How U.S. Hospitals Have Been Reduced By 'Shareholder Value,' 1975-99

by Linda Everett

Even as new, epidemic and pandemic animal and human diseases rage internationally, even as we face the resurgence of old diseases once eradicated, many in the United States still presume that the health and hospital system will be there for them when they need it. Hospitals are, after all, a critical part of society's infrastructure.

But for the last three decades, the post-industrial economic policies and budget slashing of the "Southern Strategy," combined with the health maintenance organization (HMO) revolution transforming health care from a profession to a "profit center," have decimated U.S. hospital infrastructure. And today, 60-75 hospitals and well more than 1,000 hospital beds are closed down annually.

The hospital crisis in the United States is so acute, that even in the nation's most prosperous counties, critically ill patients are "boarded" for their entire hospital stays on gurneys in open emergency-room hallways. In one recent incident in Loudoun County, Virginia—a fast-growing Washington, D.C. suburb, and the nation's fourth-wealthiest county—cardiac patients were lined up next to a boy on a gurney who had just attempted suicide. An intern, shouting over children's screams, grilled the boy about his suicide attempt, while on the next gurney lay a young woman who was in the process of losing her first pregnancy. She was bleeding heavily. There was no privacy as staff tried to examine her in her street clothes. Her frightened husband, near tears, pleaded for a room. There are few remaining places in the United States to escape such conditions.

We show here how the successive waves of such policies—President Richard Nixon's 1973 HMO legislation; the Federal Medicare Prospective Payment System; the wholesale looting by "managed" health-care policies; the rapacious attack on U.S. hospitals by for-profit hospital cartels, such as the Columbia/HCA chain of President George W. Bush's financial friend, Richard Rainwater; and the Balanced Budget Act of 1997—caused the carnage of the U.S. hospital system.

When We Did It Right

In 1941, the nation faced a shocking finding: Nearly one-third of the males ages 18 to 37 called up for the draft, were physically or mentally unfit for military duty. Out of the mobilization to reverse that crisis, Sen. Lister Hill (D-Ala.) and Rep. Harold Burton (R-Ohio) formulated the Hill-Burton Act of 1946. It became one of several turning points in which the United States committed its resources to providing for and advancing the fundamental needs of all its people.

Hill-Burton set an objective standard of the number of hospitals, beds, and medical personnel needed for every 1,000 people. It called for states to "afford the necessary physical facilites for furnishing adequate hospital, clinic, and similar services to all their people." Federal monies were made available to construct hospitals, to bring communities up to the Hill-Burton standard of 4.5 to 5.5 general-use hospital beds per 1,000 population; with extra beds for long-term care, psychiatric care, beds for isolation of infectious diseases and tuberculosis, and, later, for chronic care. With the Hill-Burton and similar General Welfare standards in force for health insurance, the nation saw a drop in life-threatening diseases and medical conditions (tuberculosis, a marker for general health, declined from 137,00 new cases in 1948, to 55,000 cases in 1960).

But, the focus fundamentally shifted in the early 1970s, with the "Southern Strategy" signalled in the election of Nixon, and then of Jimmy Carter. In 1972, hospitals receiving Hill-Burton funds were officially released from the obligation to care for the indigent. In 1973, President Nixon signed into law the Health Maintenance Organization and Resources Development Act, that established HMOs (the most prevalent form of "managed," or "shareholders' value" health care). The 1973 HMO law, and subsequent legislation, deregulated hospital and health care and opened them up for looting, which peaked in the mid-1990s when HMO and for-profit hospital chain stocks were the hottest on Wall Street. All manner of ways to restrict and deny care were deliberately approved. Instead of promoting a patient's health and welfare, doctors now were paid *not* to treat a patient, to discourage tests, hospital stays, and specialist visits–no matter what the patient's need. The more they rationed treatment, the more doctors profited from the capitated payment, among other bonuses, the HMOs provided them.

In 1980, when Carter's Federal Reserve Chairman, Paul

Volcker, initiated his "controlled disintegration" of the nation's economy with a 21% prime interest rate, the country had 5,830 community hospitals, according to the American Hospital Association (AHA). The AHA defines community hospitals as all non-Federal, short-term general hospitals and specialty hospitals whose services are open to the public. At the time, fewer than 10 million people were enrolled in HMOs.

In 1982, there were approximately 4.4 beds per 1,000 population. This was already a drop from 4.6 in 1975, when hospitals were still being built under Hill-Burton (see A. Sager and D. Socolar, "Before It's Too Late: Why Hospital Closings Are A Problem, Not a Solution," 1997). By 1983, the number of hospital beds peaked at 1,018,688 nationwide. Then, the first shakeout hit when the Federal government implemented its Prospective Payment System (PPS) for Medicare in 1983.

