Breakdown of U.S. health care parallels economic collapse

by Steve Parsons

On the eve of America's victory over the Nazis, Sen. Lister Hill of Alabama submitted legislation to Congress that expressed the nation's renewed commitment to the preservation and enhancement of life. Hill's vision, as he told the Senate on Feb. 26, 1945, was "a long-range, scientifically planned health program . . . to the end that scientific health care is readily available to all our people . . . in order to ensure that in time all parts of the country will be adequately served." Hill specified that this act was fundamental to "the practice of preventive medicine or public health," and said he believed in a "*solution* to our national health problem," the prerequisites of which were "adequate hospital and public health facilities."

In the decades since Hill laid out that vision, we built up a modern health care system that was within the reach of most Americans. And then, as the economy underwent a shift away from real industrial and agricultural production, toward "services" and usury, we have virtually succeeded in wrecking that achievement. As this article will document, this has occurred under the deliberate guidance of a gang of "experts" who believe in a Nazi concept of "triage"—the provision of health care only to those whom *they* deem worthy of it.

Senator Hill explained in his testimony that his initiative was in no small part motivated by the enormous disparity between the preeminent position of the United States in the postwar world and the pathetic condition of much of the population with little or no access to health care. This was driven home to him by "the shocking fact that nearly 40% of our young men of draft age were found to be physically unfit for military duty."

The Hill-Burton Hospital Construction Act was passed 18 months later in August 1946, and embarked the United States on a decade of unprecedented expansion of the nation's hospital and public health system. Various agencies on the federal, state, and local level worked remarkably efficiently and with a minimum of red tape to inventory existing hospitals, survey construction needs, develop programs for construction of both public and non-profit community hospitals, and, in the final phase, build new facilities.

Although the federal government often provided the majority of funds for these projects and contributed its technical experts and national perspective, Hill specified that the federal bureaucracy must not end up running or dominating these institutions or their decision-making process. It is imperative, he said in testimony in February 1945, that "local initiative be preserved and encouraged as essential to the success of any health program." The purpose, he stressed, "is to assist and encourage the states to correlate and integrate their hospital and public health services and to plan additional facilities."

The role of the Public Health Service

Central in the planning coordination of these efforts was the U.S. Public Health Service which, in 1950, drew up a plan of local public health service areas to be served by 1,228 health units for the nation's 3,069 counties. It stressed that these plans intermeshed with plans for existing or proposed general hospitals and health centers, and set minimum standards and goals for both personnel and bed space—for example, one public health doctor per 50,000 people, and one public health nurse per 5,000 people.

The Public Health Service proposed that local health units be linked with community hospital facilities so as to be able to "perform the function of coordinator of community health and medical services. . . . It would give health departments and general hospitals the joint use of expensive and specialized diagnostic equipment . . . [and] to share the specialized professional personnel. . . . It would form the basic framework for the establishment of local health programs in the control of cancer, diabetes, heart disease, and other chronic illnesses which are today's greatest challenge to public health. Moreover, through regional coordination of both hospitals and health units, a natural flow of health services, preventive and curative, would be achieved—from the simple to the complex, the routine to the specialized, from the small local hospital and local health unit to the sizable integrated medical center," according to J. Frederic Dewhurst Associates in "America's Needs and Resources: A New Survey," published by the Twentieth Century Fund in 1955.

Along with other programs, such as upgrading nursing services and locating veterans hospitals near medical schools so that medical students could both staff and train at them, the U.S. health system became an integral feature of the postwar economic expansion and a scientific optimism that would soon enable man to soar into space. The number of

hospitals and public health facilities increased substantially. During the years 1946-50, almost 600 general hospitals opened, with an average of about 40 being added each year through the mid-1960s.

Affordable health care

In the postwar period, the rising standard of living and gains in economic productivity brought medical care increasingly within the budgets of more and more Americans. In what seems incredible today, the Twentieth Century Fund study observed that "medical prices during the war and postwar years have *lagged considerably behind prices in general*. The price of all goods and services in 1950 was up 72% from the 1935-39 level, whereas the price of medical care and drugs had risen only 48%; by 1952, the consumers' price index had risen 90% and the medical care and drugs index 64% over their 1935-39 averages. Of all medical care items priced, hospital rates alone rose more rapidly than the price of all goods and services." Wages rose much faster.

