

# Managed care's scorched-earth medical and hospital policy

by Richard Freeman

There are two ways to carry out a policy of euthanasia. The first is to decree it, as was done by Adolf Hitler, and as is being pushed by former Colorado governor Richard Lamm. The second way is to implement it de facto, as has been done in this country since the 1980s: Destroy the hospital and medical infrastructure, while cutting the medical staff—especially registered nurses. The growth of cost-accounting Health Maintenance Organizations (HMOs) drives the process forward.

The U.S. health system, which during the 1960s provided decent, efficient, and relatively low-priced medical service to most Americans, no longer exists. It was a system geared to providing preventive care, and had built in redundancy. With vaccines in the schools, plentiful local doctors, and available medical services at the hospital, the chance of disease was reduced, and the likelihood of successful treatment increased. If you became injured or ill, you were taken to a hospital to be treated and cured; now, if you don't have the right medical insurance, you can be left bleeding in the street or in the hospital emergency room. There may not even be a hospital to take you to, because it was torn down. Or, once inside, you may be left unattended, because registered nurse staffing has been cut to save money.

We will look at the situation of hospitals and nurses. This comes under the heading of the consumer market basket: the basket of goods and infrastructural services, consumed by the population, necessary to sustain and expand its existence and that of the economy. An adequate market basket leads to an increasing rate of growth of "free energy," and thus of economic development. Medical infrastructure results in increasing the longevity and productivity of the population.

## Vanishing hospitals

Start with the availability of hospitals and hospital beds for patients in the United States. **Table 1** compares, for the years 1985 and 1994, the availability of hospitals and beds for community (i.e., regular) hospitals, for 15 states and the entire nation. Community hospitals are the bulk of hospitals in the United States, the others being basically long-term care, psychiatric, and veterans' hospitals. During the past

decade, ten states closed down 10% or more of their community hospitals, and nine states shut down 10% or more of their hospital beds. In extreme cases, Massachusetts eliminated nearly one-quarter, and Illinois more than one-fifth of their hospital beds.

The table also shows the ratio of hospital beds in use per 1,000 persons. In 1946, the U.S. Congress passed the Hill-Burton Act, named after its co-sponsors, Sens. Lister Hill (D-Ala.) and Harold Burton (R-Ohio). The Act, based on an extensive survey, set out to establish a minimum necessary standard of availability of hospital care, measured through the parameter of number of beds. It specified a ratio of 4.5 to 5.5 beds in use per 1,000 population, and mandated the construction of hospitals and hospital beds. In most localities, by adhering to this Act, up through the 1970s, the United States developed a good health system. But today, 14 out of the 15 states shown, as well as the United States as a whole, are below—many far below—the Hill-Burton standards.

One obtains an even more precise appreciation of the situation, by looking at specific localities (for Arizona and Pennsylvania, see *EIR*, Oct. 4, 1996, " 'Managed' Care Is Destroying Medicine, and Killing People").

Take New York City, America's largest city. **Figure 1** shows the borough of Manhattan, which has a population of 1.7 million. The map shows that in 1960, Manhattan had 78 operational hospitals. By 1995, that had been more than halved to only 33 hospitals (**Figure 2**). This had been forced through by the banks, especially under the 1970s Municipal Assistance Corporation ("Big MAC") financial dictatorship. The deadly significance is disclosed by looking at the upper "goose neck" of Manhattan (the area north of 110th Street): In 1960, it had seven hospitals; today, it has only three significant hospitals. This area contains over 450,000 people, and includes many poor areas, such as Harlem, as well as parts of Washington Heights. More than half of the poor don't have a primary care doctor; the only doctor they see is when they have to go to the hospital—yet only two hospitals exist.

