

EIRFeature

To solve health care crisis, build hospitals!

by Linda Everett

For two decades, the determining factor in the delivery of health care in the United States has been “cost containment,” legislated by the U.S. government, and dictated by a gang of self-elected health care policy “experts” armed with two decades and billions of dollars worth of cost-efficiency studies. The stated aim has been to “downsize” the American health care system. Behind the relentless whining about the “excesses” of American health care, was a frenzy to dismantle the infrastructure that provided the backbone of American medicine.

As a direct result, the viability of America’s health care delivery system is now disintegrating. Many of our public hospitals, known as America’s safety net, are in such a dangerous state of disrepair that they could lose their accreditation. Hospital bed shortages are a plague in inner cities nationwide. Whole swaths of rural Texas, California, and other states are without hospitals, doctors, or the ability to deliver emergency care. In some California hospitals, so many emergency room patients line hospital halls on gurneys waiting for a bed, that area fire departments regularly issue citations.

Because beds in hospital intensive care units (ICUs) are rationed, doctors use computer systems to weed out patients with poor statistical odds for survival. The artificial cap on the number of ICU beds means that even those patients who would survive *with* critical care fall victim to “triage,” with the rationale that they would have survived only with a “poor quality of life.” Los Angeles emergency room physicians admit they are “required . . . to perform passive euthanasia.” Heart attack victims and patients with bleeding wounds have died in the halls because operating rooms were full, or because doctors are forced to prematurely remove them from ventilators.¹

The nation is in the midst of the longest-lasting shortage of registered nurses of any time since nursing data have been collected. Nurses in surgical units say they are so understaffed that, at times, they must choose which patient they will save and which they will let die. They must decide between the death of someone’s grandmother or a



One of the most important issues in the presidential campaign is how to assure quality health care for all Americans. But as long as the program is based on "cost containment," there is no solution. Shown here is the abandoned Children's Hospital in Washington, D.C.

mother's only son. Indeed, New York City physicians describe hospital conditions there as "worse than Beirut." Emergency rooms in Brooklyn are so wretched that physicians say they are forced to violate their Hippocratic oath.

In the past, these horrors could possibly have been dismissed as isolated or cyclical occurrences; but now they are cropping up ever more frequently as daily hindrances in the delivery of care. Overcrowded hospital emergency rooms in large cities, small towns, and even rural areas have created a state of crisis in over 41 states and the District of Columbia. The American College of Emergency Physicians warned in 1989 that the crisis threatens the health of patients as well as "the future of the country's hospital system."

The crisis, and the loss of life it incurs, was entirely predictable. To the degree that care is delivered, lives saved, and bodies healed, it is because dedicated medical personnel are determined to carry out the mandate of their profession, despite what they increasingly recognize as America's cost-containment "dictatorship" over medicine.

'Downsizing' health care

Before Hitler's National Socialists could implement their euthanasia program in the 1930s in Germany, they had to convince the medical profession that broad layers of patients had to be eliminated: The sick and handicapped had to die for the good of *das Volk*—the national body of the people, they argued. The same twisted reasoning is being applied today: In the late 1970s, Federal Reserve Board Chairman

Paul A. Volcker told Americans they had to lower their standard of living. In 1983, the federal government imposed a lower standard of medical care on the elderly and handicapped with the Medicare program's Prospective Payment System (PPS). Over the following years, PPS became the most radical of many government-enforced mechanisms to ruthlessly undercut the nation's ability to deliver health care then, and laid the basis for the later enforcement of even broader regulatory measures for "downsizing."

Under PPS, the federal government no longer reimburses hospitals for the actual costs incurred in the treatment of elderly and handicapped Medicare patients. Regardless of what a patient needs, or of the medical complications involved, under PPS, hospitals receive flat, pre-determined payment rates according to the patient's diagnosis, based on diagnosis-related groups (DRGs). Hospitals are fiscally put "at risk" with patients who need costly diagnostics or treatment. While initial chemotherapy for a patient with acute leukemia might have cost \$20,000 in 1987, DRGs paid only \$4,000. Hospitals could discourage or delay the patient's admission. Or, they could treat the patient and absorb the costs or pass them on to paying patients.