In 1952, for the growing number of people who purchased health insurance, the combined premiums for Blue Cross/Blue Shield hospital, surgical, and physician coverage were just $6.65 a month, or $80 a year—just over one week's wages. The same amount of medical care, drugs, and physicians' services that consumed a week's worth of wages for the manufacturing worker in the last half of the 1930s, cost just *half* a week's wages in 1952. Back then, the average hospital stay cost less than two weeks wages for such a production worker (see **Figures 1** and **2**).

At the same time, those who could not afford private hospital treatment could increasingly get care, especially in urban areas, at the growing network of voluntary and public hospitals, with the expenses covered by a combination of public funds, philanthropic gifts, and small surcharges on paying patients.

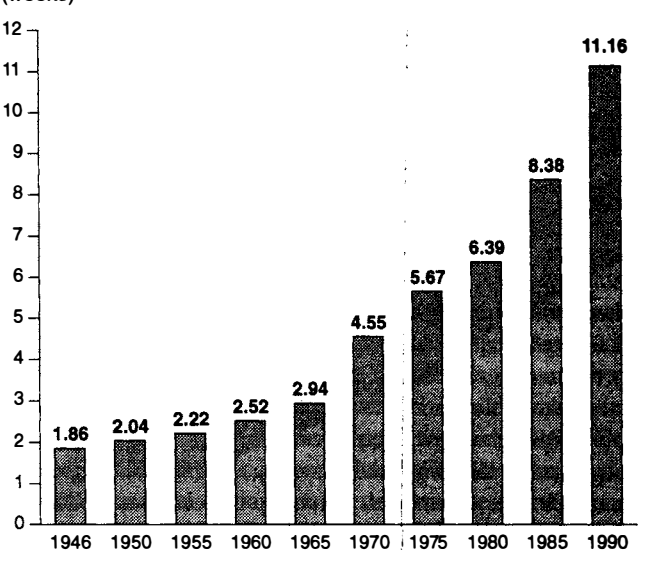
Underlying the growing availability and affordability of medical care was the fundamental approach and attitude resulting from accomplishing so many "impossible" tasks during World War II, ranging from harnessing the atom to doubling industrial output in less than four years. The Hill-Burton Act represented an approach in which Americans in the postwar period, at least until the mid-1960s, tended to define problems and set goals for solving them not based on "cost efficiency," but on getting the job done to improve the human condition. In most cases, hospitals and physicians provided the best care available for their patients regardless of cost—an attitude made possible by increasing productivity in an affluent economy and the concomitant cultural optimism.

The 'post-industrial society' shift

The root of the financial problem in our health care system stems from a shift away from that attitude and the investment policies that fostered economic growth. While the Hill-Burton Act resulted in substantial expansion of health care, it

FIGURE 1

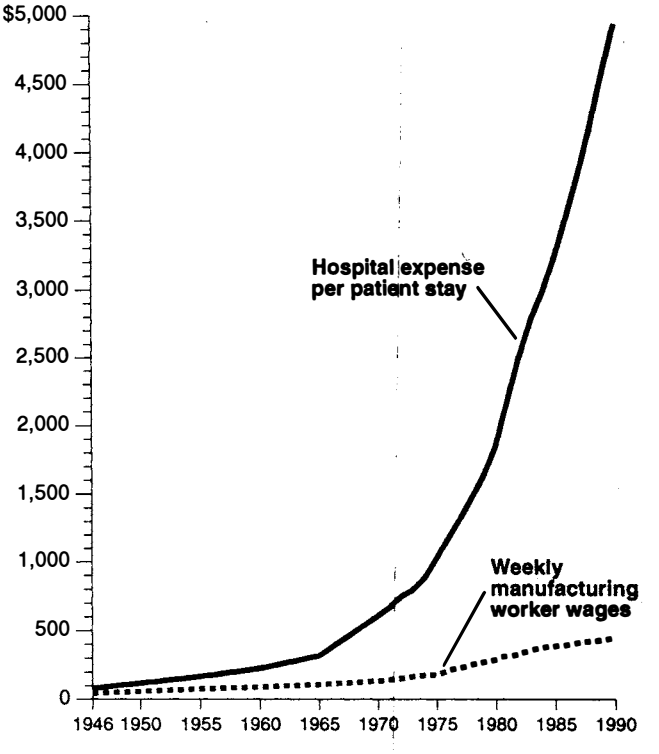
Number of weeks' wages to pay average hospital bill, 1946-90



Sources: *American Hospital Association Hospital Statistics,* 1991-92 edition; Bureau of Labor Statistics.

