Pennsylvania Hospitals And Healthcare Vanishing

by Mary Jane Freeman

> Sell not virtue to purchase wealth nor liberty to purchase power.
>
> —*Benjamin Franklin*

Pennsylvania, the cradle of American healthcare, where Benjamin Franklin and others established the first hospital on these shores and promoted medical scientific research, has had its hospital infrastructure systematically looted and shut down over the last two and a half decades. The ongoing disappearance of hospital care in Pennsylvania—in particular, of the availability of hospital beds to the people of the Commonwealth, county by county—is emblematic of the destruction of healthcare infrastructure nationwide in the "HMO era." Since the impact of the Nixon-era legislation promoting the creation of health maintenance organizations, and the follow-on of "managed care" policies which made "shareholder value" the driver for healthcare, America's hospital infrastructure and the healthcare needs of our citizens have become merely another source of revenues to bleed for loot.

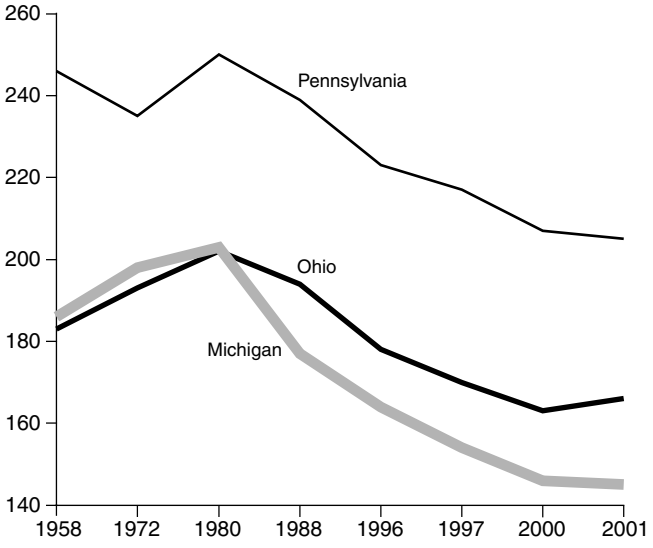
The post-1960s paradigm shift from a producer to a consumer society has left the physical infrastructure upon which we rely for our existence in shambles, as this feature, as a whole, depicts. In the healthcare field, the signing into law by President Richard Nixon of the Health Maintenance Organization and Resources Development Act of 1973, replaced the mission of healthcare to provide for the general welfare, with the diktat that "cost containment" comes first. The concept is completely antithetical to Franklin's advice, quoted above.

Rather than "containing costs," HMO/managed care policies have led to unaffordable and less accessible healthcare. Nearly half of personal bankruptcy filings are caused by medical bill debt, while the number of uninsured citizens has risen to 45 million, as jobs are cut and health insurance premiums rise. Most dramatically, the HMO/managed care policies have led to the disappearance of hospitals—hundreds of them each decade since the late 1970s.

Successful Legislation Was Undone

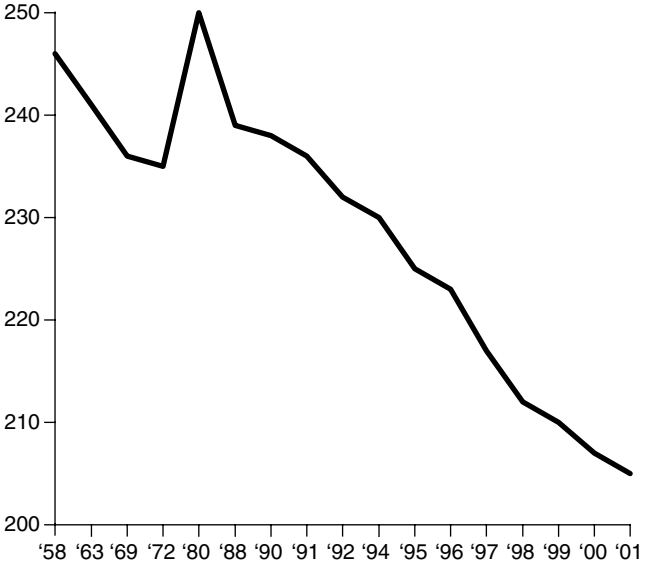
HMO policies dismantled the FDR legacy of protecting the general welfare, as carried on by Senators Lister Hill (D-Ala.) and Harold Burton (R-Ohio) in their 1946 Hill-Burton Act, which mandated and assisted the construction of hospitals and the staffing of hospital beds of various types for each of the 3,600 counties in the United States. The Act set a ratio

FIGURE 1
Gain/Loss in Community Hospitals, 1958-2001
(Number of Hospitals)



Sources: U.S. Statistical Abstracts; *EIR*.

