Click here for Full Issue of EIR Volume 23, Number 43, October 25, 1996

'Managed health care' is a crime against humanity

by Marcia Merry Baker

The past year in the United States has seen an unprecedented number of redress actions of all kinds—civil suits, state and federal legislative initiatives, regulatory agency appeals, and in-the-streets protests—aimed at curbing practices by "managed care" health services companies, including instances of wrongful death, namely murder. In addition, there are indirect effects of "managed care" policies, that are resulting in actionable denial of care, because of cuts in hospitals, medical staff, and services.

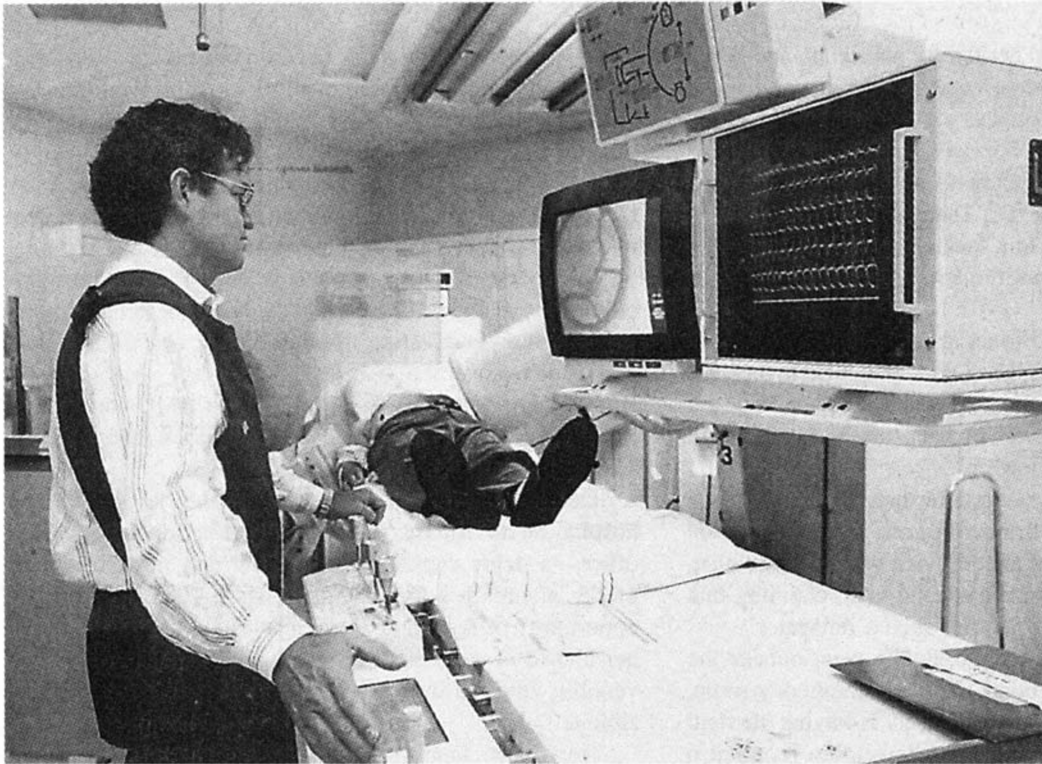
What is at issue here, regardless of the wording of any particular state law or court case, is *not abuses* of the new system called "managed care," or health "maintenance" organizations (HMOs); but, rather, the fact that the fundamental policy of "managed care" is itself a threat to the public good. The practices of managed care that are demonstrably harming and killing American citizens are not the mistakes of the system; they are *characteristic* of the managed care/HMO system. And the originators and backers of the managed care system know this.

Therefore, according to the principles stated at the Nuremberg Tribunal in 1945, under which Nazi officials and doctors were tried and convicted for "crimes against humanity," the present-day crimes of the managed care/HMO systems constitute violations of the Nuremberg precedent.

The American jurist Robert Jackson emphasized, at the Nuremberg Tribunal, that the law "shall not stop with the punishment of petty crimes by little people. It must also reach men who possess themselves of great power and make deliberate and concerted use of it to set in motion evils. . . ."