Medicare is the Federal health insurance program for 40 million older and disabled Americans. Until 1983, the Medicare program covered all hospital costs involved in treating a Medicare patient. With the PPS, Medicare reimbursed hospitals at a pre-set rate for treatment based on a list of 470 coded illnesses (called Diagnosis Related Groups, or DRGs), thereby penalizing hospitals for giving needed care exceeding the DRG payment. (Years later, this system was modified to consider the severity of an illness.) Overnight, the dramatic drop in Medicare payments led hospitals to drastically slash the length of hospital stays of elderly and disabled patients—often sending sick patients home. This was driven purely by austerity policies—not by medical breakthroughs and technologies, which, later, did allow for shorter hospital stays and a general shift to outpatient surgeries.

In rural regions, where hospitals are often the sole source of patient services available within a 35-mile radius, 700 rural hospitals closed by 1988, according to the National Governors' Association. The "trigger" for these closures, according to the Federal Office of Rural Health Policy, was the Federal government's switch to the Medicare PPS.

Destroying Infrastructure

The impact of the government's PPS and Wall Street's managed care system on U.S. hospitals was dramatic. During 1980-91, 500 community hospitals in the United States closed their doors, according to the AHA. As HMOs increased their "market share" (that is, the number of insured patients in the United States), they racheted down their payment rates to hospitals. Either a hospital accepted an HMO's lower payments—which covered less and less of the actual cost of treatment—or it lost all of its patients in that HMO, which could mean losing 20% of its patient base. Hospitals were doomed either way. While managed care was promoted to "cut health-care costs" and to cut out the "fat" in hospital care, managed care organizations (MCOs) and HMOs looted billions of dollars from the nation's health-care system by denying or delaying payments (for example, MCOs owe California hospitals more than $1 billion in back payments). The Institute of Medicine implicates managed care as a major cause for the fiscal crisis now engulfing public hospi-

Bush Protects Murderous HMOs

State regulatory laws are, for the most part, useless, since many of the managed care plans are provided by employers, and are protected by the ERISA shield—a 1974 Federal law known as the Employee Retirement Income Security Act. Such plans are protected from state health insurance oversight, even when managed care organizations and HMOs inflict injuries, permanent disabilities or even death on thousands of patients by denial or delay in needed treatments. Families had no protection when their children committed suicide after their HMOs refused to pay for inpatient psychiatric treatment.

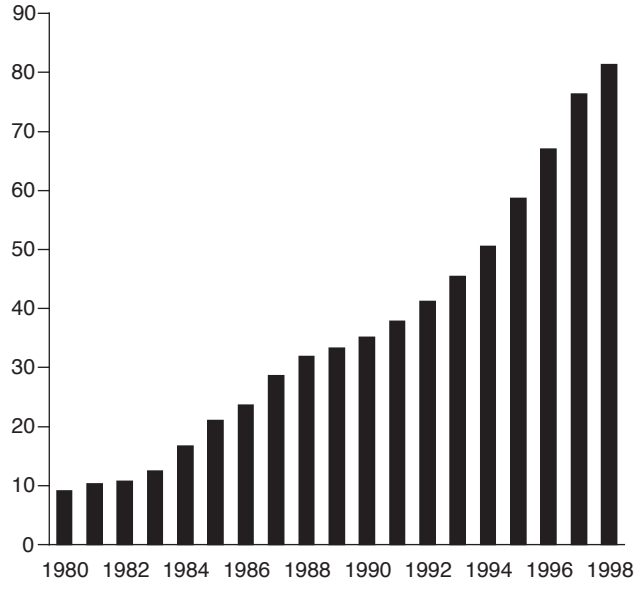
These genocidal policies—and the managed care organizations behind them—are now being protected by the "compassionate conservative" President George W. Bush. In a March 21 speech in Florida, Bush came out swinging for Wall Street's HMO shareholder values—with promises to scuttle any legislation in Congress that would allow "frivolous" suits against HMOs, by patients permanently harmed or killed by HMOs' wrongful denial or delay of treatment. Such "frivolous" lawsuits have included the case of a woman who died because her HMO refused to authorize her cancer treatment; others, when HMOs denied surgery to tens of thousands of children born with cleft palates, which if not surgically repaired, will result in life-long complications in breathing and eating—because the HMOs claim the reconstructive surgery is "cosmetic."

