Will the U.S. health system become the new Nazi model?

by Linda Everett

Before the Nazi regime could initiate the medical butchery that later so stunned the world, they had to effect a thorough transformation of the German medical profession. The traditional medical ethic that doctors should under no circumstances take a patient's life, was attacked as "erroneous." For under the Nazi regime, euthanasia for the incurably sick and insane, was considered the most "merciful treatment" and "an obligation to the *Volk*."

The new medical ethic meant doctors had to be more concerned with the health of the *Volk* than with the individual. They were "doctors to the *Volkskörper*" (the national body or people's body). This demanded, according to Nazi medical professor Rudolf Ramm, "a change in the attitude of each and every doctor, and a spiritual and mental regeneration of the entire profession." This reorganization process was known as *Gleichschaltung,* or a meshing of gears of German medical layers in either a voluntary or coercive unification with Nazi ideological requirements.

There is alarming evidence that we in America are today witnessing just such a "meshing" within our health care system. While not exactly a direct analogy to the Nazi concept of "duty to the *Volk,*" American doctors are being told that they have to subordinate the interest of the individual patient to live, to the budget restrictions of the economy as a whole. What monetarists inside and out of government have created over the last decade and half is a monstrous machine which, under the guise of cost-containment, systematically dismantles the science, education, and practice of traditional medical care. To the degree our health care delivery system contributes to its fundamental purpose in nurturing human life, it is especially targeted by recurrent budget cuts, managed health care schemes, and mandatory "quality of life" protocols.

But the goal is actually not to save costs, even if the Health Care Finance Administration's (HCFA) William Roper employs an army of actuaries whose expertise is used not unlike that of the Nazis who hit upon the cost-efficiency of making soap out of the carcasses of work camp victims. By one estimate, an outrageous 15-25% of every dollar spent on health care annually goes to "researching" the development of new cost-containment schemes!

Perhaps America's health care system has not been ordained to sacrifice the sick for the health of the *Volkskörper*—yet.

But what is clear, is the signal emanating from Wall Street, the insurance cartels, and the ruling hand of the Eastern Establishment, all of whom are committed to the economic and industrial collapse of the country. To guarantee their monetarist grip, America's health care vision must conform. It cannot simply be shrunk or distorted—the vision must be destroyed, lest the nation continue to demand the science, hope, and manpower to overcome the numerous medical crises before us.

Right now, doctors are being trained to think primarily about the "financial ramifications and cost-benefit equations" of their treatment decisions; elderly patients are brutally manipulated into believing that saving them deprives the next generation of "dwindling" resources; indigent pregnant women, desperate for critical prenatal care, are set against the needs of heart and cancer patients; and AIDS victims are told to go die quietly in a hospice.

No, our sick and elderly are not yet dying for the *Volk,* but they are daily triaged for an economic regime that differs from Hitler's ravages only in degree. The destruction of America's health care system is now rapidly approaching the point of no return.

The fallacy of cost-effective health care

The incessant screaming about the costs of health care set the stage for handing over the reins of the nation's health care to a bunch of fiscal experts who have no compunction about sacrificing tens of thousands of lives. The fallacy of such supposed cost-containment or budget-gutting behavior can be seen in the total collapse of the health care delivery infrastructure and its supporting industry today. And the patient, at the mercy of such cutthroat behavior, ends up dead. As one medical economist noted, "The ultimate economy in medicine is death." Here are two examples.

- Last year, 14 congressmen had to sue to get HCFA to stop killing people by illegally and repeatedly denying Medicare benefits to thousands of elderly patients for "part-time or intermittent" home health care. After home care

benefits were drastically cut in the early 1980s, HCFA then launched further restrictions that were never published or debated. It refused to pay for home care for more than four days a week—no matter how little time each day that care took. So patients who needed care for one hour a day for five days a week, were denied care, while those who needed 27 hours of care over four days qualified for it. When someone needed help for five different days, he was denied benefits for the fifth day and lost Medicare coverage for the other four days as well. Medicare continued to illegally deny the claims of patients who won their appeals again and again. One patient died after her fourth successful appeal. The Federal District Court judge in the case labeled the government's action as "reprehensible." We call it murderous. These are not bureaucratic oversights.

- In October 1988, HCFA tried the same underhanded conniving when it announced to home care providers that Medicare would cut reimbursement for in-home dialysis treatments by 48%. Neither the 20,000 patients depending on these services nor their providers were consulted, nor was there the mandatory comment period. Home health care companies based their reimbursement rate on exactly what Medicare itself proposed for the treatment five years ago! Essentially, Medicare tried 1) to intimidate home care providers to cut costs and make it financially impossible for them to operate; 2) to eliminate the large majority of immobilized sick and elderly patients unable to travel for dialysis treatment; and 3) to shift all costs to Medicaid of patients who must be lifted and carried by trained personnel in ambulance transport three times a week (easily $100 per round trip three times weekly). The intention here was not cutting costs but cutting out, much as Britain has, a whole segment of the population past a certain age or illness level which the government no longer intends to have treated. Again, this after a court injunction restrained HCFA's actions.