FIGURE 2
Gain/Loss in Pennsylvania Community Hospitals, 1958-2001
(Number of Hospitals)



Sources: U.S. Statistical Abstracts; *EIR*.

of 4.5-5.5 beds per 1,000 population as a baseline to build an adequate infrastructure for a good national healthcare system.

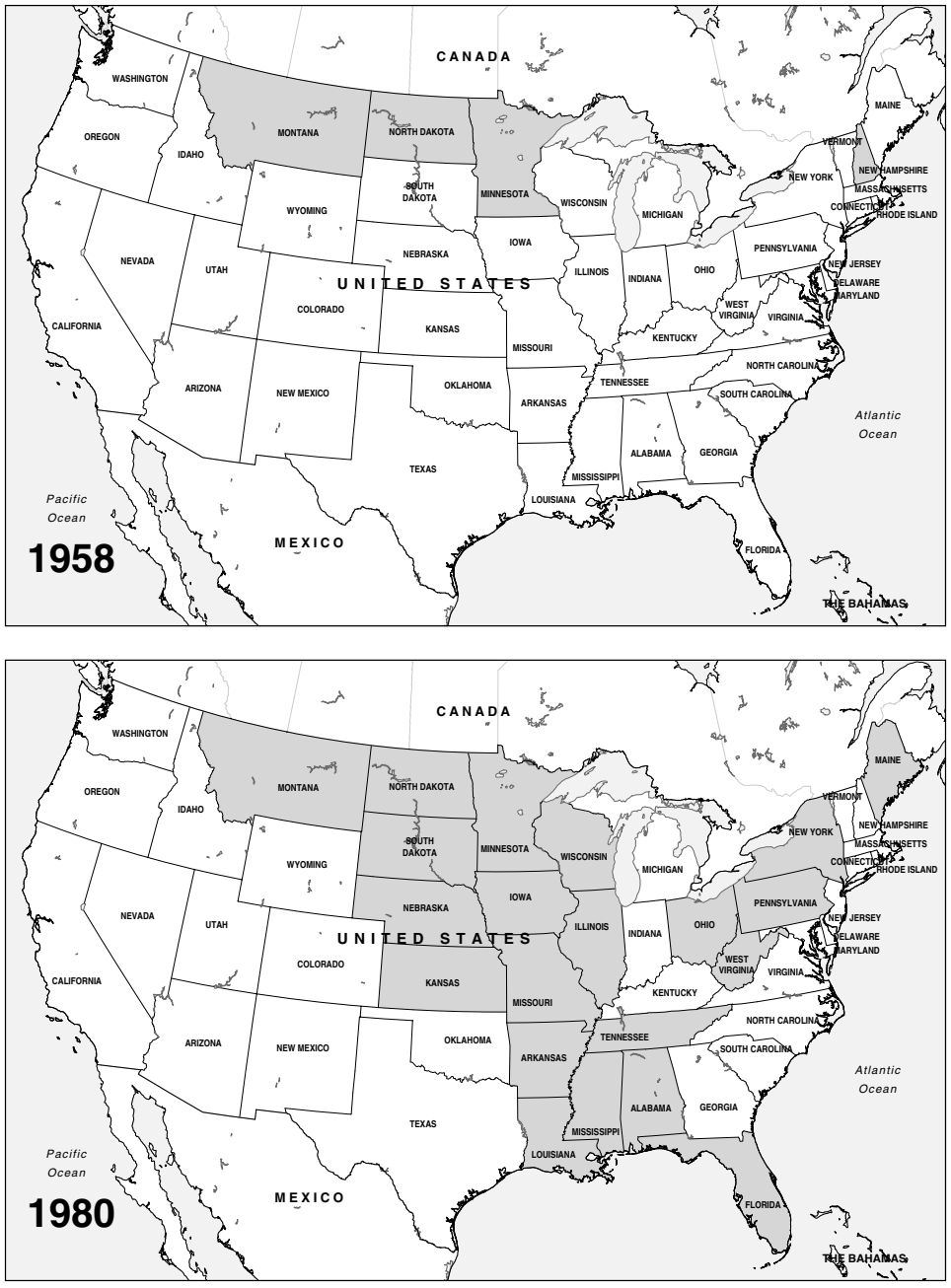
From 1958-1980 under the Hill-Burton mandate, 583 community or general acute-care hospitals and 378,000 staffed community hospital beds were added to America's healthcare infrastructure for preserving life, advancing medical science, or coping with emergencies, epidemics, or natural disasters. But between 1980 and 2001, the shift into HMO-dictated cost accounting policies hit. The result was: 902 community hospitals and 161,000 beds *disappeared* between 1980 and 2001.