Now, Bush will collaborate on his HMO "reform" with Sen. Bill Frist (R-Tenn.), whose family ran Columbia/HCA with Richard Rainwater. Frist is considered Columbia/HCA's man in Congress. It is also rumored that Bush will appoint Thomas Scully, who runs the Federation of American Hospitals, the trade group of for-profit hospitals, of which Columbia/HCA is an important member, to run the Health Care Financing Administration (HCFA). HCFA is the influential Federal agency that administers the Medicare and Medicaid programs.—*Linda Everett*

FIGURE 1

Enrollment in Managed Care Plans—HMOs, PPOs, and others,* 1980-98

(millions)

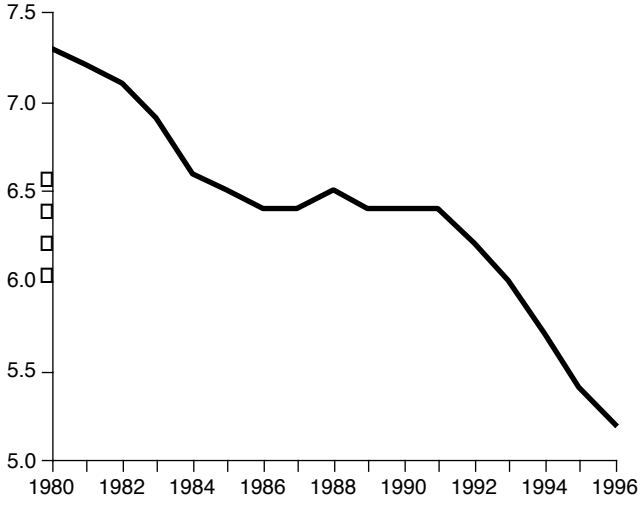


*HMOs, Health Maintenance Organizations; PPOs, Preferred Provider Organization; and other variants of managed care plans are also included in the statistics.

FIGURE 2

Average Length of Hospital Stay is Cut

(days)



Sources: U.S. National Center for Health Statistics; *Statistical Abstract of the United States, various years.*

tals, which serve a disproportionate share of low-income and uninsured patients.

HMOs also profitted by simply denying treatment for which they were paid to provide. For instance, most states have instituted Medicaid managed-care plans to cut state Medicaid costs. Medicaid is the Federal-state program that covers health-care costs for the indigent and disabled. The states pay an HMO an annual sum to provide medical services to Medicaid patients. But, once the HMO has the Medicaid contract—and the state funds—the HMO slashes provision of medical services dramatically through any number of ways, leaving itself with considerable profits. In 1997, a Federal review of Montana's Medicaid program for the mentally ill found that, once managed care took over, inpatient days dropped 96%, residential services dropped 85%, intensive outpatient services dropped 25%, and outpatient visits dropped 76%. At the same time, the Federal government, particularly in the ongoing Columbia/HCA fraud cases, exposed how managed-care plans intentionally overcharged Medicare for billions of dollars.

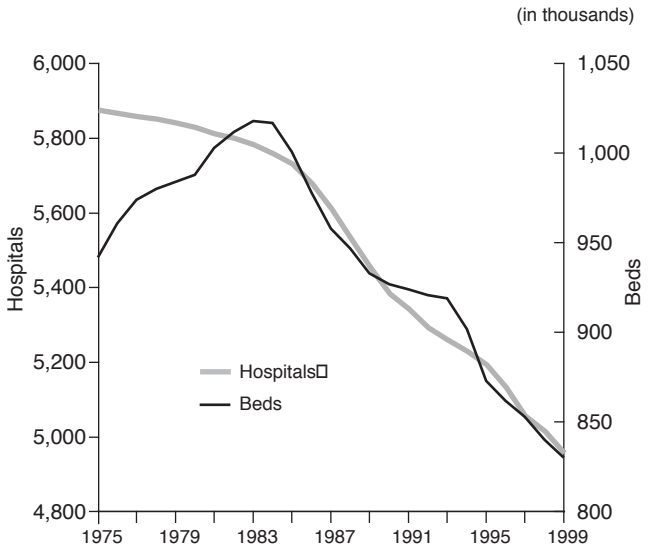
The health insurance industry and its managed care subsidiaries, by their genocidal policy of ripping up medical treatment protocols and public health standards, triggered the closing of hospitals. MCO accountants set limits on who was allowed to receive hospital care and refused payment for more; hospital stays were consequently reduced, and patients refused admission; hospital occupancy rates were lowered; and HMOs then complained that they were paying for too many "empty" hospital beds! States now based their criteria of hospital beds needed in a region on HMO standards of diminished care. While new technologies did reduce the need for many hospitalizations and shortened stays, the "shareholders' value" policies of managed-care organizations forced the severest drop in hospital occupancy rates (see **Figures 1** and **2**). But now that so many hospitals have been closed, emergency rooms and critical-care wards in many regions are jammed to overflowing.