Social Security gendarmes

The same relentless preying on the disabled appears endemic in the Social Security Administration. SSA has a campaign to intimidate, punish, and coerce the 700 independent judges who review appeals of those who have been denied Social Security benefits into reducing the benefits the judges award. Any judge who awarded benefits in 70% of his cases was targeted for review by SSA. Again, only a lawsuit (from the Association of Administrative Law Judges) stopped SSA's actions.

Now, SSA wants its own staff attorneys to be appointed judges to decide these cases, and thus totally control the appeals process according to the budget restrictions SSA sets—not according to the very real needs of the disabled. It is no wonder then that the SSA would consider drastically restricting the ability of millions of elderly and disabled people to appeal the government's denial of their Social Security, Medicare and welfare benefits. With the government losing 50% of the appeal cases in which the blind, disabled or aged were unfairly denied benefits, the new plan to limit evidence would have "saved" billions.

Who is fooling whom? Is the country "saving" anything or are we just dismantling our health care capability? When each HCFA or foundation or insurance company "study" is activated, another part of the patient population is targeted for triage.

Framework for rationing in place

The framework for rationing medical care is already in place, the Perspective Payment System (PPS). Since its inception, Medicare's PPS has so underpaid hospitals for treatment of elderly patients that it is frequently charged with causing patient dumping, premature discharge of elderly patients, destroying the financial stability of hospitals, and fueling the nursing shortage. By the government's own accounting last summer, the hospital market basket has increased by 28.3%, while Medicare payments have increased only 12.16%. Government costs restraints mean that 60% of all hosptials will lose money this year, for others, the profit margin is "zero."

Because Diagnosis-Related Groups (DRGs)—through which the Medicare system sets fixed payments for a given treatment, regardless of the hospital's actual costs—do not cover the complicated medical treatment of chronically ill or long-term cancer patients, just a few of these cases can put a smaller hospital on the brink of bankruptcy. Over the last two years, 160 of those community hospitals did just that and closed.

To stave off impending crisis, the National Rural Hospital Association filed suit on behalf of some 2,700 rural hospitals against the federal government calling its Medicare payment system to rural hospitals "unconstitutional." The Department of Health and Human Services (HHS) is using the 1946 Hill-Burton Act to further cut reimbursement to rural hospitals. Hill-Burton's "community service" stipulation is construed by HHS to mean that rural hospitals cannot turn away patients, including Medicare patients, no matter how low the reimbursement. The hospital's ability to provide community service and free care is jeopardized and thus, their due process rights are violated. Urban hospitals receive an average of 39.6% more than rural hospitals in payments for each DRG. As a result, over 87 rural hospitals shut down in 1986, another 40 community hospitals closed in 1987, and some 600 more rural hospitals are expected to close by 1990.

The nation's network of emergency service, initiated through the Federal Emergency Medical Sevices Act of 1973, is also being dismantled. With the 1981 Omnibus Budget Reconciliation Act, the federal government shifted the burden for financing sick services back to the states and local governments. This left vast portions of our rural areas without even a working ambulance or rescue capability to get patients to hospitals 30 to 45 to 60 minutes away. The national net-

work of regional trauma centers that can handle major disasters with special personnel and equipment and blood supplies, appears permanently stalled as well.

The damage from DRG under-reimbursement rates from Medicare, Medicaid, and private insurers is compounded as states run out of Medicaid funds. Whole swaths of some cities are without hospitals altogether. Texas, Florida, California, Illinois and a host of other states increasingly face emergency room closings or have emergency care available on intermittent or "standby status" only (closed to ambulances), according to bed availability.

With DRGs, came the predictable reduced length of hospital stay and less bed utilization. Per diem costs for non-Medicare patients zoomed since fewer patients absorbed the same overall expenses. With less utilization, Medicare cost-cutters, totally aloof to the medical needs of an increasingly sick indigent population and to AIDS patients, demanded that hospitals decertify more beds or face penalties. Beds were cut, but it is only a matter of time before cities in general will face the resultant crisis now seen in New York City.

Hospitals that are 'worse than Beirut'

One physician, with the appropriate experience, has characterized New York's hospital conditions as "worse than Beirut." Patients with heart attacks and strokes now often wait 12-36 hours to get into intensive care units. On any given day there are 400-500 patients waiting for a bed. For weeks, acutely ill patients are kept and treated in emergency rooms. Receiving their medications and meals is totally contingent on whether staff from other parts of the hospital are available to administer it. Patients wait 7-8 weeks for elective operations, if there is a doctor available to do it. Otherwise, these full-paying patients seek out a different hospital.

Now the state will install an expensive computer system to monitor the number of beds available throughout the system to shuffle emergency patients from hospital to hospital. Up until last year, the state was still calling for removing hospital beds from service "to save money." Over the last decade, over 13,000 hospital beds were decertified. All of this crisis management is needed just for normal daily activity, but what happens if a calamity occurs?

