'Managed care' and nursing: Back to the 19th century

by Linda Everett

Registered nurses, the backbone of the nation's health care system, are the nation's largest health care profession, with more than 1.9 million jobs (1998-99). Yet, so-called "managed" health care and "market-driven reforms" have so deeply cut into the health care delivery infrastructure and staff numbers, that there is now a growing and alarming shortage of registered hospital nurses, the immediate result of which is increased rates of patient morbidity and mortality.

This suffering is *preventable,* and allowing it to continue amounts to rolling back gains in hospital care to the point of 19th-century standards.

Shortages are growing

The trends in shortages of nurses are shown even by the crudest estimates of the U.S. Bureau of Labor Statistics (BLS). Using very rough calculations—which do not address meeting the full medical needs of the country, or the increasing needs of its aging population—the BLS projects that the nation will need more than 2.6 million working registered nurses by the year 2005—an increase of some 700,000 RNs. By 2010, other Federal projections indicate that the demand for registered nurses will grow twice as fast the expected increase in the RN workforce. By 2015, the Federal Division of Nursing expects that 114,000 jobs for full-time equivalent RNs *will go unfilled* nationwide.

The rising complexity of acute care is only one reason why the projected 36% increase in demand for hospital RNs, will outstrip supply by the year 2020. The principal reason for the nursing shortages is the genocidal looting by the managed care system of the U.S. health care delivery system. Under "market-driven" concerns, a hospital's survival depends upon its willingness to cut its own costs by increasingly cutting its capacity to provide for the community's needed services. In *Special Reports* in 1995, *EIR* warned that under such "reforms," 70% of U.S. hospitals were undergoing massive restructuring, to eliminate "excess" hospital beds and to cut 40% to 50% of RN staff through "downsizing" or "rightsizing" or other schemes that resulted in an increase in patient morbidity and mortality levels.

David Schildmeier of the Massachusetts Nursing Association described to *EIR* at that time, how "wave after wave" of cuts had decimated the ranks of hospital RNs for more than a decade. During the early 1980s, hospitals invested heavily in nurse educators, who trained new registered nurse graduates for specialized areas, creating highly skilled staffs within hospitals. Then, Schildmeier reported, these staff-development nurses were "dramatically curtailed" in the first round of cuts by hospitals, when the brutal impact of managed care/health maintenance organization (HMO) policies was first being felt.

Among the first cadre to be eliminated were clinical specialists, who are masters-degree nurse experts in specific fields, such as cardiology, oncology, or pediatrics, who act as consultants in hospitals to the nursing staff, "to train them, to bring them along" in these specialized fields. The rationalizations given by hospitals complying with managed-care pressures, was that their facility had to "remain competitive" for managed care/HMO contracts.

The remaining core RN staff came under attack during another wave of cuts in the mid-1990s, when hospitals paid hundreds of millions of dollars to notorious management consultants, like Milliman and Robertson, or American Practice Management, that demanded that hospitals undertake straight "slash and burn" policies to redesign hospital delivery system to "cut costs." Their first target was to cut labor costs by laying off RNs who, in some cases, were told to reapply for their same job at lower pay.

Primarily, the overall national pattern was to replace experienced RNs (who usually have a four-year degree in bachelor of science in nursing, have passed a state licensing exam, and often have furthur training in specialty areas, such as geriatrics, pediatrics, or cardiology), with cheaply paid, unlicensed aides, who would then provide direct patient-care procedures, such as inserting urinary catheters and starting intravenous tubes. Aides were even assigned to perform some complex, high-risk procedures such as changing sterile dressings and stapling head wounds.

In one mid-1990s survey, 41% of hospitals reported that their unlicensed aides had less than 40 hours of training; 58% said their aides had between 41 and 120 hours of training.

Thousands of nurses protesting congressional cuts in hospital bedside care in March 1995.

(Reported in *Nursing Economics,* March-April 1994, Vol. 12, No. 2.)

In California, the most managed-care-saturated state in the country, all 24 hospital regions were below the already inadequate national average of 3.4 registered nurses per 1,000 residents; 23 of the 24 regions fell below the national average of 13.7 total hospital employees per 1,000 residents, according to reports from the California Nurses Association.