FIGURE 2

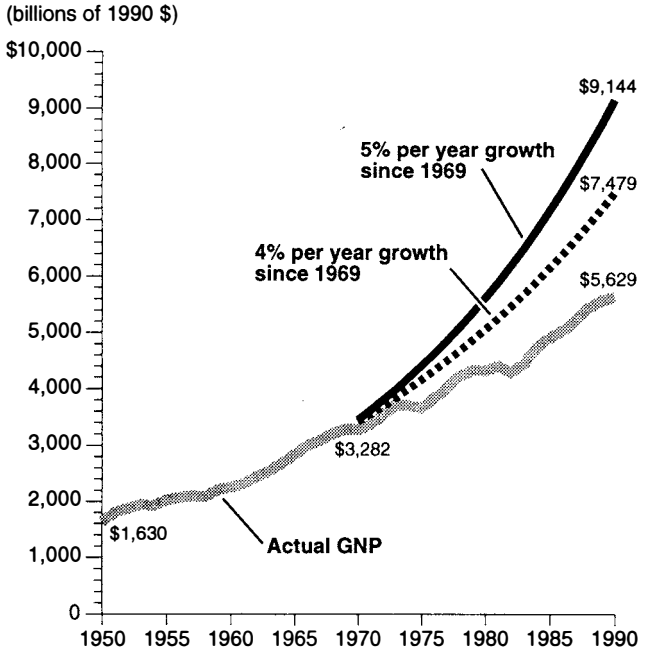
Hospital costs outpace rise in wages



Sources: *American Hospital Association Hospital Statistics,* 1991-92 edition; Bureau of Labor Statistics.

FIGURE 3

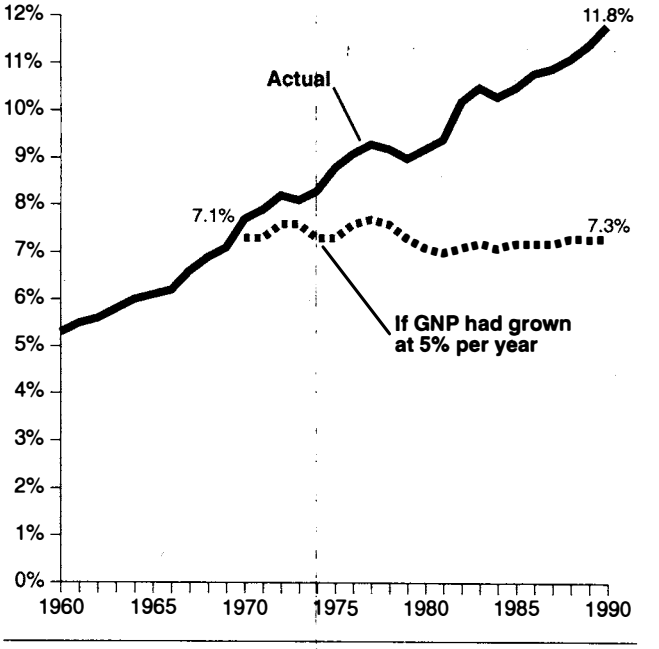
Growth in GNP if growth rates of the 1960s had been maintained



Sources: *American Hospital Association Hospital Statistics,* 1991-92 edition; Bureau of Labor Statistics.

FIGURE 4

National health expenditures as percent of GNP



Sources: *American Hospital Association Hospital Statistics,* 1991-92 edition; Bureau of Labor Statistics.

fell short of attaining Lister Hill's goal of attaining a system adequate for "solving" our national health problems.