During this time, the American population continued to grow. Up through 1980, the Hill-Burton ratio of beds to 1,000 people improved. But after 1980, it declined dramatically.

Figures 3 a-c show that whereas in 1958, only 4 states met the Hill-Burton minimum ratio, 21 states had sufficient hospital infrastructure by 1980. But by 1990, the number of states above the minimum required level had fallen to 14, and by 2000, it was nearly back to the 1958 level—only 5 states. This reversal of the post-World War II buildup of the nation's community hospital base, intersected the takedown of the entire physical economy—especially America's manufacturing base, as *EIR* has documented.

FIGURES 3a-c

States with Federal-Standard Level of Hospital Beds per Capita



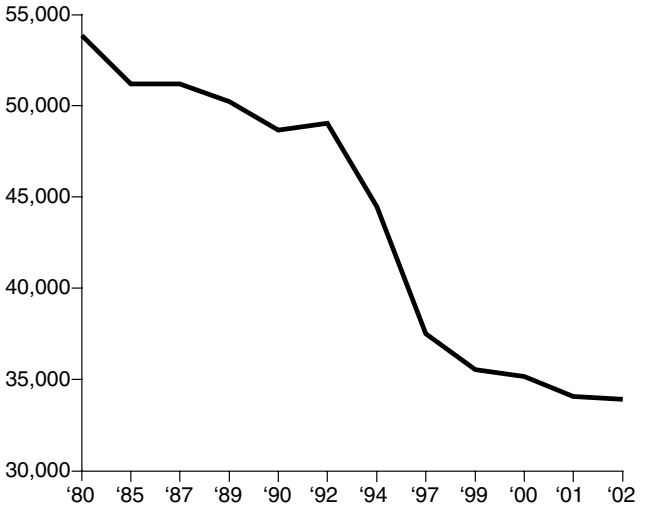
The 1946 Hill-Burton Act was successful in its purpose to lift most counties about a minimum standard of 4.5 hospital beds per 1,000 population. From five states in 1958, 21 states in 1980 were fully over the minimum. In the HMO era, the number has fallen back to five.

Figure 1 shows this shutdown of hospitals in three key industrial heartland states—Michigan, Ohio, and Pennsylvania. Only five other states had larger 1980-2001 losses of hospitals than these three; they were California (which saw 120 hospitals shut), Illinois (49), Massachusetts (39), New York (59), and Texas (79). Nationwide, all but five states lost hospitals between 1980-2001. Exact data are not yet available for 2002-2004, but the trend continues.

The dramatic shutdown of Pennsylvania's community hospitals since 1980 is shown in **Figure 2.** U.S. Census data shows that 45 hospitals, or 18% of those in the state in 1980, have been lost, along with 15,000 staffed beds—26.5% of the

Source: U.S. Statistic Abstracts; EIRNS, 2004.

