Health-Care 'Fundamental Infrastructure' Threatened by Medicaid-Cuts Mentality

by Marcia Merry Baker

A bipartisan, widespread resistance movement came into being this Spring, against the Bush Administration's commitment to cut government outlays to the 1960s-enacted program for health care under the Social Security law, known as Medicaid. Though intended as a temporary-use safety net for citizens in need, Medicaid now has become the only resort for some 55 million Americans. The President's Fiscal Year 2006 budget called for $60 billion in cuts to the program over ten years; and Medicare cuts are pending as well.

Medicaid enrollment has risen dramatically as the economy declined over the past five years, going from 33 million in 2001, to over 55 million today. Accordingly, all the systems of health-care provision of the nation—hospitals, clinics, health centers, nursing homes, etc.—have become tightly tied to the flow of Medicaid payments. In fact, if Medicaid payments are cut to these facilities, the potential source of care is jeopardized for an additional 45 million Americans, who currently have no health-care insurance at all, along with those still under some kind of coverage. At stake is our health infrastructure, which needs to be built up, not taken down.

The principles of how to think about what to do, have been laid out in a mass circulation paper, *Recreate Our Economy* by Lyndon LaRouche, issued in April this year; and on health care in particular, in "Situating Health-Care Policy—What Is Infrastructure?" released March 24 (www.larouchepac.com).

Besides the obvious urgency and timing of LaRouche's policy intervention, his paper is of special relevance to bipartisan deliberations under way, because a bipartisan Commission on Medicaid has been called for, to decide what to do instead of blindly continuing the "cuts mentality."

Sen. Jay Rockefeller (D-W.V.), drew out this point March 9, when he took up leadership of a newly formed Senate Democratic Medicaid Working Group, saying, "Medicaid is our health-care safety net. It is the fulfillment of the promise the Federal government has made to our nation's most vulnerable citizens—pregnant women, children, the elderly, and the disabled—that they will have access to health care when times get tough. Medicaid is also much more than that—*it is the foundation of our health-care infrastructure through its support of hospitals, doctors, and nursing homes, which deliver critical care throughout the country,* especially in rural areas and small communities that make up much of West Virginia" (emphasis added). His point applies equally to poor, inner-city areas.

What follows is a review of the vulnerable condition of the major components of the U.S. national health-care infrastructure—from hospitals, to clinics, health centers, nursing homes, and medical staff-to-population ratios. What stands out is that *the entire system is on the edge,* after decades of Federally promoted downsizing, and privateering, in the name of such deregulation-serving ruses as "competition . . . health management . . . health maintenance organizations . . . eliminating bed overcapacity," etc. Loss of facilities has already reached the point of upping the death toll in areas such as Southeast Washington, D.C., Detroit, Los Angeles, as well as in rural areas.

Advocates for the various sections of the national health-care system are now making last-ditch appeals to be spared cuts in Medicaid, Medicare, and other Federal payments, in order to save the vestiges of their particular operations and provide care for desperate people. But what the crisis now requires of lawmakers, specialists, and average citizens alike is to have an overview of the whole national health-care infrastructure—to see what is required, and restore and expand every needed aspect, on a basis of agreed-upon priorities.

In turn, acting to rescue health care can only be successfully done in the same mobilization as for emergency measures for the economy as a whole. "Hard" infrastructure, as well as "soft" (schools, hospitals, etc.), is in crisis—including Amtrak, waterways, and power generation. At the center of it all is the necessity for immediate intervention to preserve the very core of the industrial base of the nation—the machine-tool and factory complex now on the line with the financial crisis of General Motors and the entire auto sector.

Some of the key parameters of health-care infrastructure are indicated in this series of maps produced by the North Carolina Rural Health Research and Policy Analysis Center, Cecil B. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. They are available in the Cartographic Archive on its website (see www.shepscenter.unc.edu).

Public Hospital Base Downsized

The first map (**Figure 1**) shows the high degree of dependence on Medicaid revenues of U.S. hospitals. The second map (**Figure 2**)