Internists, who most frequently manage hospital patients, reported that under PPS they felt pressured to prematurely release sick patients, and to underutilize medically necessary tests. Some 65% of those interviewed said that PPS seriously diminished the quality of patient care.²

The combined impact of PPS, stringent government regu-

latory constraints on hospitals, and plans with flat, per member fees like HMOs (health maintenance organizations) and their many derivatives, directly contribute to poorer treatment outcomes. One study found, "Hospital mortality rates were positively and significantly associated with the percentage of patients aged 75 years and over, with the percentage of patients with comorbid conditions and the length of hospital stay." In other words, the very sick elderly are triaged under PPS. Stringent certificate-of-need restrictions on new diagnostic technologies were also proven to "have particularly adverse effects on outcomes for patients with conditions most affected by the regulation."³

Medicare's PPS has had a disastrous impact on the nation's 5,384 acute care community hospitals that are the backbone of our health care infrastructure. These are the short-term, non-federal, general hospitals in rural and urban centers, under public or private (for-profit or non-profit) ownership. More than 558 community hospitals have closed between 1980-90. California has lost 54 facilities. Texas lost 92 hospitals since 1986, leaving 58 counties without hospitals. The Pacific and mid-Atlantic regions lost one-third of their facilities.⁴

The major causes cited for destroying the financial stability of hospitals are 1) Medicare's PPS, 2) low Medicaid reimbursements, and 3) other government cost-containment regulations. According to the American Hospital Association, more than 60% of U.S. hospitals lost money under Medicare in 1990. But, when combined with Medicaid—the federal-state program that provides health care for the poor—the impact is worse. Many fiscally strapped states deliberately underfunded the Medicaid program in order to balance their budgets. Others, like Oregon, reimbursed hospitals for as little as 54% of the cost of treatment to Medicaid patients. Some states failed to pay hospitals at all, or so delayed hospital reimbursements that "borrowing became a way of life" for hospitals. In Massachusetts, hospitals paid in excess of \$1 million monthly in interest on loans taken just to make ends meet. Hospital associations in dozens of states finally sued state Medicaid programs for fairer reimbursement rates.

Cutting the nation's safety net

In 1989, several hospital groups estimated that the trend to pay less and less of actual hospital expenses would mean that 2,700 more hospitals—40% of the total in operation—would close or convert to other uses by the year 2000, leaving only 4,100 hospitals nationwide.⁵

As the rate of collapse accelerates in federal, state, and county public health, drug abuse, and mental health programs, larger numbers of uninsured, impoverished, and immigrant people are seeking treatment in state- or county-subsidized public hospitals, known as the nation's "safety net." The urban public hospitals, frequently reeling from acute lack of funds and shortages, care for patients other hospitals won't treat. For this reason, the National Associa-

tion of Public Hospitals, which represents 100 of the nation's largest public hospitals, calls public hospitals the de facto national health care system in metropolitan areas. But many of these often ancient hospitals are in such a state of disrepair, that they are about to lose their accreditation.

Closing a public hospital that provides enormous number of services, however inadequate, has an immense impact on the population's ability to get care at all, and results in a significant decline of patients' health status.⁵ Kings County Hospital Center in Brooklyn, New York is one example. The 160-year-old, 1,200-bed structure is equipped with a major trauma center, a burn unit, a psychiatric center with a learning center for children with developmental disabilities, and an addictive diseases service. Kings County medical staff were the first to demonstrate that yellow fever is spread by the mosquito; its Renal Dialysis Unit pioneered in the treatment of kidney disease. The Center's Ambulatory Care Department is among the largest in the city, with 130 clinics. But, conditions at Kings County were so deplorable in 1991, that the head of the center's emergency department told *EIR* that the medical staff found flies in an operating room, landing on the exposed brains of a neurological patient during an operation. To replace Kings County Hospital Center, or any one of the massive public New York hospitals, is estimated to cost \$1 billion each.

The plight of rural hospitals

America's 2,460 rural hospitals, which constitute half of all short-stay, non-federal general hospitals, were hit the hardest by Medicare's PPS. Between 1983 and 1990, more than 270 rural hospitals closed, often with devastating impacts on their communities' economic health.⁶ Hundreds of counties no longer have hospitals. Now, as in the 1940s, people with injuries or in cardiac crisis may have to drive over 100 miles for care.

Medicare's DRGs effectively reversed what the 1946 Hill-Burton hospital construction program did to assure that rural families had the benefits of community hospitals. Hill-Burton provided funds to build 2,000 hospitals in rural communities during the 1950s and 1960s. Those hospitals thrived throughout the 1970s, until Medicare cut reimbursement rates to below hospital costs.