Yet, HCFA's second in command, Glenn D. Hackbarth says, "We could do just fine with fewer hospitals." Hackbarth states unequivocally, "In the next 5 to 10 years, we can do with fewer hospital beds than we have today. We don't need as many hospitals as we have right now." HCFA, William Roper, and Hackbarth are all looking at balance sheets—not lives—and criminally ignore the increasing needs of our growing elderly population and the catastrophic devastation by the AIDS epidemic.

With DRGs, physicians are pressured to release patients before it is medically appropriate and to dangerously delay admitting elderly patients until they "are sick enough" to pass DRG criteria. They are threatened with sanctions from the

Peer Review Organization (PROs) unless they change treatment patterns for what they consider "medically inappropriate" reasons. PROs directly contributed to the demise of rural hospitals.

Certificate of need programs and other stringent economic rate controls used to slow the acquisition of advanced diagnostic equipment and technology has been cited a possible cause contributing to higher death rates among patients in heavily regulated hospitals than those with less government regulation. Yet, HCFA's William Roper says "continued restraint . . . is necessary and does not compromise beneficiaries' access to the quality of care they receive." But the fallacy of cost-effective medicine has been demonstrated repeatedly in the way it jeopardizes not only the lives of individual patients but also the viability of America's entire hospital system.

The present climate against new medical technologies is actually undercutting the country's capacity to spur new breakthroughs in medical-scientific fields. Investors are dissuaded from developing new life-saving technologies because it is unlikely that financially strapped hospitals will purchase or be reimbursed for using them. Yet, not only does the newer equipment pay for itself, it saves more lives than outmoded technology.

With DRGs came an oppressive demand for documentation. Hospital administrators saw a 100% cost increase from paperwork alone. They were forced to cannibalize medical staff and critical diagnostic equipment for accountants, form processors, and sophisticated cost-calculating computers. Fewer lab technicians led to slower and less accurate testing.

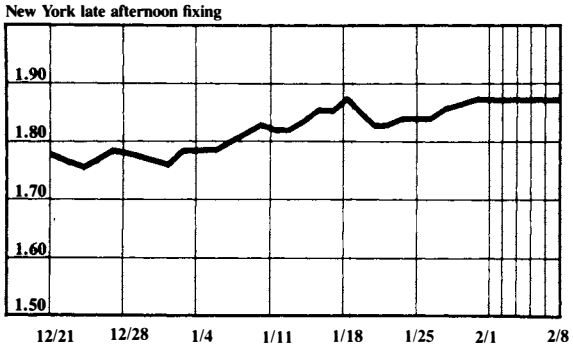
Underpaid, overworked nurses are driven out of their field by the burden of regulatory documentation and expanded patient load. Medicare budget cuts meant hospitals laid off 125,000 licensed practical nurses and nurses' aides since 1983. That forced medical facilities to have registered nurses perform non-nursing duties that take up 10-60% of a nurse's time. By 1986, a shortage of nurses was reported by 83% of U.S. hospitals. Now, 18% of the nation's hospitals turn away patients due to shortages. In some New England Veterans Administration hospitals, *over half of the beds were taken out of service* due to lack of staff. Thus, as a direct result of "cost-effective" policies, the nursing crisis has become so acute that HHS had to established a totally new Commission on Nursing to study the frightening shortage of 600,000 nurses by the year 2000.

With sharp reductions in hospital nursing staff, patients who need assistance with eating do not get it. Instead, they starve. Some 60,000 patients die of starvation in U.S. hospitals every year. One-third of all U.S hospital patients are malnourished and a half-million more face critical complications because of it. If a patient loses 30% of his ideal body weight in the hospital—as one-third of all patients do—the chance of his or her living through an operation is reduced to about 5%!

Currency Rates

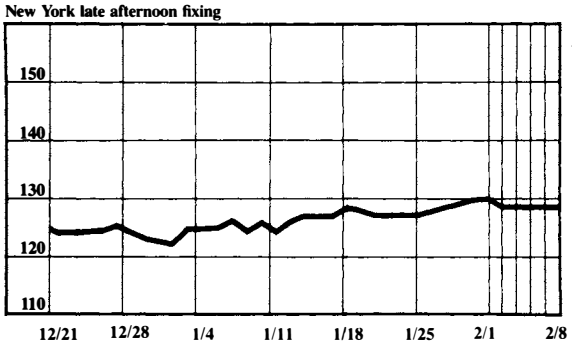
The dollar in deutschemarks

New York late afternoon fixing



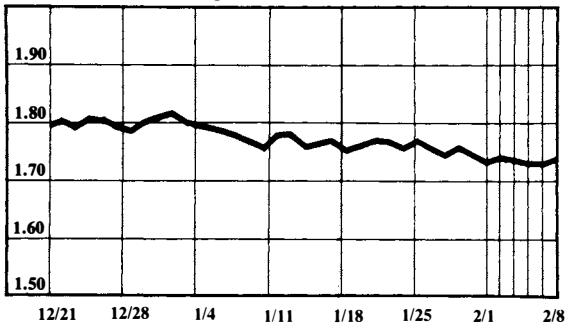
The dollar in yen

New York late afternoon fixing



The British pound in dollars

New York late afternoon fixing



The dollar in Swiss francs

New York late afternoon fixing