The borough of Brooklyn has more than 1.5 million

TABLE 1

**Managed care's forced shutdown of hospitals and beds, 1985-94**

| State             | 1985         |                  | 1994         |                | Change 1985-94   |               |                   |             | Beds per<br>1,000 population<br>in 1994 |
|-------------------|--------------|------------------|--------------|----------------|------------------|---------------|-------------------|-------------|---|
|                   | Hospitals    | Beds             | Hospitals    | Beds           | Number shut down |               | Percent shut down |             |   |
|                   |              |                  |              |                | Hospitals        | Beds          | Hospitals         | Beds        |   |
| Texas             | 480          | 66,061           | 422          | 59,395         | 58               | 6,666         | 12.1%             | 10.1%       | 3.29                                    |
| California        | 479          | 83,232           | 427          | 77,963         | 52               | 5,269         | 10.9%             | 6.3%        | 2.50                                    |
| Illinois          | 238          | 54,925           | 207          | 43,158         | 31               | 11,767        | 13.0%             | 21.4%       | 3.69                                    |
| New York          | 259          | 78,986           | 229          | 76,607         | 30               | 2,379         | 11.6%             | 3.0%        | 4.21                                    |
| Michigan          | 193          | 37,546           | 169          | 31,291         | 24               | 6,255         | 12.4%             | 16.7%       | 3.30                                    |
| Minnesota         | 165          | 21,933           | 143          | 18,104         | 22               | 3,829         | 13.3%             | 17.5%       | 4.01                                    |
| Tennessee         | 145          | 25,230           | 126          | 21,946         | 19               | 3,284         | 13.1%             | 13.0%       | 4.30                                    |
| Massachusetts     | 112          | 25,892           | 95           | 19,918         | 17               | 5,974         | 15.2%             | 23.1%       | 3.31                                    |
| Alabama           | 129          | 19,703           | 114          | 18,100         | 15               | 1,603         | 11.6%             | 8.1%        | 4.32                                    |
| Washington        | 103          | 13,173           | 88           | 11,409         | 15               | 1,764         | 14.6%             | 13.4%       | 2.17                                    |
| Louisiana         | 145          | 20,190           | 132          | 18,946         | 13               | 1,244         | 9.0%              | 6.2%        | 4.41                                    |
| Missouri          | 141          | 25,734           | 129          | 23,201         | 12               | 2,533         | 8.5%              | 9.8%        | 4.43                                    |
| Pennsylvania      | 241          | 56,221           | 230          | 50,353         | 11               | 5,868         | 4.6%              | 10.4%       | 4.18                                    |
| Mississippi       | 108          | 13,036           | 98           | 12,485         | 10               | 551           | 9.3%              | 4.2%        | 4.72                                    |
| Oklahoma          | 118          | 13,692           | 110          | 11,565         | 8                | 2,127         | 6.8%              | 15.5%       | 3.58                                    |
| <b>U.S. Total</b> | <b>5,732</b> | <b>1,000,688</b> | <b>5,229</b> | <b>902,061</b> | <b>503</b>       | <b>98,627</b> | <b>8.8%</b>       | <b>9.9%</b> | <b>3.46</b>                             |

Source: American Hospital Association, "Historical Stats: Emerging Trends in Hospitals, 1995-96 edition," "Historical Statistics, 1986 edition."

people. In 1960, Brooklyn had 56 operational hospitals; today, it has 28. In Brooklyn's easternmost zone, East New York, live 175,000 people, of whom 30-39% are officially below the poverty level. They have *no* hospital.

**Figure 3** depicts the situation for New York City overall. In 1960, New York had 154 functioning hospitals; by 1990, it was down to 79. The number of New Yorkers per hospital rose from 50,000 in 1960, to 92,000 in 1990.

New York City typifies the situation that is emerging elsewhere around the country:

- The Detroit Medical Center, the city's largest private employer, recently announced that it will cut 2,500 jobs, eliminate 360 hospital beds, and close two hospitals, to meet demands from health insurance plans to cut costs.

- On April 9, 1995, the *Pittsburgh Tribune-Review* reported that the spread of HMOs and large hospital chains will "shrink hospital facilities by as much as half," and "reduce staffs for in-patient care by 30 to 50%" in southwestern Pennsylvania.