FIGURE 4
Loss of Community Hospital Beds in Pennsylvania, 1980-2002
(Number of Beds)



Sources: Pennsylvania Counties, Health Profiles, Commonwealth of Pennsylvania Dept. of Health, State Center for Health Statistics and Research.

total. Data from the Pennsylvania Department of Health's Bureau of Health Statistics and Research, only available from 1980 on, has smaller aggregate totals for hospitals and beds, but shows larger losses for this period: 47 hospitals lost (20%); and 19,764 beds (36.7%). **Figure 4** uses the Pennsylvania Bureau's statistics, adds 2002 data, and shows the drastic decline of beds since 1980. Even before this, the seismic 1977 shutdown of Philadelphia General Hospital had left tens of thousands of indigent citizens in the nation's fourth-largest city without a public hospital to go to.

Pennsylvania Shakedown— Sharks in the Water

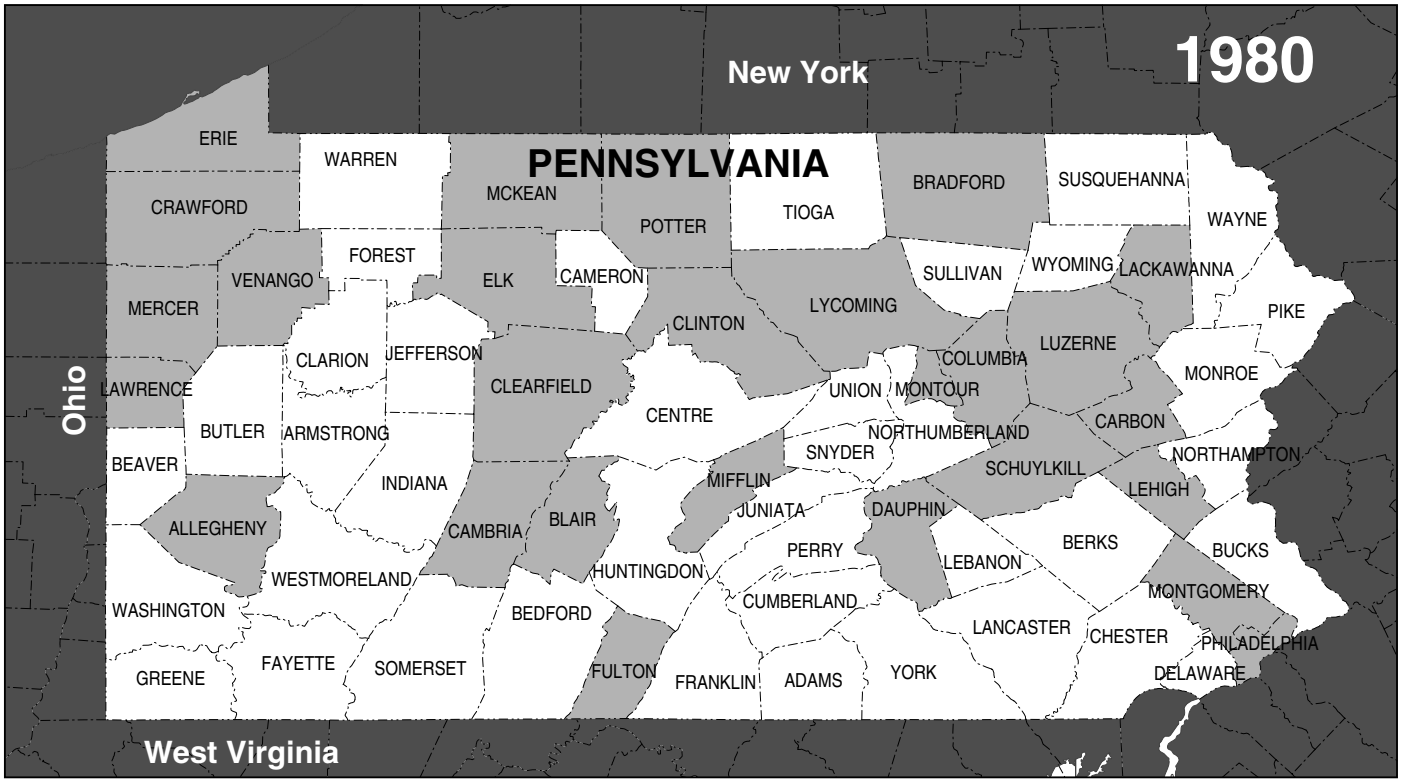
It was in 1986—the endpoint of the 1980-1988 fall shown in Figure 3—that Wall Street merger mania hit Pennsylvania's health system. Sherif Abdelhak, in cahoots with others using the Allegheny Health, Education, and Research Foundation (AHERF), began an ambitious strategy of acquisitions of hospitals, medical schools, and primary care physician practices, to create the largest statewide integrated healthcare delivery system. Full service healthcare for all Pennsylvanians was not the objective, but rather gaming the market—as Enron notoriously did to California's deregulated electricity "market." In fact, the financial tools used by Abdelhak to fuel the "growth" were similar to Enron's: faked balance sheets, hidden internal cash transfers, raids on hospital endowments, and piling up of debt from acquisitions.