Rural hospitals, because of their areas' shrinking population base, have limited ability to raise revenues, and have less flexibility in upgrading equipment or renovating outdated structures. Their shrinking scope of services and fewer technological resources made it difficult to recruit and keep medical personnel without offering the higher wages of urban hospitals. Rural hospitals have a higher concentration of non-paying and elderly patients.

Under PPS, smaller hospitals can lose a year's profit on just one or two complicated cases. Despite the fact that median cost per patient is 20% higher in rural hospitals,⁷ the U.S. Department of Health and Human Services (HHS) set

The LaRouche program to restore health care

This summary of Lyndon LaRouche's health care policy was issued by Democrats for Economic Recovery, LaRouche in '92.

1) The prerequisite for restoring the U.S. health care system is to commit the nation to a program of building our way out of the depression. This requires federalizing the Federal Reserve, that is, transforming it into a national bank that would issue credit, in accordance with the American System economic principles of Alexander Hamilton, to revive the nation's collapsing water, power, transportation and urban infrastructure, while creating an initial 6 million productive jobs. This means ending once and for all the era of post-industrial madness, and necessarily includes a thorough restructuring of debt, including selected debt moratoria and cancellations.

2) A new Hill-Burton Commission shall be established to upgrade our health care system, to oversee the construction of new hospitals, medical centers, and long-term care facilities, and to equip them with the most advanced medical technologies. Hundreds of thousands of beds must be added, including those used for intensive care. Closed emergency wards and trauma centers must be re-opened, and new ones built. Public health services must be expand-

ed and improved. All of these must be staffed by far greater numbers of doctors, nurses, and other professionals, necessitating an expansion of our nursing and medical schools.

3) We must launch an Apollo-style, crash research program to fight degenerative diseases and epidemics with the best technologies available, especially employing the frontier technology of optical biophysics to find a cure for the species-threatening AIDS virus and other infections now careening out of control.

4) Fourth, the federal government shall regulate health insurance companies to ensure full payment of medical expenses and complete medical coverage for policyholders, with premium prices based on an average cost for entire communities, not on an individual's "risk factors." Forms will be standardized, and bureaucratic paperwork kept to a minimum.

The federal government will also provide a safety net for those without insurance, through revamped Medicare and Medicaid programs and a new catastrophic health insurance plan funded by the federal government. This will enable the restoration of our network of public and private hospitals. As people go back to work through the millions of jobs that this program will create, more and more employers and employees will be able to afford health insurance at the same time that the growing state and local tax base will increasingly be able to absorb health care costs, thus decreasing and eventually ending these federal subsidies.

Medicare reimbursement rates for rural hospitals at 39.6% less than urban hospitals for identical DRG cases. HHS employed fraudulent methodology to understate rural hospital cost increases, and arbitrarily adjusted downward the rural wage index.

In 1988, the National Rural Hospital Association sued the federal government on behalf of 2,700 rural hospitals whose administrations called the DRG payments "unconstitutional." The suit, which charged that the DRGs jeopardized the ability of rural hospitals to provide community service, is still not settled. Although there were small rate increases to bring rural rates up to par with urban rates by 1995, the damage was done: Three-quarters of rural hospital closures left frail, elderly people in rural areas without access to hospital care. Scores of hospitals were left at financial risk of failure, and 7,456 more rural hospital beds were cut between 1983-85. After PPS successfully deprived a significant number of rural counties of their only hospital, the congressional General Accounting Office "studied" the problems affecting the survival of rural hospitals, and recommended that only a federal initiative targeting rural hospitals would help.

The fact is, providing hospital care in rural areas is associated with higher costs, just as treatment for some patients is higher than others. The United States, as a nation, has to accept that responsibility—not penalize communities for existing in rural areas by triaging their acute care facilities and decimating their economy.

Standing room only

Even more dramatic than hospital closures, is the *loss of hospital beds* in urban and rural areas. By 1988, community hospital beds plummeted below the Hill-Burton standard of 4.5 to 5.5 beds per 1,000 patient population. Many states sank below their 1940 level. Of course, population shifts out of rural areas, an increasing ability to perform surgeries on an outpatient basis, shorter hospital stays, and fewer admissions under PPS all contribute to the need for fewer hospital beds. However, the drive to cut beds out of the system has more to do with the ideological drive to "downsize" our capacity to deliver care, despite the increased demands hospitals face in treating the growing elderly population, victims of AIDS, the HIV virus, and tuberculosis. Glenn D. Hackbarth, deputy

director of the Health Care Financing Administration (HCFA), which enforces Medicare PPS, made it clear in 1988: "We could do just fine with fewer hospitals than we have today."