- In Massachusetts, industry analysts estimate that 20-50% of existing hospital beds in the state will be closed in the coming years, on top of those which have already been closed.

Many rural areas of the country have been left without hospitals, so that it requires a 35 to 75-mile trip to reach one.

This is a matter of life and death. A person can die on the way to a hospital, due to the fact that a closer hospital

had been levelled; or arrive there in such weakened condition after a long trip, that the doctors cannot help him; or die in the hospital because staffing was cut; or die at home, because he or she was discharged too early. But the financiers justify the shutdowns, claiming there are not enough sick people to fill the hospitals. It is true that some medical procedures, which 30 years ago would have required a few days' hospitalization, can be performed today on an outpatient basis. Conversely, there are some medical procedures today that require hospitalization, such as a hip replacement, which were performed less frequently 30 years ago, if at all. But the main reason for low hospital occupancy rates, is the scorched-earth practices of HMOs and insurance companies: By providing insurance coverage for only limited stays, they throw people out of hospitals, or they refuse to admit people to hospitals in the first place. Then, they claim the hospitals are underutilized, and shut them down!

Also left out of the equation, are the 39 million medically uninsured—more than one out of every ten Americans—who are not covered by insurance, nor Medicaid or Medicare. Basically, they can't afford to go to hospitals. Their needs are not translated into "effective dollar demand," and remain unmet.

### Eliminating registered nurses

Registered nurses represent the front line of the hospital medical system. They used to constitute half the hospital staff.

FIGURE 1  
Hospitals in  
Manhattan, 1960

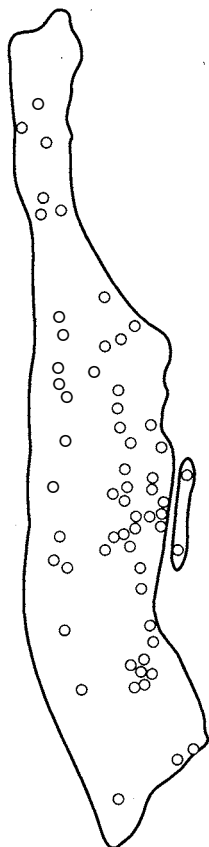


FIGURE 2  
Hospitals in  
Manhattan today

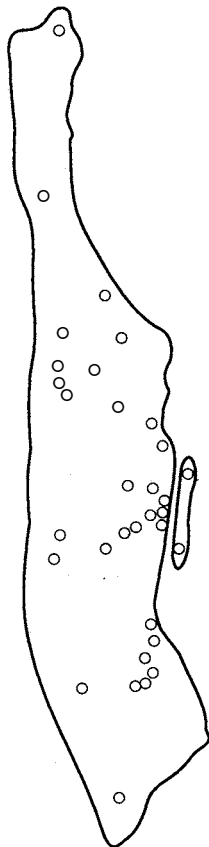
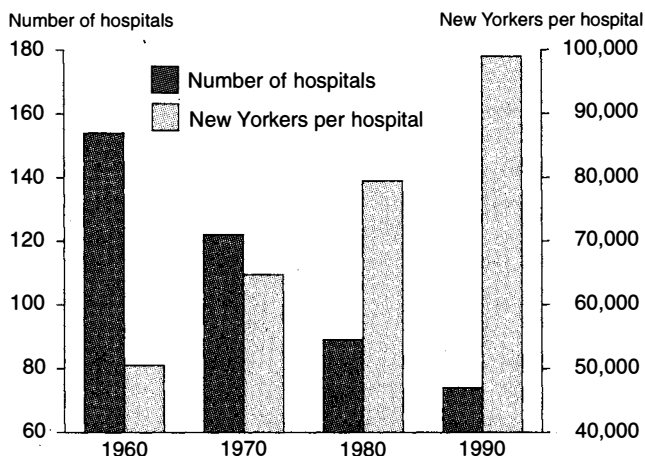