In this *Feature,* we provide a summary report on crimes of the managed care/HMO system, in three categories: 1) two case studies of denial of care to individuals; 2) examples of denial of care to whole subgroups of the population, and classes of patients; 3) examples of deliberate destruction of health care infrastructure, knowingly causing deprivation of medical services. We provide particulars of one of the most prominent companies of the managed care era—Columbia/HCA, know

© 1996 EIR News Service Inc. All Rights Reserved. Reproduction in whole or in part without permission strictly prohibited.



A physician uses high-resolution X-ray imaging to screen a valve in a patient's heart. Under the regime of managed care, high-tech solutions are deemed too expensive, and the "gatekeeper" doctor is expected to keep consultations with specialists to a minimum.

for its success in shutting hospitals, denying care, and posting mega profits.

What is required, is to put an end to the entire managed care system, and to mobilize to restore a public-interest health system, along with the general effort to restore the national economy to working order.

How to begin? In 1946, principles of national health care were embodied in the so-called "Hill-Burton" law, a hospital construction program based on the principle of universal care: "That the State plan shall provide for adequate hospital facilities for the people residing in a State, without discrimination on account of race, creed, or color, and shall provide for adequate hospital facilities for persons unable to pay therefore. . . ."

Today, we need an updated Hill-Burton approach, reflecting the standards, staffing, and logistics for all aspects of medical and public health care that should be put in place for modern treatment. Many of the recent state laws and directives against HMOs/managed care, contain key concepts of what should figure in an overall revamping of the U.S. health-care system. On p. 33, we provide excerpts from some recent state initiatives. And as a reference point for this discussion, we reprint excerpts of the original Hill-Burton Act, which was in effect from 1946 until 1974.

We also provide a timeline, from the 1970s to the 1990s, of how the Hill-Burton approach was replaced by "managed care" policies, which acted as a cancerous growth on the hospital and public health system of the nation.

Personal case studies

The standard definition of "managed care," as given by the *Washington Post* (July 1994) is: "A health care plan, such as a health maintenance organization (HMO), that 'manages' or controls costs by monitoring how medical professionals treat patients, limiting referrals to expensive specialists and requiring preauthorization for hospital care and other services to hold down costs."

This is the polite terminology to rationalize limiting or denying care to patients, contravening the physician's expert opinion, and cost-cutting at hospitals and other health facilities.

The consequences of this are what you would expect—thousands of instances of patients harmed or dead because of standard HMO/managed care practice. The number of such cases annually has grown, as the HMO and managed care enrollment grew from about 6 million in 1980 to 60 million today. Over 50% of all U.S. physicians are now employees of HMO-type large groups.

The two personal case studies below are representative of the HMO/managed care system:

Michigan: In the first lawsuit of its kind in the United States, Mrs. Sharon Bush filed a suit on Sept. 16, 1986, charging that the structure of her HMO, and the financial criteria used to govern medical decisions, were inherently "responsible for the failure of its physicians to deliver medical care."

The events began when, in August 1985, Bush, of Sagi-

naw County, complained to her family physician, and HMO "gatekeeper," Dr. Paul Dake, of vaginal bleeding unrelated to her menstrual cycle. Dr. Dake was a member of an individual practice with Group Health Services (GHS) of Michigan, a Blue Cross HMO, who saw patients also for Bush's HMO. According to court filings, Dr. Dake did not order a Pap test, nor did he refer Bush to a specialist until the following February. He prescribed antibiotics, which had no apparent effect.

Bush was then referred to an obstetrician-gynecologist, Dr. Frederick Foltz, of Valley OB-GYN, which receives referrals from GHS. Dr. Foltz also failed to take a Pap test, or to ascertain whether one had been taken. He changed Bush's antibiotic prescription.

In April 1986, eight months after her original doctor's visit for her problem, Bush, now in great pain, again went to Dr. Dake, and demanded another visit with the specialist. Dr. Dake refused to authorize a second visit, claiming that she was not sick enough to require such a referral.

By May, Bush, now desperate, finally went outside the HMO, to the Saginaw General Hospital emergency room, where she was admitted, and diagnosed as having cervical cancer that had spread through her body. She required a series of operations and other treatment.

