in this Article, cause them to "speak with a special voice to which we should listen" and place an even greater urgency to incorporate their concerns in decisions affecting their local health care.²⁰³

202. The discrimination experienced by Arabs and Muslims has necessarily caused some mistrust in how they are treated by both the government and private actors and how they are depicted in the media. One example of the source of this mistrust can be found in a blog responding to a *New York Daily News* article about Victory Memorial, which commented, "Afeela Habooza and his wife can't get what they need, like a female doctor and a special goat meat diet. Tough \$hit. Go the f back to your country so you can get what you so richly deserve." Comment by Byron (Dec 21, 2007 11:33:41 AM), in response to Joyce Shelby & Rachel Monahan, *Bay Ridge Hospital Shuts Baby Unit*, N.Y. DAILY NEWS, Dec. 21, 2007, available at http://www.nydailynews.com/ny_local/brooklyn/2007/12/21/2007-12-21_bay_ridge_hospital_shuts_baby_unit.html.

203. See Matsuda, *supra* note 31, at 324.

IV. CONCLUSION

This Article has attempted to provide dual arguments—one theoretical, the other empirical—in support of greater community participation and accountability in a comprehensive form of community health planning. As civic republican scholars have contended for over two decades, the principles of equal participation in a deliberative process will not only promote feelings of community and civic empowerment, but will also result in better decision-making as a multiplicity of possible alternatives are subject to scrutiny. Moreover, a deliberative process that incorporates the diverse voices of the *entire community* has more legitimacy and a greater likelihood of success as potential conflicts and disagreements are resolved within the decisionmaking process, rather than after decisions have already been made by a few select individuals.

Key policymakers have already raised the need for health planning and important developments are currently in motion. In remarks made in New York City, the Commissioner of the New York State Department of Health commented that the State might have avoided the Berger Commission if there had been long-term health planning in place.²⁰⁴ The chair of the State Assembly's Health Committee has included the reestablishment of a network of regional planning agencies as part of his universal health care proposal.²⁰⁵ The Finger Lakes HSA—the only fully operational HSA in New York State—co-sponsored a conference called “Avoiding the Next Berger Commission: The Role of Community Health Planning in New York State” with presentations by elected officials and health policymakers in support of community health planning.²⁰⁶ Finally, the New York City Council has commissioned a study of community health planning for New York City, which is due to be released in the summer of 2008.²⁰⁷

While the emerging interest in community health planning may be laudable, a crucial question remains as to what form of community participation and accountability will be included in health

204. Dr. Richard F. Daines, A Conversation with New York State Commissioner of Health, Robert F. Wagner Graduate School of Public Service at New York University (Nov. 7, 2007).

205. RICHARD G. GOTTFRIED, CHAIR OF ASSEMBLY HEALTH COMM., NEW YORK HEALTH PLUS: BETTER COVERAGE FOR ALL OF US AT LOWER COST 13 (Dec. 2007).

206. CTR. FOR GOVERNMENTAL RESEARCH & FINGER LAKES HEALTH SYS. AGENCY, AVOIDING THE NEXT BERGER COMMISSION: THE ROLE OF COMMUNITY HEALTH PLANNING IN NEW YORK STATE, CONFERENCE SUMMARY (2007), available at http://www.cgr.org/docs/Full_conference_Summary.pdf

207. *Id.* at 41-42.

planning. The stories of CSOH, SQUISH, Mary McKinney, Mechler Hall Senior Center, and CRSB demonstrate that community input in health care decisionmaking is not merely an abstract ideal of the democratic process, but a palpable need in the current health care system. It is clear that some form of health care reform will take place in the near future, but lawmakers must incorporate long-term planning that is inclusive of community voices to ensure the success of that reform. With or without the cooperation of government and the health care industry, community activists will continue to engage in a public dialogue about their local health care resources. In fact, a newly formed, citywide coalition of health policy experts and grassroots community-based organizations are currently advocating for both state and city funds to bring community-based health planning to New York City in a manner that ensures community participation and accountability.²⁰⁸ The challenge for state policymakers is to welcome that engagement in a manner that is meaningful, productive, and institutionalized within the health policymaking structure.

208. The members of the Coalition for Community Health Planning include Brinkerhoff Action Association, Bronx Health REACH, Brooklyn Perinatal Network, Coalition for Asian American Children and Families, Center for Independence of the Disabled NY, Commission on the Public's Health System, Community Health Care Association of New York State, Concerned Residents Organization, Jamaica Neighborhood Center, Joseph P. Addabbo Family Health Center, New York Immigration Coalition, New York Lawyers for the Public Interest, Opportunity Agenda, Primary Care Development Corporation, and Schuyler Center for Analysis and Advocacy.