FIGURE 3  
Fewer hospitals, each forced to treat  
more people



A registered nurse must graduate from a state-approved school of nursing. A majority of RNs take a four-year Bachelor of Science in Nursing (BSN) degree. In the first two years of the degree program, they are required to take courses in psychology, human growth and development, biology, microbiology, organic chemistry, nutrition, and anatomy and physiology. In the final two years, they take courses in adult acute and chronic diseases, maternal/child health, pediatrics, psychiatric/mental health nursing, and community health nursing. About one-quarter of all RNs take a two-year program granting an Associate Degree in Nursing (ADN), preparing the nurse for a specific scope of practice. Many RNs whose first degree is an ADN, return to school during their working life to earn a BSN degree. About 10% of RNs take what is called a Diploma Degree in Nursing, which combines classroom and clinical instruction over three years. They all must then pass an exam administered by a state licensing board, which certifies them.

(There are also licensed practical nurses, LPNs, who take a 12- to 14-month post-high school course that focusses on

basic nursing care.)

In order to save money, the policies of the HMOs are forcing the replacement of these skilled RNs with technicians, *many of whom have only two to four weeks of training*. The techs know nothing about human anatomy, nothing about the processes of human life, but they are given all sorts of assignments, including invasive procedures. The cost-accounting ghouls in the managed care industry and insurance companies, such as Kaiser Foundation Health Care, Prudential Health Care, and Signa Health Care, which have done time-studies on the operations of nurses, lie that they see nothing improper or dangerous in the substitution. On these grounds alone, the managed care companies should lose their licenses to operate a hospital.

Ironically, during the 1980s, before the scorched-earth policy of managed care had become the norm, there were widely reported nursing shortages. An example is the story in *American Medical News* of May 8, 1987, headlined, "RN Shortage Acute in VA Hospitals, Congress Told." It reported that the chief medical officer of the Veterans Administration had testified to Congress about the shortage, and various other people providing testimony said that 4,000 to 8,000 new nurses were needed for the VA system alone. The real shortage did not disappear during the 1990s; instead, the managed care gang declared that nurses were no longer necessary.

In response to the need for nurses, the total population of RNs rose from 1.27 million in 1980 to 2.04 million in 1994, according to the U.S. Department of Commerce's Bureau of the Census, Nursing Division. But within the last few years, the employment of nurses at community hospitals, which represent 85% of all hospitals in the country, diminished dramatically. In 1989, there were 3.20 RNs based at community hos-

pitals per 1,000 population. This rose to 3.39 in 1993. But, it inched up to only 3.42 in 1994. And, in 1983 and 1993, the share of the nursing staff, as a part of the hospital's labor force, fell from 43% down to 35%, while the share of technicians and administrators went up.

But this statistic for the national average of community hospital-based nurses per 1,000 population, is deceptive on two counts. First, many hospitals are increasingly resorting to hiring nurses on a per diem basis, which artificially swells the nurse count. Thus, if ten per-diem nurses fill two nursing slots in a week, there are, in reality, only two full-time nurses. Second, especially in urban centers, the 1980s trend of adding nurses has reversed, and, for the last few years, has been going downward.

Within large cities, there is a marked reduction of both the absolute number of RNs per hospital, and per 1,000 population. Once again, New York City leads the way. For example, according to the Greater New York Hospital Association, between February 1995 and February 1996, 1,316 nursing jobs, or 3% of the total in New York City, were lost, due to layoffs and attrition. Then, in June of this year, the New York Health and Hospitals Corp., which runs the City's 11 public hospitals, announced that 562 more nurses would be permanently laid off.

- At Harlem Hospital, 40 out of 230 intensive care nurses, one-sixth, lost their jobs at the end of June. Harlem Hospital, which is one of only three hospitals in the "upper goose neck" of Manhattan, receives patients at the most acute level of sickness and bodily injury. This nurse triage was so severe that a group of doctors, nurses, and community groups, sought a court order barring the permanent layoffs. The judge would not do so, but it was agreed to allow a short time to take some nurses from other wards in the hospital, train them, and place them in intensive care. These nurses were removed from other necessary functions.