Health care planning no longer considers the medical needs of the population. Instead, health care is purely cost-driven. Urban public hospital occupancy rates—the ratio of average daily census to the average number of beds maintained (staffed)—have skyrocketed. The maximum limit of operating efficiency for a general hospital was set at 80-85% occupancy rate by Hill-Burton. In 1989, the American College of Emergency Physicians warned that hospital occupancy rates higher than 85% severely curtail their ability to treat emergency patients properly. Public hospitals in New York City, Miami, San Francisco, Los Angeles, and Baton Rouge, Louisiana, now have rates of 102%.⁹ Others have occupancy rates over 85%, and some at 91%. And so far, no one has asked if hospitals with "low" occupancy rates, are actually an indicator of the medical interventions *not* being delivered to 25% of the American population who are uninsured and underinsured.

On Jan. 10, 1989, the New York State Department of Health surveyed all New York City hospital emergency rooms at midnight, and found 599 admitted patients waiting for beds. In response, the state installed an expensive computer system to monitor beds available throughout the sys-

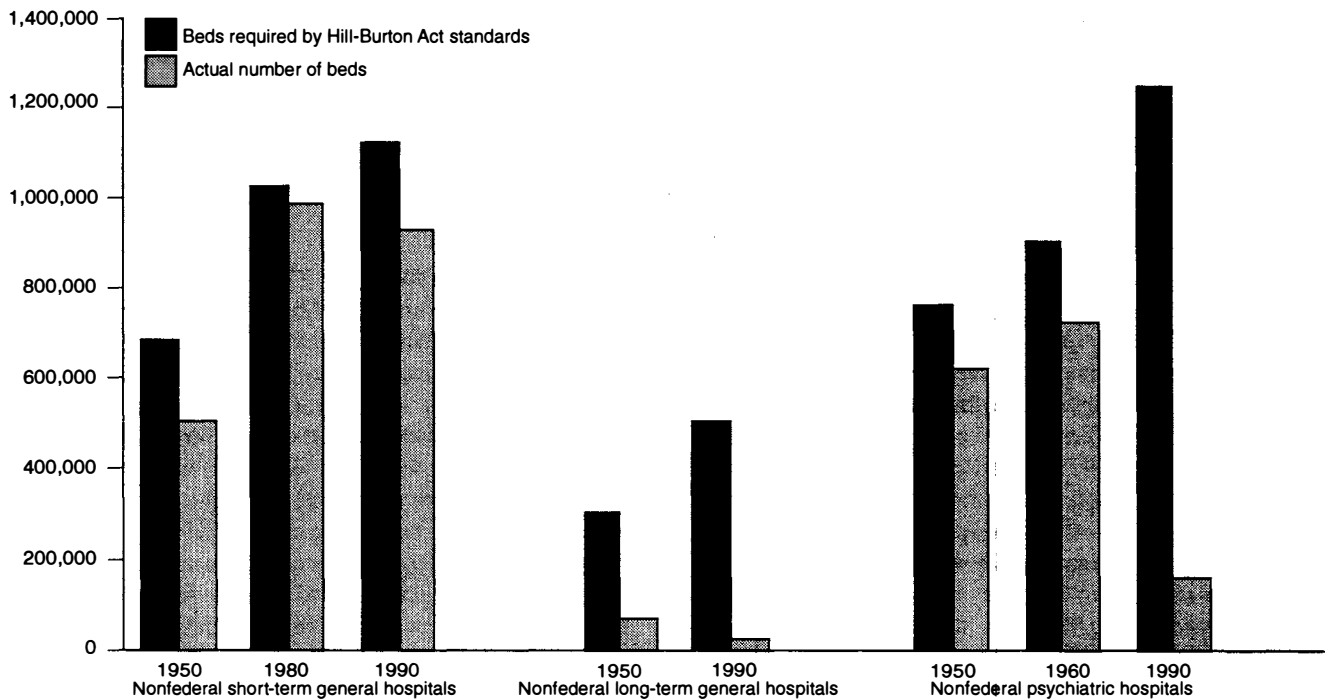
tem; but the crisis-management computer was no replacement for more beds: One year later, on Jan. 10, 1990 at midnight, another audit of the same hospitals found 960 emergency room patients waiting for beds. The number of emergency room patients during the surveys was *not* caused by any flu epidemic. If all this crisis management is needed for just normal daily operations, what happens when a calamity occurs, or a major epidemic?