FIGURE 1

Hospitals in Many Rural Counties Are Highly Dependent on Medicaid Payments

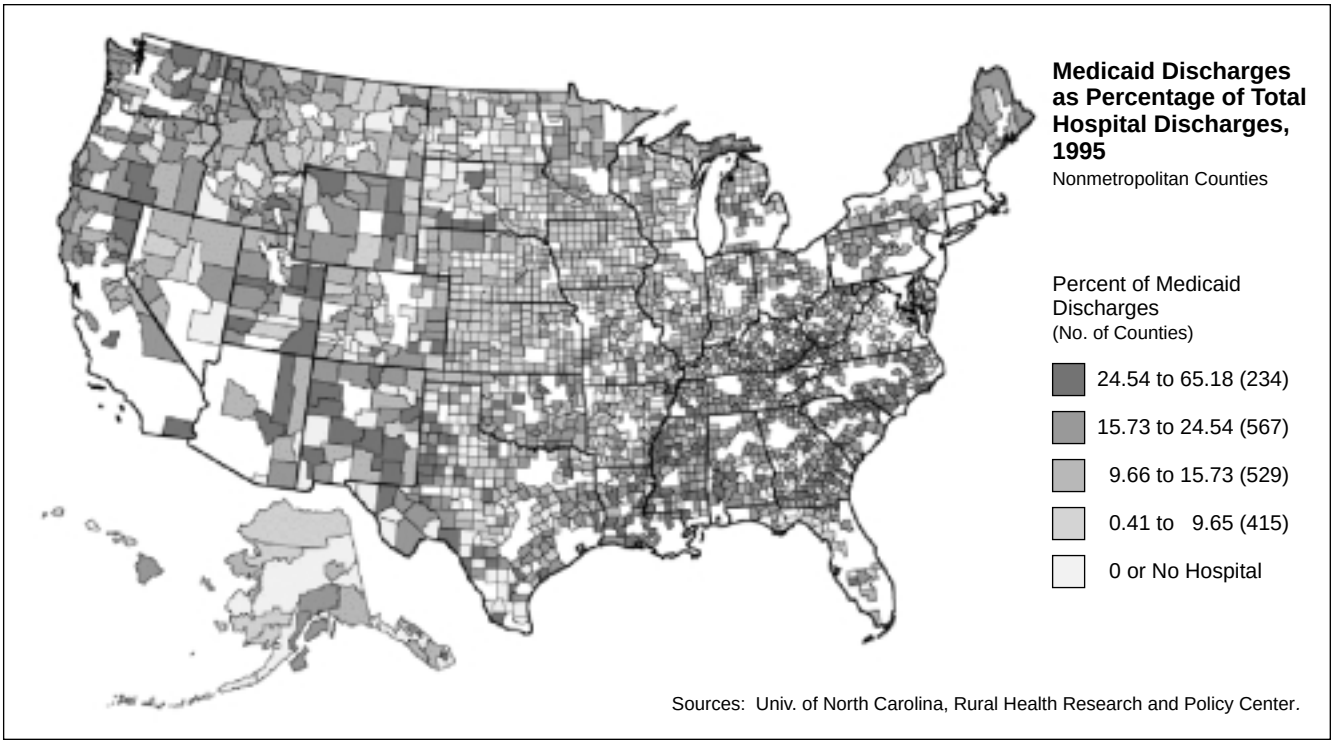


FIGURE 2

Location of 4,040 Public Hospitals, 2004

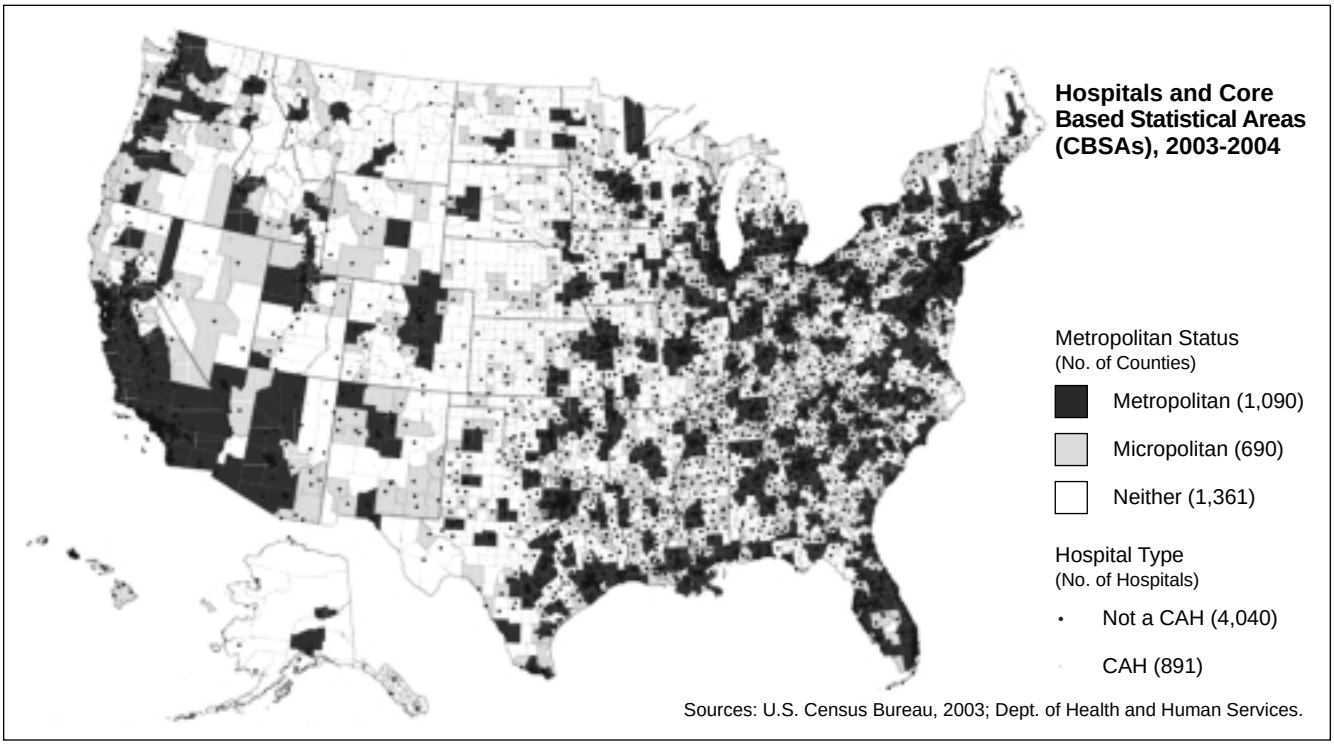
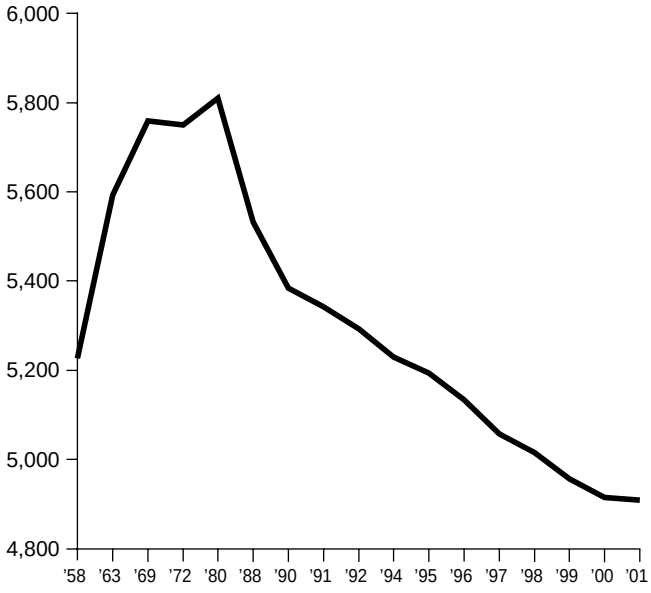


FIGURE 3

Number of Community Hospitals Declined Nationally During HMO Era

(Number of Hospitals)



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

is a reference map showing the sites of 4,040 full service hospitals. In addition to those, there are lesser-service hospitals, officially designated as "Critical Access Hospitals" (CAH), mapped in **Figure 4.**

In Figure 1, the pattern shows that in many counties, 25-65% (darkest tone) of those patients discharged from the hospital are Medicaid beneficiaries. Lighter tones show a lower percentage, but still significant. Shown are only rural counties, but the same pattern holds for inner-city-serving public hospitals.

Moreover, the public hospital base itself is being downsized. The graph in **Figure 3** shows how the number of community hospitals has dropped over the last 25 years, from a level of 5,800 in 1980, down to 4,850 as of 2001.

Up through the 1970s, what was called the "Hill Burton" policy prevailed, whose principle is that ratios of health-care delivery—hospitals, nursing homes, diagnostics, medical staff and so on—should be provided on a per-population basis, as required by where people lived, and by their demographics. Following World War II, it was seen as a Federal responsibility to provide all citizens with access to health-care infrastructure, which meant a commitment to seeing that there was a public hospital, or several—depending on density of population—present in each of the 3,069 counties of the nation. Before passage of Hill Burton in 1946, some 1,700 counties had no public hospital at all.

The 1946 "Hospital Survey and Reconstruction Act," known as the Hill Burton Act (after its bipartisan sponsors Sen. Lister Hill, Democrat of Alabama, and Harold Burton, Republican of Ohio), gave the mandate, funding, and principles in just nine pages. The graph shows the rise in numbers of hospitals from 1958 through the 1970s, as the building commenced.

But with the enactment of the 1973 HMO Act, and related deregulation of health care, this infrastructure principle was set aside, and the takedown of the hospital-based care system has ensued over the last three decades.