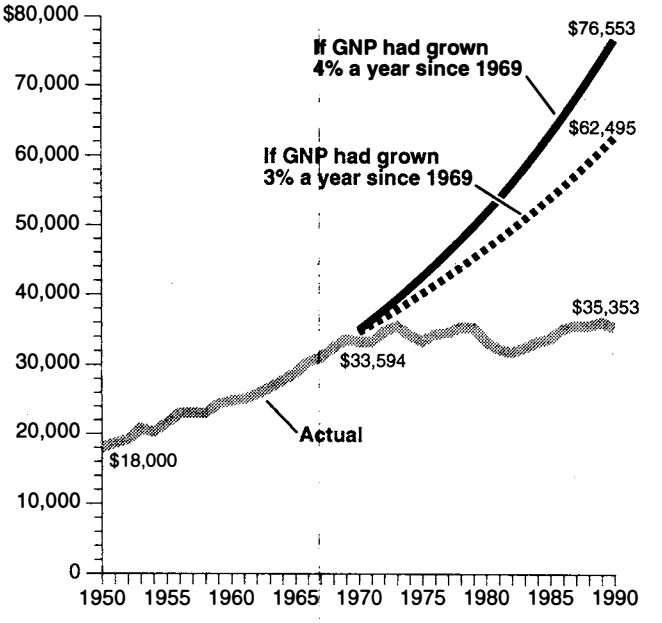
With the recession of 1957-58, increasingly debt-driven investment went to more speculative, quick-buck operations in non-productive sectors like "services," real estate, and financial paper. For useful and productive sectors like manufacturing and health care, this shift out of productive investment enormously accelerated the inflation of nominal values and costs, and stoked a spiraling increase in debt and debt service—an escalating, built-in usury "tax" on the economy. The escalation of health care costs reflected this parasitical growth of usury and debt, not an increase in economic costs per se.

After 1973, the annual increase in industrial productivity had dropped from the 2.5% average in the 1950-73 period to a paltry 1%, thus further driving up industry costs and debt, and ultimately reducing workers' real wages below the level of inflation. This meant that incomes could not support the growing costs of medical care, forcing hospitals to incur more debt for expansion and equipment, and the public to take out more health insurance, to meet costs that their incomes could not match.

The economic history is portrayed in **Figures 3-5.** Had the 4% real (constant dollar) rate of grow in Gross National Product that occurred during the Kennedy era been sustained

FIGURE 5

Actual and potential median income of families, 1950-90



Sources: *American Hospital Association Hospital Statistics,* 1991-92 edition; Bureau of Labor Statistics.

after 1969, GNP today would be more than $7.5 trillion—nearly $2 trillion higher than today's $5.6 trillion. Had a 2.5% rate of growth in productivity been sustained such that GNP could have increased by 5%, the level would be more than $9 trillion, nearly triple that of 1969 and $3.5 trillion higher than today (see Figure 3).

This has immediate implications for health costs. Every health "expert," cost accountant, and politician is screaming that health expenditures are consuming ever-greater proportions of GNP. For 1992, national health expenditures are projected to amount to about 14% of GNP, which is double the 7.1% level of 1969. But had the U.S. economy sustained a 5% real growth rate in GNP—which would almost certainly have occurred had we even approximated the historical rate of increased productivity—health care expenditures today would still consume the same proportion of GNP as in 1969 (see Figure 4).

One must be wary of simple projections of GNP, which includes useless "products" and "values" added from non-productive sectors, as well as parasitical activity. That stated, these limited comparisons nevertheless are useful, because these growth projections are made from 1969, when parasitical factors carried less weight. Also, much of the debt, usury, and administrative waste that has been added to health care costs would not have occurred had the economy progressed along the more productive trends of the early to mid-1960s.

The fall in incomes is a related problem. The disparity between personal income and medical costs only gradually increases through the 1960s, and then begins to zoom out of control at the conjuncture of Lyndon Johnson's "Great Society" and the end of the Apollo space program—the U.S. paradigm shift into the "post-industrial society" of the so-called Information Age. Today, the average hospital bill now costs the production worker *12 weeks* pay, often with much worse overall care—and that doesn't include related physician expenses.

The crisis in health care is not *costs* per se. It is that the standard of living of the vast majority of Americans has collapsed.