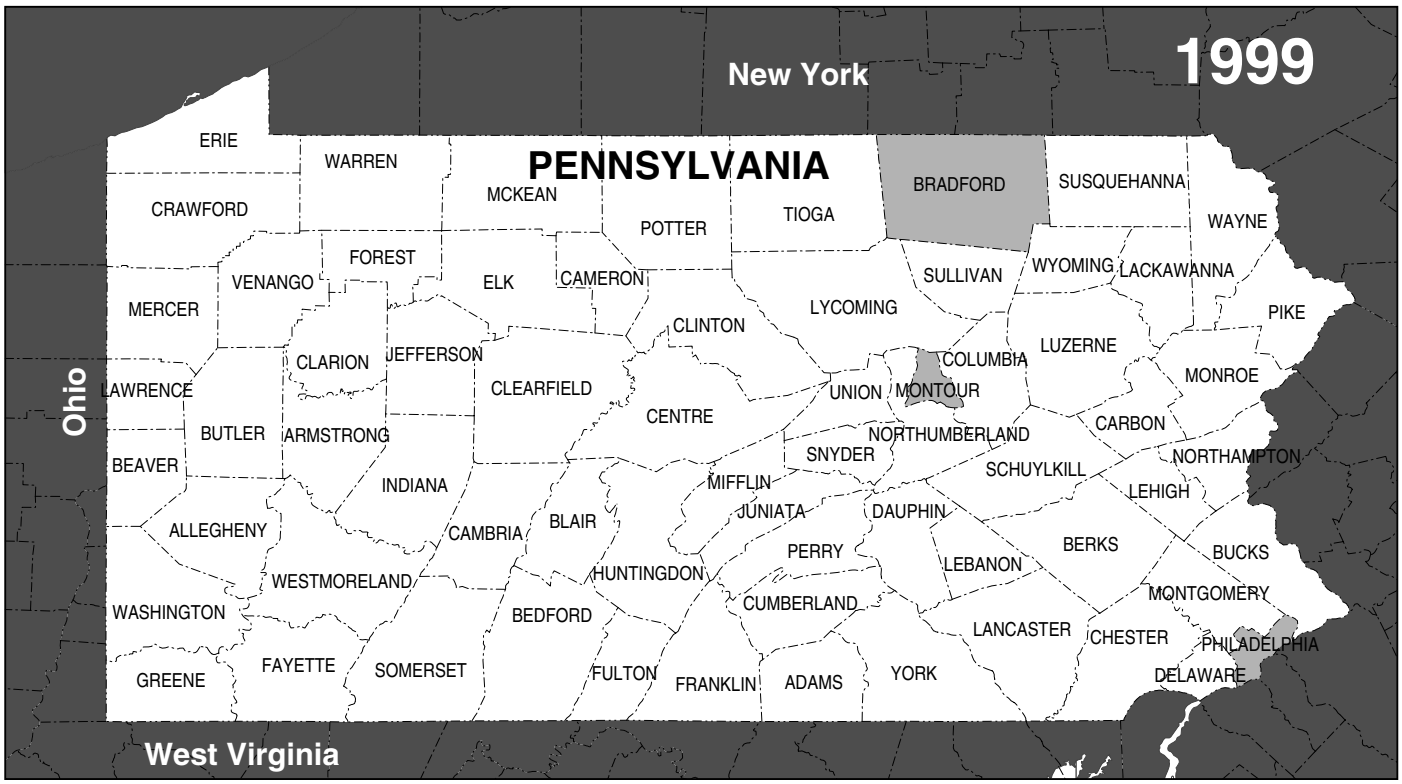
The deadly game was up in 1998, when AHERF filed the nation's largest non-profit healthcare bankruptcy. In its wake came a swath of hospital closures, thousands of layoffs, a $1.4 billion debt, dismantled physician practices, etc. Creditors ended up with 12¢ on the dollar, Abdelhak had 1,500 felony charges reduced to one misdemeanor, for misappropriating not-for-profit funds, and the state had 10% fewer hospitals and 26.7% few beds to provide for its citizens' needs.

