No 'Recovery' in Public Health of the United States

by Marcia Merry Baker and Linda Everett

Behind all the current campaign rhetoric about how to stiff Medicare and Medicaid—without saying so—and how to appear to help cover high pharmaceutical costs—without doing so—there is a fundamental crisis worsening by the week in the United States: The basic infrastructure for delivering medical care is shrinking to levels guaranteed to increase the rate of morbidity and death. This can be seen in two simple parameters: hospital bed availability, and childhood disease immunization rates.

Nationally, at the end of the 20th Century, the community hospital bed-ratio in the United States had fallen to barely 3 beds available per 1,000 people. This is below even the 1940s national average, which gave rise to the post-World War II remedial hospital-building drive under the 1946 Federal-local cooperation legislation known as the Hill-Burton Act. That drive aimed at having a community hospital in every American county, and throughout the cities, to guarantee hospital care to citizens based on a set bed-ratio level: in urban areas, 4.5 beds per 1,000 people; and in rural areas, 5.5 beds per 1,000 (sparsely settled regions, with less transport, require redundancy).

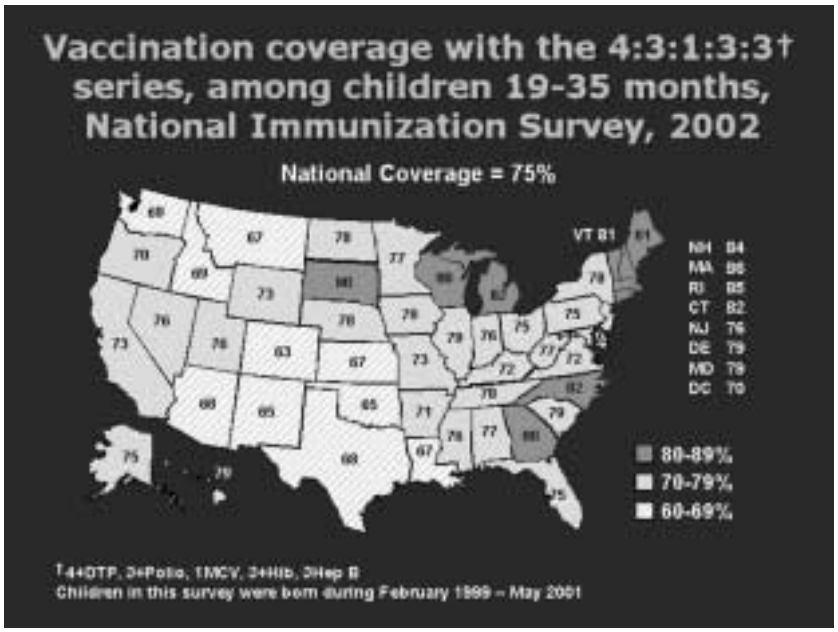
Areas With No Hospitals

From 1950 to the 1970s, the Hill-Burton policy provided many of the 3,089 U.S. counties with their first hospitals ever; and as of 1975, the desired bed-ratios were reached. At the same time, public health clinics for preventive disease and sanitation services expanded. But the shift begun with President Richard Nixon's Dec. 29, 1973 signing of the "Health Care Maintenance Organization and Resources Development Act," ushered in decades of takedown of the health-care infrastructure through deregulation of all kinds, and the underpayment for medical services by HMOs. The number of community hospitals in the United States fell 20%, for example, in the decade 1992-2001.

In 2002 and 2003, states and counties—reacting to the systemic economic crisis which has devastated their revenues—have made sweeping cuts in public health, medical payments, and staff, and thus undermined the already below-standard health-care infrastructure system. More hospitals are shutting down, while HMOs continue to loot what's left of the system.

The result is that there are today many rural counties where all hospitals have been closed, and residents must drive several counties over to find medical care. In leading urban centers—including the nation's capital—many of the last remaining hospitals are on the verge of elimination, especially those providing care for the poor.

Washington, D.C.: The entire Southeast quadrant of the nation's capital, 150,000 residents, will soon have no hospital at all. In June 2001, the fine 400-bed-plus, full-service, public D.C. General Hospital was shut down, as the result of forced action to open its riverfront site for future real estate specula-



Coverage of the most basic series of childhood vaccinations has fallen below the danger threshold of 70% in ten states, and to 61% nationally for children below the poverty line, says the Atlanta Centers for Disease Control's latest survey.

tion, and to make way for a privateer company, Arizona-based Doctors Community Healthcare Corp. (DCHC), to take over treatment of the poor at its for-profit Greater Southeast Community Hospital. But on Nov. 20, 2002, Greater Southeast declared bankruptcy; in March 2003, D.C. regulators recommended "de-licensure" of the facility, because of risk to patients from substandard care—which should close it. Mayor Anthony Williams' administration is ignoring this, in order to maintain a pretense of care for the community, but no funds or arrangements are forthcoming, and Greater Southeast's closing will leave that quadrant without a single hospital bed. Congress, which is responsible for the District of Columbia, is ignoring the crisis. On Aug. 11, some 200 Southeast residents met at the Union Temple Baptist Church, to plan marches, a petition drive, and a ballot referendum to back reopening D.C. General Hospital.