By 1990, the median family income was actually lower, in real, constant dollar terms than in 1978, and just $2,000 higher than in 1969 (see Figure 5). Had the 4% annual growth rate of the mid-1960s Kennedy-era been maintained through the 1970s and 1980s, median family income today would be $76,553—*more than double* the $35,353 level of 1990. Had only a 3% annual growth rate been achieved, income would still be $62,500, or 76.8% higher than it currently is.

At this income level, the vast majority of families would easily be able to afford the average $5,000-8,000 cost of family health insurance, and there would be no crisis of affordability. Even without insurance, most families would not face the penury and bankruptcy so often resulting today from hospitalization.

The collapse is far worse than these numbers indicate. In the 1960s, most family income was made by one primary wage-earner, usually the male head of the household. Today, roughly the same income level is maintained often by two or more wage-earners working two or more full- and part-time jobs. That means that family productivity has plummeted; more and more mothers have to work, with devastating effects on family stability and child development.

Small wonder, then, that the 1952 proportion, where 83% of health expenses were paid by individuals out-of-pocket and only 17% by insurance, has dramatically shifted today, to where only about 20% of soaring medical costs are met from out-of-pocket expenditures, with the balance picked up by insurers and government.

'Cost containment' makes things worse

In response to economic disintegration, "cost control" measures and health care reforms were instituted. But, in fact, cost controls have accelerated the breakdown and driven up costs.

While all the experts and politicians howl over the rising costs of new technologies and their "inappropriate overuse," one of the biggest factors in health expenditures has been soaring administrative costs. The nitpicking over each and every medical charge and the establishment of legions of accountants and "systems analysts" have resulted in an 8% annual increase in administrative costs for both doctors and hospitals, above the rate of inflation. This is double the average annual increase in overall medical costs, which have been rising on average 4% a year more than the inflation rate, meaning that most other costs have on average only slightly exceeded the general inflation rate.

Administrative costs now conservatively comprise 25% of medical costs. This is far above the proportion of costs in the postwar period through 1965, and is more than double the rate in other nations like Canada and Germany.

The entire process has subjugated the medical profession more and more to this army of accountants and management specialists, with medical decisions increasingly coming under the purview of "business practices" and "the bottom line."

Over the last 30 years, austerity has been enforced through social engineering and planning methodologies that have now come to dominate U.S. business practices and educational systems. The methods are labeled "systems analysis" and "systems management," and they have increasingly been applied to the medical profession. Far from augmenting efficiency, however, these methods have had the perverse result of dramatic increases in cost and loss of productivity. They deny what has been proven by sound economic practice: that investment in the most advanced innovations and technologies raises productivity and therefore earns a much greater return than the cost of the investment. This was understood by the America that emerged from World War II, by people like Senator Hill. Society's investment in health care,

especially "high-cost" technologies, and companies' spending money on the medical needs of their work force, were understood to be sound business practices because of the returns in productivity and longevity. This also accords with the basic morality of preserving and enhancing human life.

For health care, these cost-containment methods have two primary aims. First, to condition medical, business, and industry professionals, and the general population, to accept a decaying economy and society, and to induce them to participate in managing the disintegration. Second, as the "management techniques" of systems analysis and cost control spread, they undermine the moral foundations and the operational basis of American health care to the point where rationing of treatment, triage, euthanasia, and "assisted suicide" become increasingly acceptable replacements for real medicine. Such death-oriented policies are rationalized because of "limited resources" or "financial realities" that hospitals and physicians have come to accept. These policies were denounced as murder and genocide at the Nuremberg Tribunal.

Prescription for murder

Any proposed "health care reform" that does not address the broader economic depression ultimately leads to rationing of medical care. Some advocates of reform cite examples of good care from health maintenance organizations (HMOs) or the advantages of the Canadian national health system. What they ignore are the proliferating number of health maintenance organizations and related managed-care operations compromising medical care because of budgetary restraints. They also ignore the breakdown of Canada's system, where the depression is forcing the federal and provincial governments to slash budget allocations for health care. Hospital beds are being taken out of service, health workers laid off, doctors' incomes capped, and medical school enrollment limited. Waiting lists for various surgeries are mounting; 260,000 are awaiting major surgery, with 700-800 awaiting heart surgery in British Columbia alone.