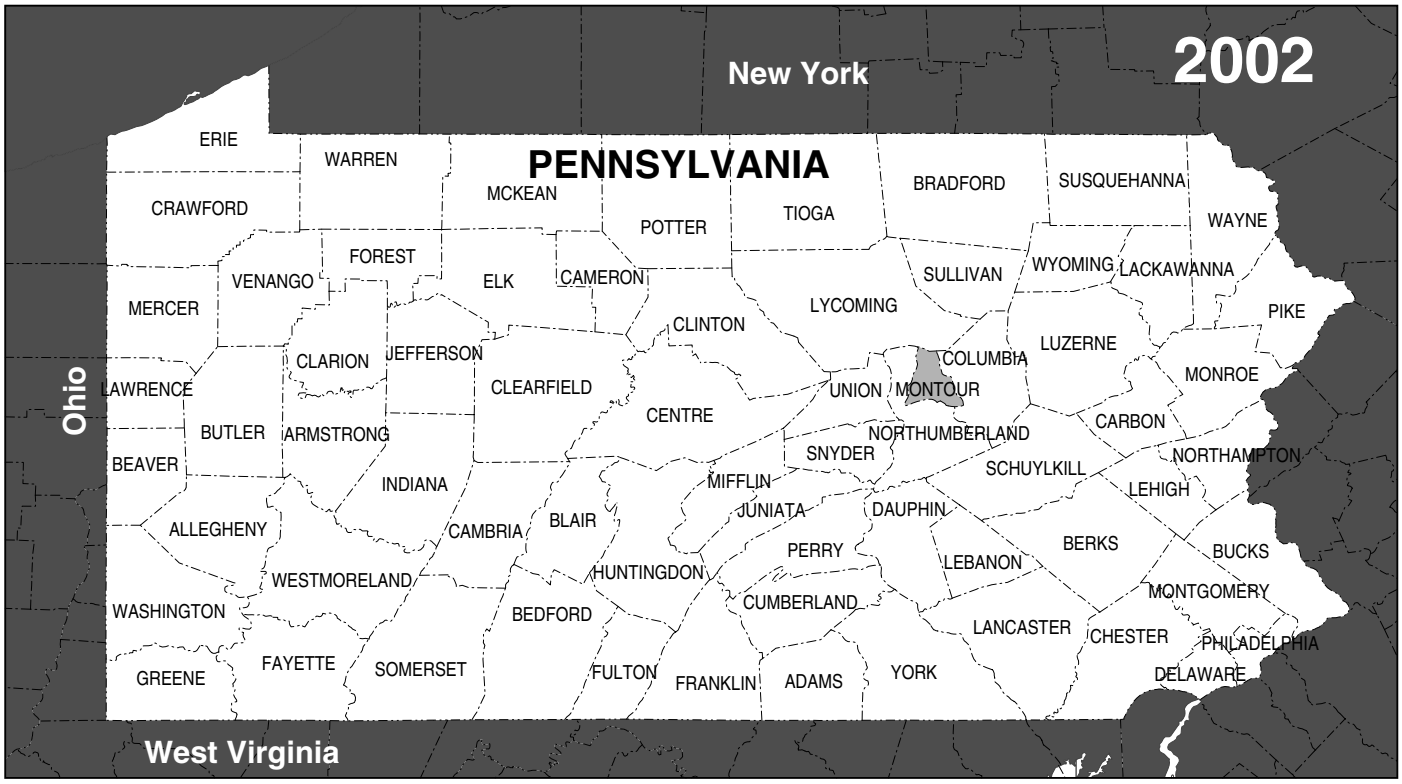
Not only was it a ruthless, folly-filled scheme, but this looting of the healthcare revenue stream hit as deindustrialization of the economy continued, reimbursement levels from HMOs were cut back, and Congress curtailed funding for Medicare and Medicaid—sources of income hospitals heavily rely upon. Adding to this, in 1996, then-Governor Tom Ridge signed SB-1441 (called a "prescription for death" bill by State Rep. Harold James of Philadelphia), axing 223,448 persons from medical assistance to help balance the budget. Ridge's cut was expected to result in over $270 million in lost hospital revenues. Lost revenues translates into lost capacity. Between 1997 and 2001, another 16 hospitals disappeared or merged, and 3,436 beds were gone.