In the course of the shrinkage of the hospital base, various Federal amelioration attempts were made. Figure 4 shows one of the most recent, the location of Critical Access Hospitals. In 1997, Congress created this designation, as a rear-guard effort to support the continuation of small hospitals in underserved areas. So, in addition to the 4,000 or so hospitals shown in Figure 2 for 2003-04, at that time there were about 891 additional CAH facilities. Today, the number of full-service hospitals has declined further, and the lesser-service CAH facilities have increased. Figure 4 gives the location for 1,086 Critical Access Hospitals as of March 2005.

Figures 5 and **6** show two more elements—healthcare centers and clinics—which became part of the national healthcare delivery system, as hospital-based systems were downsized. In Figure 5, 1,959 Federally Qualified Health Centers are shown. Among the enabling legislation is Section 330 of the Public Health Service Act, allowing grants for primary care and support services (such as transportation and translation). Figure 6 shows the grid of some 3,298 Rural Health Clinics in the non-metropolitan counties. These were authorized in 1977 (PL 95-210 Rural Health Clinics Act) *for the purpose of improving access to care for Medicare and Medicaid beneficiaries* in areas lacking infrastructure. Such areas are officially defined as "Health Professional Shortage Areas" or "Medically Underserved Areas."

In general, to provide a payments flow for their operations, the clinics and centers, and the CAH institutions, are funded by Federal mandate to receive Medicaid and Medicare payments *at cost,* rather than receiving payment at a set rate, which might be below actual costs of providing the care.

Thus, now, with the new Bush FY 2006 all-bets-are-off plans to cut Medicaid and Medicare payments, a mass wipeout of facilities is threatened—from full-service hospitals and CAH facilities, to clinics and health centers.

Resisting Medicaid Cuts

Take New Mexico, for example. Many of the state's rural counties are in the category where their hospitals have 24-