In the suit Bush subsequently filed, her complaint alleges that the HMO's "capitated gatekeeper" arrangement with Dr. Dake, was a "significant causative factor" in Dr. Dake's failure to order tests, and to make referrals in a timely way. According to press accounts (*American Medical News,* Sept. 4, 1987), GHS paid Dr. Dake a capitation fee per patient and also placed funds in two Individual Practice Association accounts for consultant, lab, and hospitalization costs. If the money remained, unspent, in the pools at the end of the accounting period, Dr. Dake and other IPA physicians would split it with GHS.

Washington, D.C. One Friday afternoon in 1995, Vicky Collins became dizzy, and fell unconscious, at her job, as an aide in the Capitol Hill office Sen. John Breaux (D-La.). She was 30 years old, engaged to be married, with no known ailments. The Hart Office Building's nurses' station was summoned. Collins was put on a stretcher, conscious, but with blurred vision and paralysis of the left side of her face. The nurse and friends wanted her to be rushed to the hospital, but Collins's HMO refused this. She was taken to her HMO doctor, who diagnosed her with a pinched nerve and sent her home. On Saturday, numbness grew over the left side of her body; on Sunday, trying to stand, she slumped to the floor. She was then taken to a hospital, where the surgeon said that she had suffered a stroke, and was unconscious; he said that she would never reawake; he recommended that her respirator be turned off. Her parents and fiancé disputed this, on grounds that hope remained.

Weeks passed, and then it was noticed by Collins's sister, that Vicky could blink to try to communicate. In subsequent weeks, she was diagnosed with "locked-in syndrome," a stroke-caused condition. Her mind is unimpaired, and she has full sensation, but she cannot move or speak.

Her fiancé and parents then exhausted all financial means to promote her further rehabilitation. Her father is a coal miner and welder; her fiancé managed the Dirksen Building parking facility. Collins was able to get off assisted respiration, and start physical therapy at the National Rehabilitation Hospital, communicating through blinks, and using a special wheelchair.

Then she was hit with a lawsuit: Her HMO had refused to cover her $25,000 wheelchair, and had not informed her. The wheelchair manufacturer sued.

Collins then discovered that the delay in getting to a hospital on the day that she had fainted in Senator Breaux's office—a delay caused by her HMO denying the request of the attending nurse and her fiancé—had cost her the opportunity of receiving a drug that could have "unlocked" her locked-in syndrome, before the condition became irreversible; with the drug, a full recovery would have been possible.

Her fiancé finally successfully fought the wheelchair lawsuit *pro se* (without a lawyer) in the courts. Finally, the HMO offered Collins a financial settlement, after sensing the heat of publicity on Capitol Hill.

By a stroke of a pen

In addition to cases of individuals harmed, there are on record the crimes of harm and death to individuals in *whole groups* (the poor, the elderly, certain classes of illness, pregnant women) targetted for endangerment by officials in the HMO/managed care system, and/or by officials in other health-care positions, and in government office. These acts are typically done in the name of "fiscally responsible" cost-cutting, but in fact, their harmful effects are calculable, and are representative of how the U.S. health-care system functions under the influence of HMO/managed care. By a stroke of the pen, people can be murdered.

- *Low-income groups.* On May 16, 1996, Pennsylvania Gov. Tom Ridge (R) signed into law a bill which immediately removed 220,000 low-income people from eligibility for medical assistance. The calculated effect of this, based on a study of similar assistance cut-off to 250,000 Californians, will be 3,500 needless deaths within six months. There are similar actions in other states. (For the projected death rate calculation, see *The New England Journal of Medicine,* Aug. 16, 1984, pp. 480-484).

Further, in those states where poor and low-income people are being put under HMO forms of managed care in order to cut state costs, the results are known to be increased suffering and death rates, from limiting or denying medical treatment. Under Medicaid, the federal government pays

50% of medical costs, and the states and localities pay the other half. To cut costs, 14 states now have federal permission to experiment with putting Medicaid under managed care.

A team of researchers led by Dr. John Ware, Jr., of the New England Medical Center in Boston, reports that poor people are twice as likely to suffer deteriorating health if they are treated by HMOs, as compared to traditional pay-for-service arrangements. The results of this study are in the Oct. 2, 1996 *Journal of the American Medical Association.* Study results show that 57% of HMO low-income patients felt that their health had declined, compared to 22% of low-income patients in fee-for-service plans.