- As part of Mayor Rudolph Giuliani's plan to privatize the City's 11 public hospitals, there is now discussion, moving toward closure, of selling Coney Island Hospital, in Brooklyn, to a managed care company, Primary Health Systems (PHS) of Pennsylvania. Coney Island Hospital has 737 RNs; PHS has announced that upon completion of the purchase, it will fire 100 of them.

- At Booth Memorial Hospital, in Queens, New York, because of tight staffing conditions, four nurses handle a shift in obstetrics. On average, they have to work on delivering and caring for 10 to 12 births among them, per shift. Yet a caesarian birth, or a child born in critical condition, immediately takes the attention of two nurses for the whole shift; two such crises, and there is no manpower left for the other children.

## Consequences

Study after study has found that nurses have a direct impact on hospital mortality and morbidity levels. Not only do

hospitals with a higher percentage of RNs and higher nurse-patient ratios have lower mortality rates, but the higher the level of nurses' qualifications, the better the outcomes and quality of care of surgical patients.

Studies have indicated that hospitals with favorable nurse-staffing levels and high RN skill mixes had a lower ratio of actual-to-predicted mortality rates: In 13 studies, a higher percentage of RNs to total nursing personnel was associated with lower-than-expected mortality rates. In addition, a higher ratio of experienced RNs to patients leads to quicker recovery, fewer complications, quicker discharge, and fewer readmissions.

Conversely, a study published in the November 1993 *Modern Healthcare* reported that a cut of just 7.75% of a hospital's registered nursing staff increased morbidity rates by up to 400% (see *EIR*, May 16, 1995, "New Threat to U.S. Health Care: Hospitals Without Nurses").

Where the nurse-to-staff ratio has been so lowered that it reaches the classification level of "poor," the readmission rates of patients is 15-37%. Cost reduction defeats itself, a point that could be made in general, regarding the elimination of preventive care and the necessary redundancy level in health and hospital systems.

Yet, HMOs and insurance companies are employing redesign plans that de-skill their staffs. One restructuring project for Massachusetts hospitals has unlicensed aides carrying out more than 100 duties usually done by nurses, including performing sterile techniques, inserting catheters, EKG testing, phlebotomies, and changing feeding tubes. The predictable consequences: A comparative study in Boston hospitals attributed 15 patient deaths to such policies.

In New York State, one "tech," wearing sterilized gloves, scrubbed out the toilet, and then, without changing the gloves, rearranged the sterilized glove supply in the cabinet, potentially spreading disease to the whole hospital.

The managed care mafia rides roughshod over nurses who balk at the lethal consequences of such a policy. As *EIR*'s Linda Everett reported, "A nurse working with only one aide in an understaffed intensive-care unit worked desperately to save her critically ill patient. The patient had gone into cardiac arrest, and the nurse simultaneously tried to guide the untrained aide in saving the life of the patient in the next ICU bed who had also 'arrested.' Both patients died. Shaken, she complained to her administration about the unsafe staffing level, and was dismissed from her job. The hospital then threatened to have her charged with murder of both patients if she tried to appeal their decision by going public with her claim."

The budget-cutters want to make these conditions permanent. The Pew Charitable Trust, for example, set up a Health Professions Commission, which released its third annual report in November 1995. The commission was headed by Richard Lamm. Among its recommendations was a restructuring of all medical licensing boards—inclusive of nurs-

ing—so that, effectively, the HMOs and giant hospital chains could dictate what the standards are for medical licensing. It also recommended that medical staff—doctors and nurses—could be reduced by 20-25% in the future.

In February 1995, the American Nurses Association released a survey of its nurses on the effect of hospital downsizing and nurse firings. The ANA noted that 79% of nurses reported that hospital cutbacks were causing a severe reduction in the quality of patient care, and 20% of nurses reported an increase in the number of errors involving patient falls,

fractures, and deaths as a result of staff reductions and subsequent overloading of remaining nurses.