FIGURES 5a-d

Counties with Federal-Standard Level of Hospital Beds per Capita







Sources: Pennsylvania Counties, Health Profiles, Commonwealth of Pennsylvania Dept. of Health, State Center for Health Statistics and Research; *EIR.*

This swath of destruction to the state's health infrastructure is indicated by the maps in **Figures 5a-d.** They show that the Hill-Burton standard of 4.5 beds per 1,000 people had been built up in 27 out of the state's 67 counties in 1980, but by 2002 this infrastructure had been wiped out. The state's two most populous counties, Philadelphia in the east and Allegheny in the west, suffered huge contraction of their health infrastructure. **Figures 6** and **7** show that from 1980-2002, 43% of Philadelphia's hospitals and 35.5% of its beds were lost, while Allegheny County lost 20.8% of its hospitals and 36% of its beds. What cannot be quantified is the untold number of lives lost needlessly because of this greed and budget cutting.

The impact of this 20-year long flirtation with market medicine has been a disaster. In June, the *Philadelphia Inquirer* reported: "Starved for payments, hospitals have been shrinking . . . especially in poor areas. Twelve hospitals have closed in Southeastern Pennsylvania since 1993. Other hospitals have quietly mothballed some beds." Overcrowding and long waits at still-operating emergency rooms has become the norm as ER visits jumped 30% since 1999, the paper reported.

As more people lose jobs and health insurance, the number of Pennsylvanians uninsured has risen to 12%. Just since February 2004, the wait list for the state's *adultBasic* health insurance program grew by one-third to over 100,000 adults. A full 69% of these uninsured work full or part time.

Heritage of Healing Must Be Restored

Hemorrhaging of the state's hospital infrastructure has not halted. The Pennsylvania Health Care Cost Containment Council's April 2004 "2003 Financial Analysis" reported that 48% of general acute-care hospitals reported losses for Fiscal Year 2003, and that 60% are barely surviving, as measured by their total margin over three years. Gov. Ed Rendell stepped in to save the 153-year old Medical College of Pennsylvania Hospital after the blood-sucker Tenet Heatlhcare Corp. had bled it dry and planned to close it this year. Much more must be done to restore adequate access and affordable healthcare (see box).

LaRouche: Healthcare As Infrastructure

From a September 2002 EIR *Special Report on* Science and Infrastructure*, the statement excerpted here was written on Aug. 23, 2002 by then-Presidential candidate Lyndon LaRouche.*

HMO law is not merely an inevitable failure, now becoming a national catastrophe; it is a predatory medical malpractice performed by shareholder value. We must reverse the presently continuing, disastrous course.

Among the principal changes to be made, we must end the worsening trend toward basing the financial system of health-care on that usurious illogic, of using case-by-case accounting as an instrument of accountants' financial control of the medical practice, respecting the functions of diagnosis and care for the individual patient. It is ultimately as injurious to the U.S. national interest to regulate the delivery of medical service on a patient-case by patient-case basis, as it would be to provide public sanitation for the sole benefit of one residence, but not the adjoining ones. My neighbor's disease is a disease of our neighborhood—or, like epidemic contagious disease, or pollution, a disease of the nation as a whole. Health-care for a society is a matter of national-security interest.