Harm to the patients

Wall Street's prescriptions for a "booming" health care industry, are disastrous for patients. As of the early 1990s, researchers were reporting the existence of an "unambiguous inverse relationship" between nurse staffing and death rate. In other words, the fewer the RNs, the higher patient mortality.

A cut of just 7.75% of a hospital's registered nursing staff has been shown to increase morbidity rates by up to 400%, according to a report in *Modern Healthcare* (November 1993).

The U.S. Agency for Health Care Policy and Research (AHCPR) has found that patients undergoing surgery at hospitals that have fewer RNs per patient than other hospitals, run a higher risk after surgery of developing avoidable complications, such as nosocomial (hospital-acquired) infections, thrombosis (blood clots), and pulmonary congestion and other lung-related problems. The study also found that hospitals that provided one hour or more of nursing care per patient day—that's about a 17% increase in nurse staffing levels—had 10% fewer patients with urinary tract infections and 8% fewer patients with pneumonia. The study found a "strong inverse relationship between registered nurse staffing and adverse patients events." (Reported in *Image: Journal Nursing Science,* Vol. 30, No. 4, 1998.)

Data collected from state agencies in 1992 and 1994, from 502 hospitals in California, Massachusetts, and New York, showed that patient morbidity indicators for preventable conditions—such as pressure ulcers, pneumonia, post-operative infections, and urinary infections—were inversely related to RN skill mix. In other words, the more RNs taking care of patients, the fewer preventable conditions those patients experience. This was reported in a 1997 American Nursing Association study.

The list of studies with similar results goes on and on. In general, as reported in the article "Nurse Staffing and Patient Outcomes," by M. Blegen in *Nursing Research* (January/February 1998), a higher proportion of RNs to patients is directly related to lower incidences of negative patient outcomes, such as medication errors, bed-sores, and so on.

Harm to nurses

Along with increasing shortages of nurses, the average age of nurses in the United States has now risen to 44 years old, which means that fewer are entering nursing, and more are leaving the profession. The nation has faced nursing shortages before, but never those associated with the "aging" of the workforce. RNs are retiring, being laid-off, or otherwise

Specific cases of illness and death

Massachusetts: A family filed a lawsuit in January 1999 against a Beverly Health and Rehabilitation Services, Inc.-owned Hermitage Health and Rehabilitation Center in Worcester, for causing the death of their father by intentionally engaging in a practice nationwide, of understaffing their facilities. The suit specifically alleges that the licensed practical nurse (LPN) in charge of the patient's care had only two-and-a-half weeks experience as an LPN when she was placed in charge of 62 patients in two of Hermitage's three units. (An LPN's training usually consists of a 12- to 18-month post-high school course that focusses on basic nursing care.)

The facility ignored her concerns that she was incapable of supervising two units, when the patient—who was suffering from respiratory depression, pneumonia, seizure disorder, dementia, and pernicious anemia—died (*Worcester Telegram and Gazette,* Jan. 30, 1999).

Massachusetts: In 1997, at one major Boston teaching hospital where nurses had gone through two years of staff "downsizing," use of unlicensed personnel, increase of patient assignments to unsafe ratios, and a dramatic rise in mandatory overtime to cover for a lack of registered nurses (RNs), a concerned hospital manager provided the nurses with a confidential report from the hospital's quality assurance department.

As described by a representative of the Massachusetts Nurses Association to *EIR,* the report "contained the hospital's own data on patient outcomes related to nursing issues. What the report showed was that patient falls had increased, medication errors (and nosocomial infections) had been increasing, patient satisfaction had been declining, and sponge counts in the operating room were routinely incorrect," that is, surgical sponges were left inside of patients after surgery. The manager saw a direct and unmistakable connection between poor RN staffing and poor patient care in the hospital's own data.

Ohio: In 1994, Christ Hospital of Cincinnati was one of the first and most aggressive hospitals to use unlicensed technicians as nurse aides. In August 1994, their patient, Rebecca Strunk, died after untrained aides missed all the tell-tale warning signs (falling blood pressure, pain) of a massive infection after Strunk's surgical hysterectomy. Aides had never reported her condition, nor the family's complaints made to the overworked nursing staff. There was a failure to order blood cultures. The infection was finally so widespread, that nothing could be done. After a $3 million settlement against the hospital in 1996, Strunk family attorney Richard Lawrence said that what killed Mrs. Strunk was the hospital's policy of "replacing educated minds with uneducated ones that can't appreciate subtle signs and symptoms before they become deadly." (This case was reported in *The American Journal of Nursing,* November 1996.)

being driven out of hospitals because of impossible working conditions—"speed-up" (routinely having to do the work of several workers), unsafe circumstances, such as caring for far too many acutely ill patients without an adequately trained staff, and so on.