Detroit: An estimated 60% of the city's residents live in "medically underserved" areas already, and major closures are proposed for the coming months. Oct. 1 is the projected closure date for St. John Northeast Community Hospital, unless contingencies are arranged. This facility serves a patient population at least half of which are uninsured or on Medicare.

The survival of two more hospitals is at stake—Hutzel Women's Hospital and Detroit Receiving Hospital, both owned and run by the Detroit Medical Center (DMC), the primary provider of medical care to some 180,000 poor and uninsured. DMC is a non-profit company with 10 hospitals and 50 outpatient facilities. It takes care of 25% of Michigan's patients under Medicaid—the state-Federal program for poor and disabled patients. In addition, Hutzel and Detroit Receiving are teaching hospitals, key to training future doctors and other medical specialists, through Wayne State University and other programs.

In mid-June, an emergency infusion of $50 million was promised by Gov. Jennifer Granholm, to buy some time for an action plan to be devised by the city of Detroit, Wayne County, and DMC to prevent a closing. Already, in response to DMC hospitals losing $400 million over the past six years—DMC has implemented cutbacks, including staff cuts. A sweeping cut of 1,000 more hospital workers has been mooted.

Clinics Shutting: Childhood Diseases Loom

The other front line of health care is networks of clinics—many based in hospitals—to provide a host of public-health services, including tests, administering TB and other medications, and especially immunizations. Over the past two years, many counties and cities have drastically cut back in public-health programs, either shutting clinics, or severely cutting their hours. Some counties now have no programs at all. One leading example is Los Angeles, where 16 clinics shut down in just the past year.

The implications of this are dire, and nowhere worse than in the falling rate of immunization for childhood diseases. Already as of 2001, ten states were below 70% immunization levels for children—considered the critical threshold level to protect the general public from epidemics. While the national average immunization coverage is 75%, these ten states are below the average by as much as 12% (Idaho, Montana, Arizona, New Mexico, Kansas, Oklahoma, Texas, Louisiana, Colorado, and Washington). Colorado ranked lowest in the nation at 62.7%. At the county and local level, the rates of immunization are even lower: The lowest three cities in the nation are: Newark at 57.5%; Detroit at 57.7%; and Houston at 61.44%.

These figures are from the Centers for Disease Control and Prevention (CDC), which on July 31 released the results of its latest survey of 2002 immunization rates of children 19-35 months old (see map). If the impact of the clinic shutdowns and service cutbacks is added to this map, then disease outbreaks appear imminent. It is known already that 1.7 million impoverished people are in the process, in 2003, of having their minimal health-care coverage revoked because of budget cuts in the Medicaid and State Children Health Insurance Programs (SCHIP), and that clinics are being shut that provide childhood immunizations and pediatric help.

Dr. Georges Benjamin, Director of the American Public Health Association, warned of the dangers of allowing "geographic pockets" of low immunization to occur. Dr. Benjamin reports that a great number of experienced people on the front lines of public-health infrastructure are being lost—those who document immunization rates in a community are no longer there. Dr. David Neuman, National Partnership for Immunization (NPI) told *EIR*, "With all the scrambling for smallpox and biological terrorism preparedness, a lot of resources and staff that was used to support public-health immunization programs have been diverted." For a time, the "herd effect," in which the majority of a community is immunized, will provide protection for those sub-groups not immunized. But, as the CDC warns, "Should vaccine-preventable disease be introduced into low-coverage geographic areas, the accumulation of susceptible persons might serve as a reservoir to disseminate diseases."

Immunization is the vanguard of public-health practice. Infants need 16-24 doses of various vaccines before the age of two to ward off preventable deadly diseases, such as diphtheria, pertussis (whooping cough), tetanus, measles, mumps, rubella, chickenpox, haemophilus influenzae, and polio. One million children under the age of two have not received all of their inoculations. Poverty is the most pervasive factor associated with low vaccination rates. For those living below the official poverty level, the national vaccination rate for 2002 was only 61.6% (for the 4:3:1:3:3:1 Vaccination Series).

As state budget cuts deepen, there are fewer public-health workers to gather accurate information; 40% of states and cities did not submit 2000-01 vaccination coverage estimates at all.