One of the largest HMOs, Kaiser Permanente, tried to force women out of hospitals just six hours after delivering their newborns; another tried to discharge patients with below-the-knee amputations in 2.5 days (see *EIR,* June 18, 1999). The result was that 70% of U.S. hospitals underwent massive restructuring by 1995 to eliminate "excess" hospital beds. By that year, the number of hospital beds collapsed nationally to 3.25 per 1,000 population—28% below the lower range of the Hill-Burton standard of 4.5-5.5 beds for every 1,000 population.

To cut their operating costs, hospitals laid off nurses and forced those who remained to work two or more shifts in a 24-hour period. (Cuts of hospital-registered nurses increase morbidity rates.) Nurses were driven out of hospitals. Now, the country is faced with a critical nursing shortage. Without

FIGURE 3

The Closedown of America's Community Hospitals and Beds



Sources: American Hospital Association; *EIR.*

a sufficient workforce of registered nurses to care for patients, hospitals nation-wide are forced to close beds daily—often at the cost of patients' lives. From coast to coast, hospitals are closing their emergency departments, either because of the lack of beds or nurses to staff them. HMOs forced hospitals to replace as much as 40-50% of their highly paid, skilled registered nursing staff with lower-paid, untrained aides, who were assigned to perform complex, high-risk procedures. In one case, an Ohio hospital called in its janitor to help staple a patient's head wound, because of its lack of trained staff (see *EIR,* June 18, 1999).

In the decade and a half between 1983, when the PPS went into effect, and 1998, when 80 million people were enrolled in managed-care plans, the number of the nation's hospital beds fell by 178,000, to a total of 840,000—a drop of 18.5%; 886 hospitals closed over that period (**Figure 3**).

Wall Street's Leeches

Hospitals, weakened by managed care policies, were assaulted on another flank by yet another "free market" force: Columbia/HCA, the largest for-profit hospital cartel in the nation. Columbia/HCA, launched in 1988 by Texas speculator Richard Rainwater, was an instrument for looting and takedown of the entire U.S. hospital system. Rainwater was the confidant and financial partner of Texas Gov. George W. Bush (see *EIR,* April 7, 2000). Bush not only supported the damage inflicted by Rainwater and Columbia/HCA between 1988 and 1997; in defense of "shareholders' values," as Texas Governor, he actively intervened to protect Columbia/HCA's operations.

Since the company's inception, Rainwater had proclaimed that the hospital system had to be run as "a private for-profit business," rather than under the concept of providing for the General Welfare. Up to 1997, Columbia/HCA intensified cost-cutting and looting at the nearly 800 hospitals, clinics, and health-service businesses it came to own nationwide. Every decision was determined strictly by the "financial objectives" of maximizing its returns to Wall Street—by any and all means. Columbia/HCA President Richard Scott enforced a system called EBDITA, "earning before depreciation, interest, taxes, and amortization." Scott demanded that each hospital group increase its EBDITA by 5-20% *every year*. They did this by slashing services and dumping thousands of professional staff, closing 25 of their more than 300 hospitals, and by making a system-wide decision to illegally drain money from the Medicare system. Patients died as a result of their profiteering.

There was no way for community not-for-profit hospitals, already weakened by HMO looting, to compete in Columbia/HCA's target areas. They were bought out, driven out, or adopted its ferocious standard of austerity.

Last year, Columbia/HCA agreed to a $840 million settlement with the Federal government for its system-wide overcharging of the Medicare program. Then, in March 2001, the Federal government announced that it would join eight whistleblower suits against Columbia on new charges of yet more Medicare fraud.

Another of Columbia/HCA's parasitical policies, was to buy up community hospitals, only to abruptly shut them down. In May 1994, Columbia gave the town of Destin, Florida (population 8,000) three days' notice and closed its only hospital. Columbia refused to relinquish the state license and "certificate of need" for the hospital's beds, thereby blocking anyone else from operating the hospital or building a new one in the same locale. This Columbia/HCA strategy intentionally left the community without a hospital, forcing patients to travel for emergency and other hospital care to Columbia's regional "flagship" facility.

Despite Columbia/HCA's insatiable avarice and rampant illegal activities, President Bush has now appointed Michael Chertoff, the lead attorney who represented Columbia/HCA during the Federal investigation into its fraud, to head the Criminal Division of the U.S. Justice Department.

The Final Assault?