In nine Minneapolis/St. Paul hospitals, where RN positions were reduced by 9.2%, one study found a 65.2% increase in injuries to RNs, who were forced to move patients and heavy medical equipment without help. In contrast, nurses have worked—unharmed—for 20 years, using the "buddy-system" to move patients. Now, staff cuts "are crippling a whole generation" of nurses, according to researcher Elizabeth Shogren. At hospitals that refuse to replace RNs lost through attrition, nurses are ordered to work double shifts several times a week and work 55 to 60 hours a week, for weeks or more, or face disciplinary action for "abandoning their patients," a charge for which they can lose their nursing license, or lose their job.

Typically, hospital RNs work round the clock in cases of major accidents or natural disasters, and they regularly provide overtime on a voluntarily basis. But hospitals now utilize mandatory overtime to meet *regular* staffing needs. In many Massachusetts hospitals, for instance, when the four-week nursing schedules are posted, there are as many as 40 to 60 unfilled shifts, or holes in the schedule; the hospital does not have enough nurses to staff the facility. Nurses ordered to work double shifts end up working 16 to 24 hours a day in some cases, and then put in another 12 hours caring for their own children.

The practice of mandatory overtime is a dangerous trend, in which overtired nurses might not be alert enough to catch subtle changes in a patient's condition. The problem is especially serious in an intensive care unit, where nurses give a lot of vasoactive drugs intravenously. A drug miscalculation can kill a patient.

An account of the problem in *The American Nurse,* in an article titled "Fighting the Clock" (May-June 1998), cited many other instances:

- One nurse at Ohio State University Medical Center was ordered, under threat of disciplinary action, to report to work

immediately, and bring along her 7-year-old son, because she could not get a babysitter. She was told that her son could be accommodated by keeping him outside the hospital's 56-bed cardiac unit where she worked. But, she was expected to care for several critically ill cardiac patients while also supervising her son.

• A nurse in Massachusetts, after completing his 12-hour shift on the surgical intensive care unit of Boston University Center, was ordered to work the next 12-hours with an open-heart surgical patient in crisis, because the hospital had not scheduled adequate staff to cover the higher number of more-acute patients. The patient pulled through, but the nurse nearly crashed his own car when he fell asleep at the wheel on the way home.

Nurses unions are pursuing "protection," in the event that mandatory overtime may lead to patient injury or death under a nurse's care. Unions want hospital management to sign a statement that they are forcing the nurse to work overtime "under duress," against his or her will. One Massachusetts hospital had 280 instances of forced mandatory overtime in three months. Yet, no state or regulatory agency stopped the dangerous practice—which no other industry would tolerate—and which nurses now call the "biggest safety issue in the world."

No typical shortage cycle

Overall, hospitals nationally have slashed RNs and "de-skilled" nursing staff to the point that it is no longer posssible to appropriately treat the growing number of elderly and acutely ill patients. (See, for example, "Trouble in the Nurse Labor market?" by P. Buerhaus et al., *Health Affairs,* January/February 1999.) Clearly, this crisis will escalate along with demographic changes in the population: Hospital use by Americans aged 45 to 64 is nearly double that of people aged 15 to 44. Further, hospital usage rates are an additional 2.5 times higher among people aged 65 to 74.

Consider also, that since 1996, there has been a concerted effort to close Veterans Administration hospitals and medical centers, contracting with area hospitals to provide hospital services to veterans. Many of these veterans, especially those older patients with injuries sustained from Korea or World War II, have significant and complicated medical conditions, with acuity levels that demand much more specialized nursing attention.

A survey of hospitals by the Hays Group found that 81% of patient care managers have a major shortage of registered nurses. (Reported in "Where Have All the RNs Gone?" *Hospital and Health Networks,* August 1998.) Hospitals nationally also report shortages in critical and acute care

nurse specialists.