Although based on a subjective survey of patients, Prof. Sara Rosenbaum, director of the Center for Health Policy Research at George Washington University, said that "the new findings are consistent with a long line of research showing that poor people with health problems tend to do worse in prepaid [managed care/HMO] health plans. The results tell me that we are going much too fast in converting Medicaid to a managed-care program."

• *Heart disease patients.* This disease is the major cause of death in the United States (900,000 deaths yearly), and the pattern of HMO/managed care treatment shows higher death rates than under traditional care. A major form of surgery that has been developed since the 1970s, is the coronary-artery bypass graft, or CABG (pronounced "cabbage"). The pattern of managed care/HMO is to consign enrollees who require this surgery to "discount" hospitals; hospitals are pressured to compete for HMO business, and for Medicare and Medicaid cases, by stripping down services. Data from the Health Care Financing Administration, the federal monitoring agency, show that this pattern results in higher mortality rates.

For example, take Good Samaritan Hospital in Los Angeles. Mortality rates increased there when Good Samaritan set about in 1986 to offer cut-rate, assembly-line open-heart surgery to attract HMO and Medicare/Medicaid business. Good Samaritan's heart cases soared from 250 in 1985 to 1,300 in 1989 and 1990, the peak years, when the hospital offered big discounts to managed care firms, in exchange for volume referrals of patients.

The mortality rate went up. In fiscal 1989, HCFA found that 6.7% of the hospital's Medicare CABG patients died on site, or within 30 days of discharge—not a low rate. As business grew, the mortality rate climbed higher. In fiscal 1990, it was 8.2%; in fiscal 1991, it was 7.2%. Each of these is a percentage point above what HCFA considers the expected range, given the patient profile at the hospital. Then, in 1991-93, Good Samaritan's 30-day mortality rate for Medicare cases jumped up to 10.4%. Under scrutiny, the rate has since been lowered.

• *The elderly.* HMO/managed care treatment of the elderly, as shown especially in states with older populations (California, Arizona, Florida), where the HMOs have concentrated their enrollment, shows a clear pattern of harm. This is especially evident since the move by President George Bush, in 1990-91, to allow HMOs to receive federal funds for Medicare and Medicaid. The expected harmful results were known in advance.

The survey done by Dr. Ware (noted above) tracked 2,235 adult patients with chronic conditions, such as high blood pressure, diabetes, and congestive heart failure, in Boston, Chicago, and Los Angeles, from 1986 to 1990. The patients were given extensive surveys about whether they felt their health had declined or improved. They found that 54% of HMO elderly patients believed that their health had declined, compared to 28% of the elderly in fee-for-service plans.

In Arizona, five Medicare recipient residents have filed a class action lawsuit against the federal Health Care Finance Administration, for care allegedly denied them by their HMO—the Family Health Plan (FHP, second nationwide in number of Medicare enrollees). The plaintiffs' suit gives specifics on the impairments resulting from lack of care, for example, the loss of a leg by a 71-year-old woman, Grigoria Grijalva.

Destroying infrastructure, denying service

From 1980 to 1993, the United States lost 675 hospitals, and the staff, equipment, services, and productive employment related to those hospitals. This decline—described in detail elsewhere in this report—was characterized by the intervention of individuals and companies associated with the "managed care"/HMO "hospital management" movement, to selectively acquire, merge, alter, or shut down public health assets of the community, knowingly causing harm.

Example: Columbia/HCA, the for-profit hospital buy-out company. A dossier released July 31, 1996, by the Service Employees International Union, contains the following example:

"In May 1994, Columbia/HCA gave the city of Destin three days' notice when it closed Destin Hospital in Florida. Despite public protest and a petition with 11,000 signatures, Columbia closed the hospital, leaving only the emergency room open. In August 1994, Columbia closed the hospital altogether, but held onto its state license and certificate of need, which means no one can operate a hospital in Destin. In justifying the closure, Columbia/HAC's CEO David Vandewater said, 'You can't just have a hospital on every corner.' But, the nearest hospital is not just around the corner. Townspeople must now travel 45 minutes in traffic to get hospital care. Destin Hospital was missed last summer [1995], when Hurricane Opal slammed into the Gulf Coast. (*Healthcare Forum Journal,* March-April 1995 and the *Lakeland Ledger,* 5/7/96)."