The delivery of health-care by the medical profession is "entrepreneurial" in respect to its most essential characteristic: the application of the developed creative mental powers of the individual professional; public-health policy is a matter of the interdependency of the universal and particular role of the professional. *The provision of available health-care is universal; the professional care for the patient, is a privileged action by the relevant individual professional's direct relationship to the patient.*

The arrangement under which quacks, guised as financial executives or accountants, engage in the malpractice of medicine, must be ended, and banned from future recurrence.

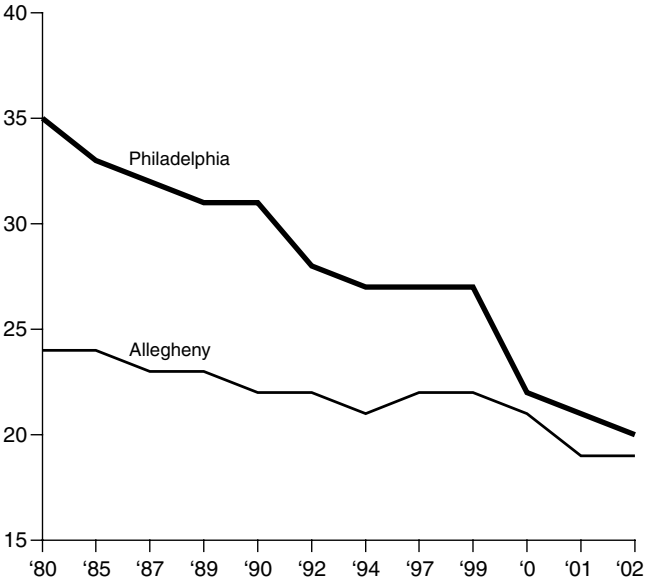
The leading edge of the process of rebuilding our national health-care system, will be the emphasis of public effort, by the Federal and state governments, on buttressing existing full-service general hospitals, and re-establishing them where closures of essential such institutions have occurred. Full-service general hospitals which function as teaching institutions, are crucial. Such an emphasis on general hospitals, and enhancement of their relations with the related research functions of universities, will provide the technological lever of reconstruction of the nation's health-care potential as a whole.

On the financing of health-care, we must return to the pre-HMO system. Health-care as a whole, is a bulk-purchase, not a retail sales outlet. The forecast payments from private patients, and from those under insurance or related programs, must be supplemented by the combination of contributions to hospital budget-requirements, and also capital improvements, by fund-raising, with contributions from agencies of government as that last-resort amount which enables the institution to meet the requirements of relatively indigent patients.

FIGURE 6

Loss of Hospitals, Allegheny and Philadelphia Counties, 1980-2002

(Number of Hospitals)

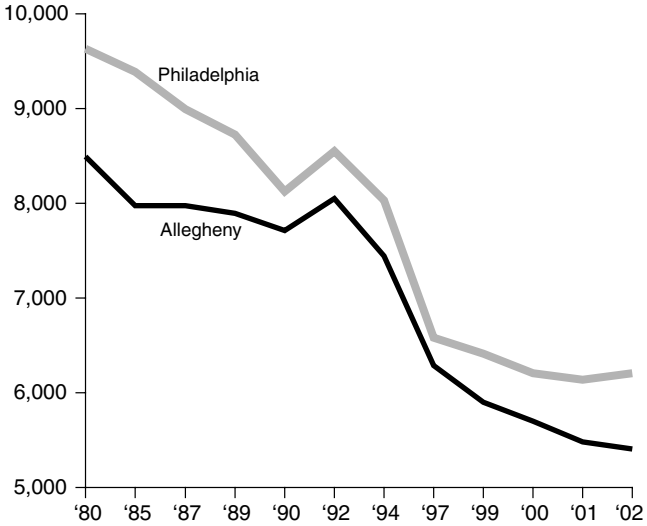


Sources: Pennsylvania Counties, Health Profiles, Commonwealth of Pennsylvania Dept. of Health, State Center for Health Statistics and Research; *EIR.*

FIGURE 7

Loss of Hospital Beds, Allegheny and Philadelphia Counties, 1980-2002

((Number of Beds)



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