FIGURE 4

Location of 1,086 Public "Critical Access" Hospitals, 2005

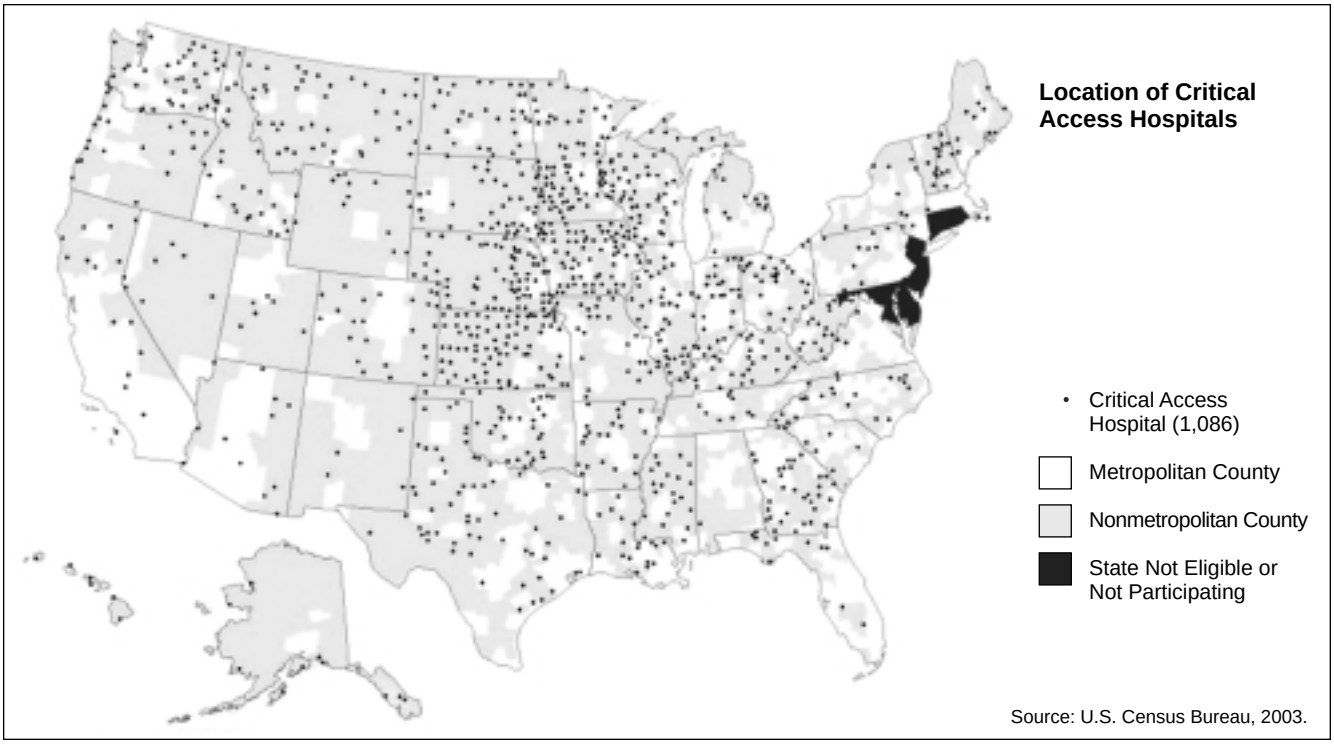
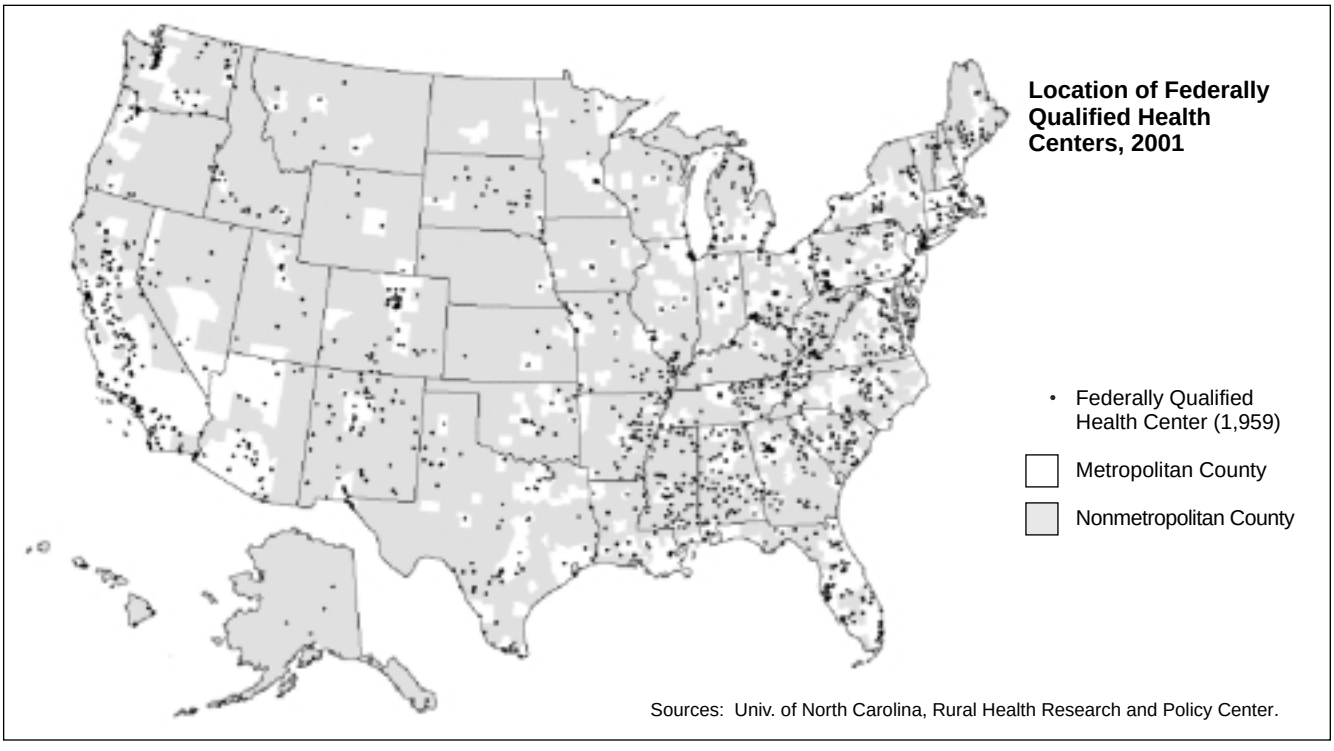


FIGURE 5

Location of 1,959 Health Centers, 2001



65% of their discharged patients covered by Medicaid (Figure 1). Cuts in Medicaid mean automatic financial crises for these hospitals. It was from New Mexico that there arose the key national bipartisan initiative to resist cuts. Republican Rep. Heather Wilson acted within days of the Feb. 6 FY 2006 Budget release by President Bush, which called for $60 billion over ten years in "savings" in Medicaid. On Feb. 17, a large House group filed H.R. 985, "To provide for the establishment of a Bipartisan Commission on Medicaid," and to disallow any cuts during the next fiscal year, in Medicaid programs. Many Republicans and Democrats joined Wilson, including, for example, Jim Gerlach (R-Penn.), and John Conyers (D-Mich.)—from states suffering rapid de-industrialization.

However, they were not able to strike the Administration's Medicaid cuts of some $20 billions, from the Budget Resolution passed by the House in late March for FY 2006. The Senate did succeed in striking all cuts, by passing, on March 21, an amendment with bipartisan sponsorship by Senators Jeff Bingaman (D-N.M.) and Gordon Smith (R-Ore.).