Yet, last year, HCFA's director Gail Walinsky charged the hospital industry with wasting Medicare dollars on "excess hospital beds," claiming that "One out of every three hospitals beds in the U.S. is empty." What she neglected to mention, is the difference between *certified* beds and *staffed* beds. Hospitals "close" hundreds of beds because they don't have the nurses to *staff* them. Cutting beds is not a choice hospitals make voluntarily. New York State lost 5,000 beds by decertification in the last five years, and thousands more earlier than that, because hospital construction and capital acquisition are often tied to bed reductions, and federal regulatory formulas financially penalize hospitals with less than 85% census.

Emergency room nightmares

Such policies fuel the crisis in hospital emergency rooms in the country's largest cities, which now treat 104% more emergency patients than they did in 1980. There were a total of 92,080,647 emergency room visits nationally in 1991

Hospital bed shortage



alone. Emergency rooms (ERs) are overwhelmed with AIDS-related emergencies, the homeless, the chronically mentally ill, the deinstitutionalized mentally ill, and the escalation in drug-induced or violence-related emergencies, as well as those sick, uninsured patients who lack access to primary care. But, the American College of Emergency Physicians (ACEP) has found that overcrowding is not due to uninsured patients using ERs for “inappropriate care.”¹⁰ Emergency patients are sicker than they were ten years ago, and have more serious symptoms. Studies found many of those who leave the ER without care after waiting for hours, should have been hospitalized.

Overcrowding is so severe that ambulances are turned away from emergency rooms about 25% of the time. Among the causes: shortage of health professionals, too few ICU beds, high inpatient daily census, more uninsured patients, and hospital bed reductions. Also, private hospitals have been closing their ERs in order to eliminate the majority of non-paying patients. In Los Angeles County, where only 15 of the original 23 Los Angeles designated trauma centers still receive patients, 15 hospitals have closed or downgraded their previously fully functioning emergency departments to “standby status,” i.e., they are open to *only* walk-in or private ambulance patients—not 911 ambulances, thus eliminating most indigent patients. Ambulances are then forced transport patients to as many as four to six hospitals before finding an available bed.

Trauma centers could prevent tragedy

When hospital emergency rooms and intensive care units are so overburdened, it is likely the crisis will compromise a region’s trauma care centers as well. While most hospitals have emergency rooms, only 11% have fully staffed and equipped certified trauma centers. All existing trauma centers are hospital-based. Trauma care could save as many as 64% of the 140,000 Americans who die from injury every year. But there has never been a federal mandate to form a nationwide network of centers.

The concept of a trauma system began with the wartime experience of military doctors during World War II, and the Korean and Vietnam wars. They found that getting critically injured soldiers to a skilled surgical team within the “golden hour” after injury saved lives normally lost. Plans to apply the trauma care approach to civilian emergency care on a regionalized system began in late 1960. But, by 1988—22 years after the initial recognition of the need for a national network of trauma centers—implementation had almost stagnated. At that time, only Maryland and Virginia had all the components of a regional system in place. The District of Columbia and 19 other states had incomplete statewide coverage, or lacked essential components. Twenty-nine states had yet to initiate the process of designating trauma centers.¹¹

Each state has its own criteria for what constitutes a trauma center: What is considered a Level II center in one state,

may be Level I in another. Although the American College of Surgeons Committee on Trauma has standards for trauma center classification, it is up to the state health departments to utilize them. Without universal certification criteria, major discrepancies abound. For instance, the American Hospital Association found that 1,000 general hospitals had certified trauma centers in 1987; by 1989, only 664 existed. A government study shows 370 centers nationally, with an additional 65 that closed over the last five years. However, a recent survey of all state Emergency Medical Services directors, using the ACS’s criteria, found the actual number of trauma centers to be about 250, with 61 centers closing in the last two years. The majority of centers closed because the high costs involved were never covered by Medicare or Medicaid, and because of uncompensated care in general. The Trauma Care Systems Planning and Development Act of 1990 committed \$60 million over three years to assist in the establishment and support of centers. However, even these funds appear to have evaporated.

Can the vicious cycle be broken?