Without an economic recovery, an array of think tanks and health economists typified by Dr. William Schwartz, Henry Aaron, and Alain Enthoven are laying the basis for the next stage of cost-cutting: rationing health care. In an article in the March-April 1985 *Harvard Business Review,* Aaron and Schwartz wrote: "Two stages in the control of rising medical costs could develop. In the first stage, government, physicians, and business would join in trying to eliminate useless medical services. . . . *The second stage requires cutting down on beneficial services on the grounds that the medical gains are too small to justify the costs.* . . . If Americans are unwilling eventually to enter stage two, any respite from rising medical costs will be short-lived" (emphasis added).

Aaron and Schwartz, who collaborated in a 1984 book published by the Brookings Institution entitled *The Painful Prescription: Rationing Hospital Care,* know that they are writing a prescription for murder. Their targets, which they maintain must be broken in order to curtail costs, were identified by Schwartz in a March 5, 1989 commentary in the *New York Times*. "The real culprits in rising health-care costs are a rapid increase in hospital prices—wages and supplies—and the explosion of new and expensive technology," he wrote.

Aaron is aware of the collapse of both U.S. productivity and the economy. It was he who noted that had the United States continued to increase productivity by the historical 2.5% rate after 1973, the government deficit would be well over $200 billion smaller than it is today—an amount that would readily pay for covering the uninsured and much of the added costs of new technologies.

But instead of addressing the necessity of increasing real U.S. output and productivity, and raising our standard of living, Aaron focuses on cost-cutting and rationing, which he knows cannot solve the problem.

The RAND experiment

Institutions like Brookings are dictating Aaron and Schwartz's "economics." In an interview published in the Fall 1989 issue of *Health Affairs,* Schwartz credits the RAND Corp. for launching him from a research career into a new role as one of the most prominent health policy analysts. Over several years beginning in 1971, Schwartz was transformed into a "health economist" at numerous RAND Corp. training sessions.

Those RAND sessions 20 years ago were designed to set the agenda and control the debate for rationalizing what would soon be a disintegrating economy. For medicine, as Schwartz remarked, the issue of cost containment "would soon become a very serious concern for the United States."

Ever since World War II, the RAND Corp. has functioned as an intelligence operation profiling the U.S. population and institutions and developing programs for shifting social mores and cultural paradigms. In plain language, it is a think tank set up to manipulate public opinion and set into motion brainwashing scenarios aimed at inducing society to abandon morality. For eight years, from 1974 to 1982, RAND conducted a Health Insurance Experiment in preparation for the myriad cost-control schemes that are now decimating U.S. health care.

In 1979, when Schwartz began collaborating with Aaron on the *The Painful Prescription,* the objective was to make the subject of rationing an acceptable issue for scholarly debate, paralleling the push to make euthanasia acceptable. In the *Health Affairs* interview, Schwartz noted: "Because our society had never contemplated rationing medical care on a nonprice basis—we have always rationed by price—we thought it was important that we get some insight into the process. Nonprice rationing of medical care means that some services simply may not be available even if a person is fully

insured."