Then the Medicaid-cuts issue became a matter for budget reconciliation between the two chambers. On April 13, a House group of 44 Republicans wrote to the Chairman of the House Committee on the Budget, asking that the House/Senate reconciliation process remove any reductions in Medicaid. Seven of these Republican Representatives were from Pennsylvania alone, with six from New York, and several from Illinois, Michigan and other de-industrializing regions.

Look again at the map in Figure 1, and all across Pennsylvania's northern tier, the counties are shown as places where Medicaid covers a major portion of hospital caseloads. All three Republican Representatives representing these counties called for no Medicaid budget cuts; including, in north-central Pennsylvania, Rep. John E. Peterson (R), co-chairman of the bipartisan Congressional Rural Caucus.

On April 26, the entire House voted 348-72, passing a non-binding resolution instructing the House-Senate budget conferees not to cut Medicaid, and instead, to form a bipartisan Commission to study what to do. Nevertheless, the final Conference report ignored this, and on April 28, was rammed through the House, under strict party-line force, calling for $10 billion in Medicaid cuts—unspecified—over the next one to five years.

In parallel with Congress, Republican and Democratic Governors have pleaded with the Federal government to find a way out of the crisis, by not cutting treatment and infrastructure. The funding of Medicaid calls for both Federal and state inputs, which puts the states in crisis, given the worsening economy. As the economic base of states erodes—especially the industrial, populous centers—state revenues are collapsing at the same time as state Medicaid enrollment grows.

As of FY 2004, 10 out of 50 states saw over 25% of their state budget outlays going to Medicaid. The top ten states, in percentage of the FY 2004 budget going to Medicaid, are: Tennessee (33.3%), Missouri (30.7%), Pennsylvania (29.5%), Maine (29%), New York (28.3%), Illinois (28.1%), Vermont (27.5%), New Hampshire (26.4%), Mississippi (26.3%), and Rhode Island (25.5%).

In reflex reaction to the revenue decline and budget crises, most state lawmakers have tried to shave, cut, and "adjust" rather than demand national economic emergency measures. During Fiscal Years 2004 and 2005, all 50 states have reduced payments to health-care providers; 49 have put new limits on pharmacy costs; 30 states have reduced eligibility for Medicaid; 25 increased co-payments; and 22 have reduced benefits in various ways. This bettered nothing.

The hopeless make-more-cuts process has taken extreme form in several states. In Missouri, Gov. Matt Blunt (R) proposes ending Medicaid coverage for 125,000 people, and moots eliminating the program altogether by 2008. Florida Gov. Jeb Bush (R) is moving to reduce Medicaid enrollment drastically, and cut services.

Clinics, Health Centers Threatened

Even the system of clinics and health centers, provided over the past 40 years as a comedown from a hospital-centered network of health care, is on the line, because Medicaid is their largest source of funding. The grid of Community, Migrant, and Homeless Health Centers, for primary and preventive care to underserved areas, came into being as part of President Johnson's War on Poverty in the 1960s. Over 1,000 health centers—both the ones shown (Figure 5), and another 1,500 additional centers called "look-alikes" of Federally-Qualified Health Centers, currently serve one-quarter of all Americans below poverty. Of those served by these 2,555 centers, nearly 36% are on Medicaid, and another 40% are uninsured, so the Medicaid cuts will be devastating.

There is a special irony associated with health centers and proposed Medicaid cuts: President Bush has made a big deal about health centers. He said on Jan. 27 in Cleveland that he was a "big backer of expanding community health centers to every poor county in America. We really want people who cannot afford health care—the poor and the indigent—to be able to get good primary care at one of these community health centers, and not in the emergency rooms of the hospitals across the United States of America."

Over the period 2001-05, the Administration backed funding for new health centers; the FY 2006 budget calls for $26 million for 40 new centers. But the reality is that 929 poor