Nurses are fighting these conditions through their union contracts—trying to specify staffing and workload responsibilities—by going to court, by demonstrating, and through public education. Last year, 35,000 nurses marched in the nation's capital to protest. Yet, no action by a single group can redress the situation; a national fight is required. The axioms of managed care and a decent nationwide health system cannot co-exist.

## Profile of a public health asset-stripper

The largest U.S. operator of for-profit hospitals, Columbia/HCA Corp., is the result of the February 1994 merger of Columbia Hospital Corp. with Hospital Corp. of America (HCA).

Columbia was founded in 1987, when Dallas lawyer Richard Scott and Ft. Worth moneybags Richard Rainwater, the brains behind the Bass family fortune, bought two hospitals in El Paso for \$60 million. After gaining the trust of the doctors and staff by making much-needed repairs, they sold 40% to the doctors, so that the doctors would have a financial incentive to maximize profits and minimize costs. Since then, Columbia has been investigated a number of times by state regulators around the country, for "cream skimming," that is, Columbia doctors admit only patients with treatable conditions, and who are able to pay, turning away the indigent and people requiring expensive care.

In 1993, Columbia merged with Galen Health Care, which operated 73 hospitals; Galen was the result of the split-up of Humana Corp., into the group of hospitals under Galen (and eventually bought by Columbia/HCA), and the group of HMOs which retained the Humana name. Besides hospitals, Columbia specialized in offering rehabilitation, out-patient, and home health services.

HCA was founded in 1968, when Thomas Frist; his son, now U.S. Sen. Thomas Frist, Jr. (R-Tenn.); and Jack Massey, the founder of Kentucky Fried Chicken Corp., purchased a hospital in Nashville, Tennessee. By 1973, HCA had 50 hospitals, and by 1983, it owned 376 hospitals in the United States and seven foreign countries. In the late 1980s, the Frists began to sell off hospitals to raise cash, and in 1989, they took the firm private in a \$5.1 billion leveraged buy-out. The massive debt incurred required an acceleration of asset sales, leading to the 1994 merger with Columbia, in a stock swap valued at \$5.7 billion.

Columbia/HCA Corp. now owns over 340 hospitals, 130 surgery centers, and 200 home health agencies in 36 states and Europe. One of the largest shareholders is Senator Frist.

Columbia/HCA's strategy, according to ValueLine, is to grow by buying more and more hospitals, "to build a provider network capable of serving such health care purchasers as HMOs and large employers." However, this leaves out a key part of Columbia/HCA's strategy, which is to "rationalize" health care by buying most of the hospitals in a community, then shutting some of them down, and forcing business to increase at the remaining hospitals. The company aggressively markets its services at bargain prices to HMOs and other health care "bulk buyers." Indeed, one of the things Wall Street finds most exciting about Columbia/HCA, is that "same-store revenues" of the company's hospitals are rising, with admissions in the first half of this year up 3%, while admissions nationwide were falling. Standard & Poors' in September 1983 reported that Rainwater calls this the "WalMart approach to health care."

By the end of 1994, Columbia/HCA had 42,357 beds, with an occupancy rate of 44%, and an average stay of 5.7 days. In 1995, Columbia/HCA acquired HealthTrust, Inc., and its 119 hospitals, for \$3.6 billion. So far this year, Columbia/HCA has acquired another 26 hospitals.

Revenues in 1995 were \$17.695 billion, with profits of \$961 million, giving a "healthy" margin of 5.4% profit derived from unhealthy people. Forty percent of the revenue comes from non-hospital care.

Columbia/HCA now seems to be eyeing a direct entry into the managed care field, with a proposed acquisition of Blue Cross & Blue Shield of Ohio.

According to a *Wall Street Journal* article on Oct. 14, investors are beginning to worry about "Columbia/HCA's desire to buy more bricks and mortar," because "America has too many hospitals." Wall Street is also worried that the stupendous growth rates of the past few years can no longer be sustained, because Columbia/HCA has "already taken over every one in sight."—Anthony K. Wikrent