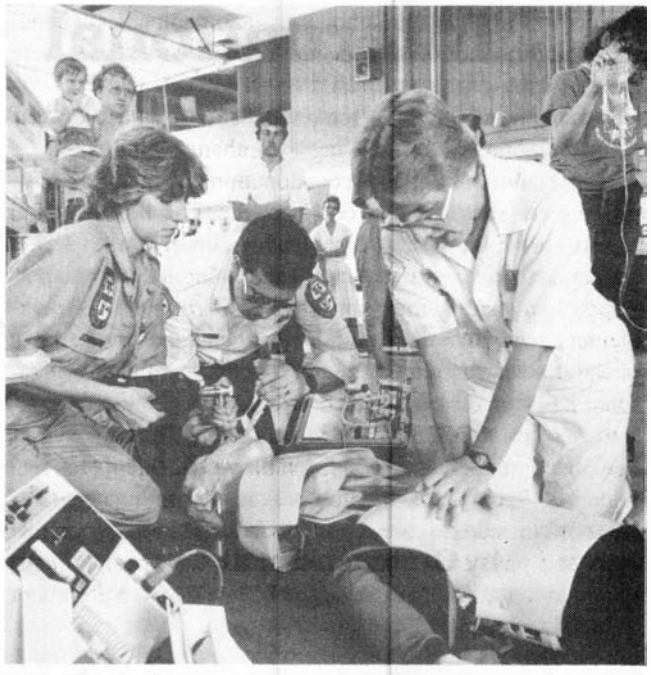
Schwartz was not talking about "rationing"; he meant killing, and said so explicitly. His book with Aaron discusses how the British national health system—which spends approximately half as much money per capita as the United States—allows patients to go untreated and die. Using dialysis as an example of a treatment that is not "cost-efficient" when given to the elderly, Schwartz and Aaron wax eloquent about how the British apply a triage system based on age and disability that functions virtually in the open. Much is made of how physicians can be induced to shift their attitudes and mores to accept such a system.

Schwartz explicitly makes the connection between cost-containment and such triage. "I would predict that, as resources are constrained in the United States, we are going to see more and more physicians convincing themselves that older patients are not suitable candidates for this or that procedure, using [various] excuses." What of patients who don't want to die, even patients who can afford treatment, but are using what will become all-too-scarce technological resources? Schwartz answers icily: "We will face the difficult issue of how to deal with the . . . patient who is reluctant to accept no for an answer and who insists on the right to buy whatever care he or she wants. . . . The issue is whether the United States will readily allow an escape hatch through which people . . . can get care in an otherwise constrained system. . . . *You can't on the one hand set cost limits and at the same time tell physicians they must do everything that is possible. Something will have to give, and I suspect it will be our traditionally high standards*" (emphasis added).

'Managed competition'

Another leading RAND protégé in the field of health "economics" is Alain Enthoven, a Rhodes Scholar who trained at RAND from 1956-60. Enthoven then spent the next decade as an analyst in the Operations Research branch of Robert McNamara's Department of Defense. Enthoven is perhaps the number-one spokesman for reforming the health care system into one of "managed competition." He is also one of George Bush's two key advisers on health issues (the other being Dr. Mark Pauly at the Wharton School).

"Under managed competition," wrote Enthoven in a *New York Times* commentary on Jan. 25, the health market "would be driven by consumers whose agents would keep them well informed about the cost and quality of care." What this means is that an explosion in managed care establishments like HMOs would give "consumers" a "choice" among different health plans, based on price and quality differentials. This would essentially torpedo the "fee-for-service system [which] encourages the health care industry to inflate costs." Under managed competition, in which a fixed-price per person would be paid to providers, costs would supposedly be much lower because HMOs would zealously guard against over-utilization of expensive technology. As in any free market, the sick would get treatment according to what they could pay.



Will skilled health care personnel be there when you need them? Shown here is a Virginia program to train rescue workers in cardiopulmonary resuscitation.

This, of course, does nothing to make health care more affordable, which would require initiating an economic recovery that could double wages—what would have obtained had the Kennedy-era growth rates continued. What it does do is put the lid on payment to health care providers and rations treatment.

The Heritage Foundation advocates a program which would utilize broad-based "sponsors" that would coordinate negotiations with health care providers and set budgets and rates, which is another variation on the same theme. For that matter, so is the Democratic play-or-pay "AmeriCare" scheme proposed by Sens. George Mitchell (D-Me.), Donald Riegle (D-Mich.), Jay Rockefeller (D-W.Va.), and Edward Kennedy (D-Mass.). This would establish a "federal health expenditure board" to do the same thing as Heritage's "sponsors," or Enthoven's "managed competitors," or a beefed-up Health Care Finance Administration-type operation under a national health program.

Yale management professor Theodore Marmor, in debunking conservative criticism of national health insurance, matter-of-factly discusses rationing as something done by every country in the world. "The question is how and how much," he wrote in the Fourth Quarter 1991 *Health Management Quarterly*. Both the U.S. and Canada, with diametrically opposed systems, ration health care now. "Rationing, in this context, is another name for allocation. Whether it is objectionable" depends on the "choices" available.