FIGURE 6

Location of 3,298 Rural Health Clinics, 2002

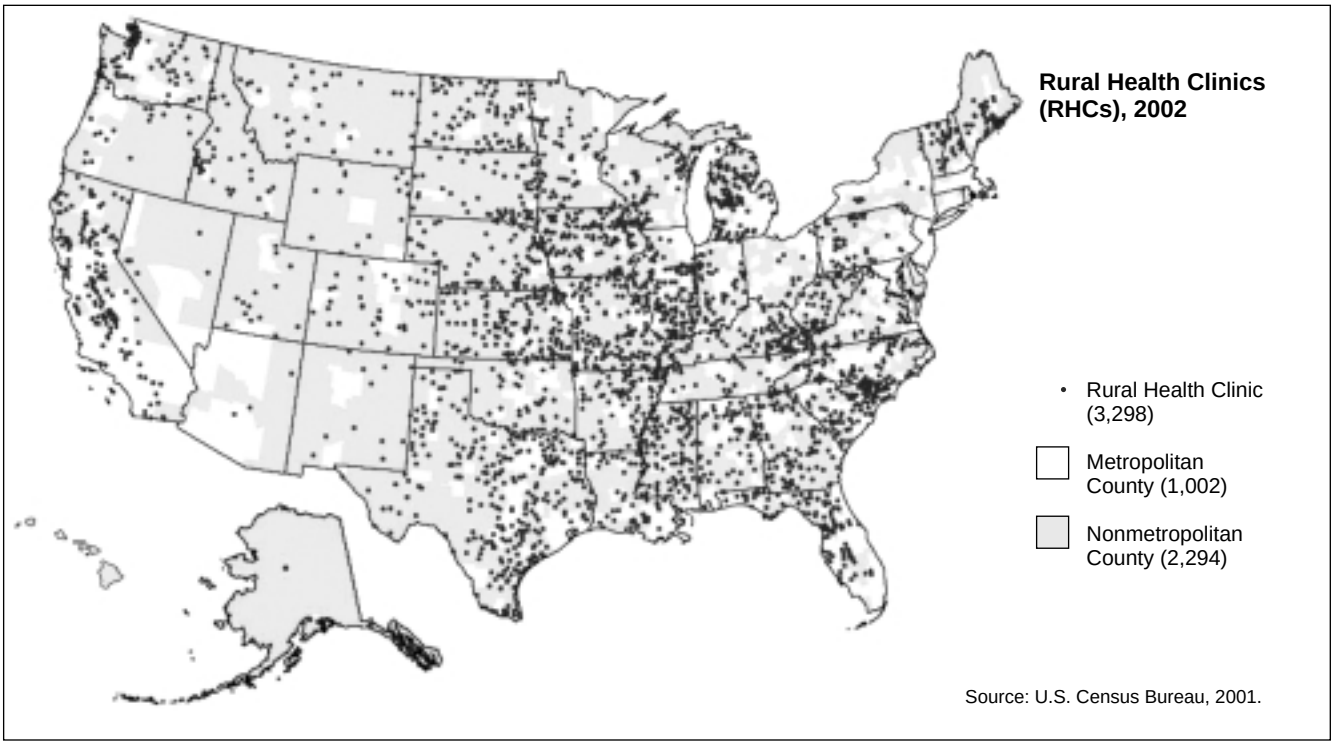
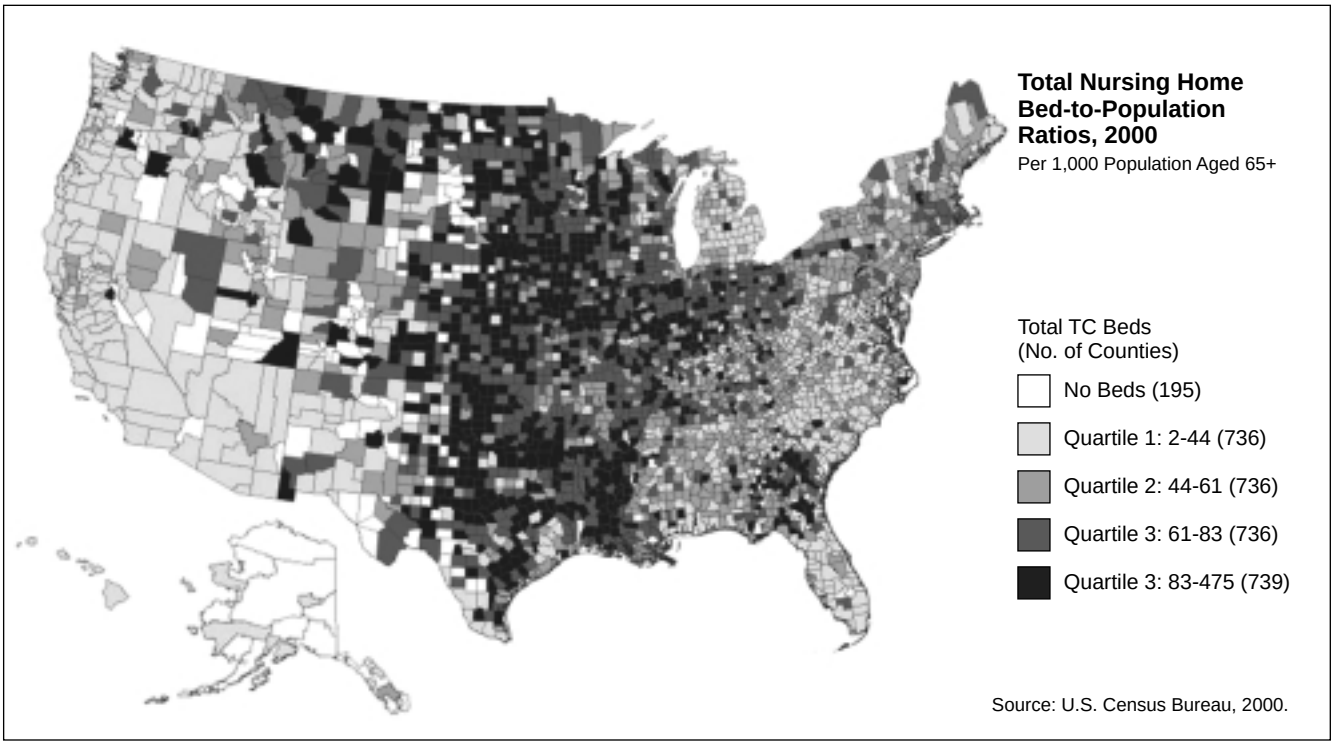