The Balanced Budget Act of 1997 (BBA) was passed by the Southern Strategy swamp in the U.S. Congress—the Gingrichite Republicans, backed by Vice President Al Gore's Democratic allies. The BBA, touted as "a solution to the funding crisis of Medicare," slashed $433.3 billion from the Medicare and Medicaid payments to hospitals and nursing homes during 1998-2007. Together, these programs encompass about 70 million people. Medicare and Medicaid constitute

44% of all hospital revenue. The BBA earmarked about $71.2 billion in cuts to hospitals during 1998-2002.

The BBA cuts are razing the nation's hospitals, forcing some to close their doors, or to shut entire departments such as pediatrics or obstetrics, or to end programs such as home health care. This assault comes on top of 30 years of post-industrial policies and two decades of HMO-insurance company looting. As the number of uninsured people in the United States climbs to 44 million, hospitals are forced by the BBA to sever critically needed outreach programs. Hospital Associations from coast to coast report that their hospitals are hemorrhaging red ink and teetering on the brink of closure. During 1995-99, some 286 hospital emergency rooms closed their doors permanently. Between 1997, when the BBA was passed, and 1999, a total of 101 hospitals have closed, and 23,000 beds have been lost. In Southeastern Pennsylvania alone, the region's 80 hospitals have cut 3,000 beds.

By 1999, the nation's hospital beds dropped to 3.0 per 1,000 people. Well-to-do Northern Virginia had just 1.58 beds per 1,000 people in 2000. **Table 1** shows the ten most populous states in the country, which led in the number of hospital shutdowns during 1985-99, based on AHA figures. For instance, Massachusetts lost 79, or 29% of its hospitals in that period, and 9,583, or 37% of its beds. Consider also how managed care is a major cause for the fiscal crisis now engulfing our *public* hospitals, which serve a disproportionate share of low-income and uninsured patients. This drive to destroy the General Welfare is best exemplified by the fascist Gingrich Conservative Revolution's explicitly genocidal plan to close D.C. General Hospital, the only public hospital in the nation's capital, and the only full-service hospital in the city's Southeast quadrant.

Nursing Homes Closed

The BBA also slashed payments to nursing homes in several ways. First, it instituted a Medicare PPS (flat-rate reimbursement) for nursing homes. More importantly, it repealed the Boren Amendment, which required that states pay nursing facilities services under Medicaid using rates that are "reasonable and adequate." With the repeal, states are forcing some homes to refuse Medicaid patients. This resulted in the closing of nursing home beds—400 closed last Summer in Delaware County, Pennsylvania alone. These closures are significant because they result in elderly patients being "boarded" in hospitals.

When the BBA was enforced, five of the ten largest for-profit nursing home corporations in the United States went into bankruptcy. The Louisville-based Vencor, the major for-profit chain of 216 nursing homes that filed for bankruptcy in 1999, and Ventas, the real estate investment trust that owns its facilities, agreed in March to pay $104.5 million to settle Federal allegations that Vencor defrauded government health programs.

Unless and until the United States reverses this 30-year trend and takes up once again the U.S. Constitutional principle of the General Welfare, as defined by the Hill-Burton standards, there's no halting the precipitous collapse of every aspect of the U.S. health and hospital system.

TABLE 1
The Closedown of America's Community Hospitals and Beds, on a National and State Basis

	Beds per 1,000 Population		Hospitals and Beds Shut Down, 1985-99			
	1985	1999	Hospitals	Percentage	Beds	Percentage
Massachusetts	4.45	2.64	33	29.5%	9,583	37.0%
Michigan	4.13	2.65	48	24.9	11,402	30.4
Minnesota	5.23	3.45	31	18.8	5,475	25.0
California	3.16	2.22	84	17.5	9,560	11.5
Illinois	4.76	3.11	40	16.8	17,267	31.4
Tennessee	5.29	3.76	24	16.6	4,603	18.2
Washington	2.99	1.93	17	16.5	2,081	15.8
Missouri	5.11	3.70	23	16.3	5,481	21.3
Louisiana	4.50	3.84	23	15.9	3,408	16.9
New York	4.45	3.79	41	15.8	10,062	12.7
Alabama	4.90	3.73	20	15.5	3,397	17.2
Ohio	4.41	3.03	30	15.2	13,336	28.1
Texas	4.03	2.83	72	15.0	9,237	14.0
Pennsylvania	4.74	3.59	31	12.9	13,222	23.5
U.S. Total	4.19	3.00	776	13.5	170,688	17.1

Sources: American Hospital Association; Bureau of Census, U.S. Department of Commerce; *EIR.*