Certainly, large numbers of private community hospitals have survived and managed well despite the destructive policies described here. Those economically viable hospitals may have the financial flexibility to maneuver beyond the crisis of low reimbursements. They may have a “good” patient mix that allows them to shift costs to private payers. But Medicare and Medicaid are being used to gut the system further. As capitated and managed care programs are expanded, both they and private insurers will heighten their competitive frenzy to increase profits. They will do so at the expense of hospitals, by excluding larger chunks of hospital expenses incurred in inpatient and outpatient treatment (as in HCFA’s bundling plan), medical education, and capital projects, among others.

The result is a slow, now recognizable strangulation of a hospital’s ability to develop innovative services, replace outmoded equipment, or make plant renovations. This leads to cash flow problems, resulting in poorly maintained equipment, loss of staff, loss of vendor credit, and inability to purchase critical medications and supplies. At that point, many hospitals “go bare,” that is, they simply drop their professional liability insurance, and use the cash to cover payroll or to purchase needed medications. Once it is evident that the quality of patient care suffers, physicians no longer admit their patients.¹² Developers, in turn, are dissuaded from bringing newer, more efficient life-saving technologies online if hospitals are unable to purchase them or will not be reimbursed for using them, no matter how much new technologies save lives and pay for themselves. Such hospitals then become part of expected “shakeout” of hospitals which couldn’t “compete.”

Hospital administrators who feel secure now should understand that there is no stopping sharks in the middle of

a feeding frenzy. In the present system, government cost-efficiency "experts" see hospital capital infrastructure funds as "fat" to be cut from reimbursement rates. Managed care operators see such funds as being taken out of their potential profits. They will therefore demand deep rate discounts from the hospitals, and with each cut and discount, hospitals lose future viability. Note, too, that health care cost-management is the fastest growing segment of the health care industry. It rakes in \$7 billion a year—dollars that once went into the delivery of health care to patients. Now, it fuels an "industry" built largely on sucking profits out of "managing" the collapse of health care—the antithesis of what once was the medical profession's impetus, and this nation's commitment to developing the medical science and technologies to defeat disease and enhance human life.

Notes

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Candidates vie for ways to cut health care

In the wake of Sen. Harris Wofford's (D-Pa.) successful 1991 electoral strategy of championing health care reform, all the so-called front-running presidential candidates have jumped on the "health reform" bandwagon. With the notable exception of Lyndon LaRouche, they have adopted one or another incompetent prescription for overhauling health care, generally advocating some form of universal insurance coverage, while making cost containment the linchpin: that is, limiting the scope of coverage, treatment, and payments to doctors and hospitals.

George Bush's plan is an attenuation of the conservative "market competition" program of the Heritage Foundation. Its centerpiece is a series of vouchers, tax credits, and tax deductions, up to \$3,750 per family, which would supposedly enable these families to purchase health insurance. Yet insurance costs an average of \$5,000-8,000 per year. Bush has virtually no specifics on how he would fund this expanded coverage, other than to propose a cap on Medicaid increases, which would result in less coverage and lowered eligibility for the poorest people. His proposed Health Insurance Networks would function like HMOs, to further restrict payments to health care providers.

In their emphasis on "managed competition," **Paul**

Tsongas's proposals are closest to Bush's among the Democratic contenders. Tsongas would have health care providers bid for contracts from health insurance groups—either large companies, groups of small employers, labor unions, or so-called public plans that government would fund to cover the uninsured. Again, the aim is to limit medical treatment in order to contain costs.

Bill Clinton is pushing what is essentially the "pay-or-play" plan of the Democratic congressional leadership, in which employers would either provide health insurance or pay a tax into a government insurance fund. This fund's expenditures would have a Federal Health Expenditure Board—cost-cutters who would impose spending caps and, like the Medicare and Medicaid programs, limit the scope of treatment.

Bob Kerrey, who dropped out of the race after the March 3 primaries, called for a national universal health insurance system similar to Canada's, which would replace employer plans as well as Medicare and Medicaid. The federal government would then impose heavy new taxes to fund the system, and set a "global" budget—that is, fix the total amount of health payments, regardless of need. Both private and state-run insurers would compete for the funds, with the bulk of money going to the bidders, who will most rigidly enforce cost controls and limit treatment.

Neither **Jerry Brown** nor **Tom Harkin** has spelled out specific programs. **Pat Buchanan** has said little on the issue, other than vague talk of "medical IRAs."