All this adds up to a crisis. The American Association of Colleges of Nursing warns that the lack of nurses is no typical "shortage cycle," like the pervasive shortfall of nurses in the mid-1980s. Undergraduate enrollment in nursing schools dropped by 6.6% in 1997, and 5.5% in 1998, continuing a four-year downward trend. This trend was caused, in part, by the publicized lie that there was an "oversupply" of nurses—along with hospital beds, and that U.S. medical care had to be retooled for a post-industrial style of managed care.

In particular, this lie was promoted by the Pew Health Professions Commission, which in 1995 called for closing 20% of the nation's nursing programs. The commission's proponents said we needed 500,000 fewer nurses.

Exacerbating the overall shortage of RNs and acute care specialists is the lack of advanced level, Ph.D. nursing faculty at nursing colleges. Sixty-four of 159 nursing school deans associated with the American Association of Colleges of Nursing, reported in April this year, that recruitment difficulties hampered their ability to increase school enrollments: "Lower enrollments equals less revenue equals less faculty," they said.

The vicious cycle of pressures from ruthless managed-care policies, and Federal budget cuts, is making it impossible for some hospitals to afford continued support of the traditional volunteer hospital "preceptors"—clinical nurse specialists who act as mentors and train third-year nursing students in hospital settings. Because of staff shortages, nurse mentors often must care for 12 to 14 patients, as well as take responsibility for students' assigned patients, in addition to fulfilling an educational role in giving instruction and supervision.

A 1995 Lewin-VHI study cited the lack of "availability of clinical training sites for appropriate clinical education as one of the *major* problems facing education today for nurse practitioners, clinical nurse specialists, and other nurses with advanced practice skills. The data show that this availability is the single most important factor in determining a school's ability to expand its advanced practice nurse training capacity."

In the world of free-market health care, the training of nursing students is seen as cutting into the nurse-mentor's "productivity." This view is diametrically opposed to Presidential pre-candidate Lyndon LaRouche's notion of development of the workforce as a precondition for the production of a nation's infrastructure—and thus a glaring problem.

"Many agencies feel the need to have every minute of their nurses' time accounted for in terms of revenue-generating activities," states Anita Hufft, dean of Indiana University Southeast School of Nursing. So, some hospitals refuse a working partnership with area nursing colleges—thereby undercutting the nation's ability to prepare for the future, let alone caring for the sick today.

Ecuador banking: IMF demands euthanasia

by Manuel Hidalgo

For the past several months, Ecuador has been faced with a banking crisis linked to major exchange and fiscal problems, collapsing export income, capital flight, and recession, a situation that is fast becoming the norm for all the countries of South America's Andean region. Ecuador and its banking system are the mirror in which Peru and Colombia, among others, can see their own futures not many weeks and months down the line.

The dramatic paralysis of the country that followed President Jamil Mahuad's March 11 announcement of a brutal International Monetary Fund (IMF) austerity "packet," had as its active ingredients the ongoing banking crisis combined with speculative attacks against the Ecuadoran currency, the sucre, which has lost at least 50% of its value since Feb. 12, when the government allowed it to float.

A bank holiday

All of this had been preceded by rumors of a shutdown of one of the country's leading banks, Banco del Progreso, which in turn forced Mahuad to decree a surprise bank holiday for seven days, and to freeze a large percentage of banking deposits ($3 billion, according to the political opposition) for a full year, in order to avoid an immediate collapse of the banking system. According to Marino Canessa, director of the Ecuadoran Association of Private Banks, "some $1 billion has fled, due to the degree of uncertainty in the country in recent months."

But all these measures are like a painful postponement of the last days of a dying invalid who has been suffering for months: Since last August, 10 of the country's 39 banks have been targets of formal intervention, have been shut down, or have had their operations temporarily suspended. So far, the rescue has cost the government at least $1 billion, with Filanbanco receiving the lion's share.

The response of the International Monetary Fund and the international financial community to this crisis has been to demand that the Ecuadoran government allow the bankruptcy of a series of banks, and to then use $2 billion of state funds to "recapitalize" those which remain—that is, to clean up the mountain of bad debt afflicting the nation's banks by absorbing it as government debt, so that the international banks can then move in and buy up those banks at firesale prices, exactly as is occurring in Mexico, Argentina, and elsewhere.