FIGURE 7

Ratio of Nursing Home Beds Per 1,000 Persons Aged 65+, by County, in 2000



counties lack any health center at all; and the Medicaid and other cuts now proposed, are feeding a shutdown process for those centers that do exist! The 929 counties have over 20 million residents, with large numbers in Oklahoma, Texas, Montana, Kentucky, and Arkansas. The Rural Health Clinics (Figure 6) are likewise jeopardized.

Nursing Homes Targetted

Medicaid finances care for nearly 70% of nursing home residents, and Medicare, a large part on top of that. The national map in **Figure 7** gives one aspect of fundamental infrastructure—the number of nursing home beds per 1,000 persons 65 years of age and over, by county, as of 2000. Since that year, the pattern—which shows wide variance (from 2-44 beds per 1,000, to close to 400 beds)—has intensified to the point of severe shortages. In some rural counties, for logistics reasons, more beds per population are desirable—hospital beds, nursing homes, etc.—because travel is longer, in-home aid less possible, and baseline facilities must be maintained even where population is less dense. The map indicates that tendency.

However, the major problem overall is a shortage of skilled nursing home facilities, on a beds-per-1,000 basis. For example, as of February this year, the state of Connecticut had no available beds in nursing homes! Their 247 chronic-care and convalescent nursing homes, with 29,800 beds, were over 95% filled, and families were desperately searching, and on waiting lists for years, for how to find care.

Of all health-care providers, nursing homes operate at the lowest margin, about 2.8%. Medicaid and pending Medicare cuts will, overnight, create widespread, mass shortages of beds.

Take Pennsylvania, for example. The 732 nursing homes in the state could face a $219 million cut over the next year, as reported in May by the Pennsylvania State Health Care Association, representing nursing homes. Association Director Alan Rosenbloom said, "Facilities themselves will come under assault. . . . Now, they stand to lose 6-7% of the Medicaid program, which represents half their revenues. Facilities in these situations may have to make decisions to reduce staff, reduce access to care, and undermine quality of care in the long run. We could potentially see closures." It is the same nationwide.

In 1997, 20% of nursing homes were driven into bankruptcy when the Federal government cut Medicare payments, under the neo-con, "Balanced Budget Act" mentality. Certain cuts were then suspended for the ensuing years until now, when the Bush Administration intends to impose Medicare payment reductions on top of proposed Medicaid cuts.

In terms of caring for people with mental retardation, Medicaid serves about 95% of people who rely on intermediate-care facilities. As of 2002, there were 6,749 institutions certified for Medicaid re-imbursement, to care for the mentally retarded.

Figure 8 shows that large parts of the country lack even a doctor. There are 173 counties—those with the darkest tone—with no primary-care physician at all. At the next gradient (lighter grey tone), there is only one primary-care physician per 5,000-22,000 residents, and so on. The map shows this pattern only for rural areas, but poor inner-city areas have the same lack in effect.

"A physician crisis" was the description used by Representative Peterson (R-Penn.) at a March 22 Washington, D.C. press conference on rural health. He referred to many problems, including the loss of surgeons and obstetrician-gynecologists, to the point where in many rural areas today, there is an "inability to serve its own populations."

Take the case of Gadsden County, Florida. There is no natal unit at the public hospital at all. And there is not one Ob-Gyn in the county.

Public-Health Infrastructure Deficit

Apart from declining ratios of medical staff and facilities per population, there are serious declines in public-health infrastructure. The map in **Figure 9** focusses on the baseline measure of public-health workers per 100,000 persons. In the 1970s, there were over 200 public workers per 100,000 people, on average, nationally; but by 2000, this had fallen to 156, and the gap was not made up for by high-tech resources. Since then, the situation has worsened, despite the focus on preparedness to defend against bio-terrorism, potential natural diseases such as SARS, or a potential deadly influenza pandemic.

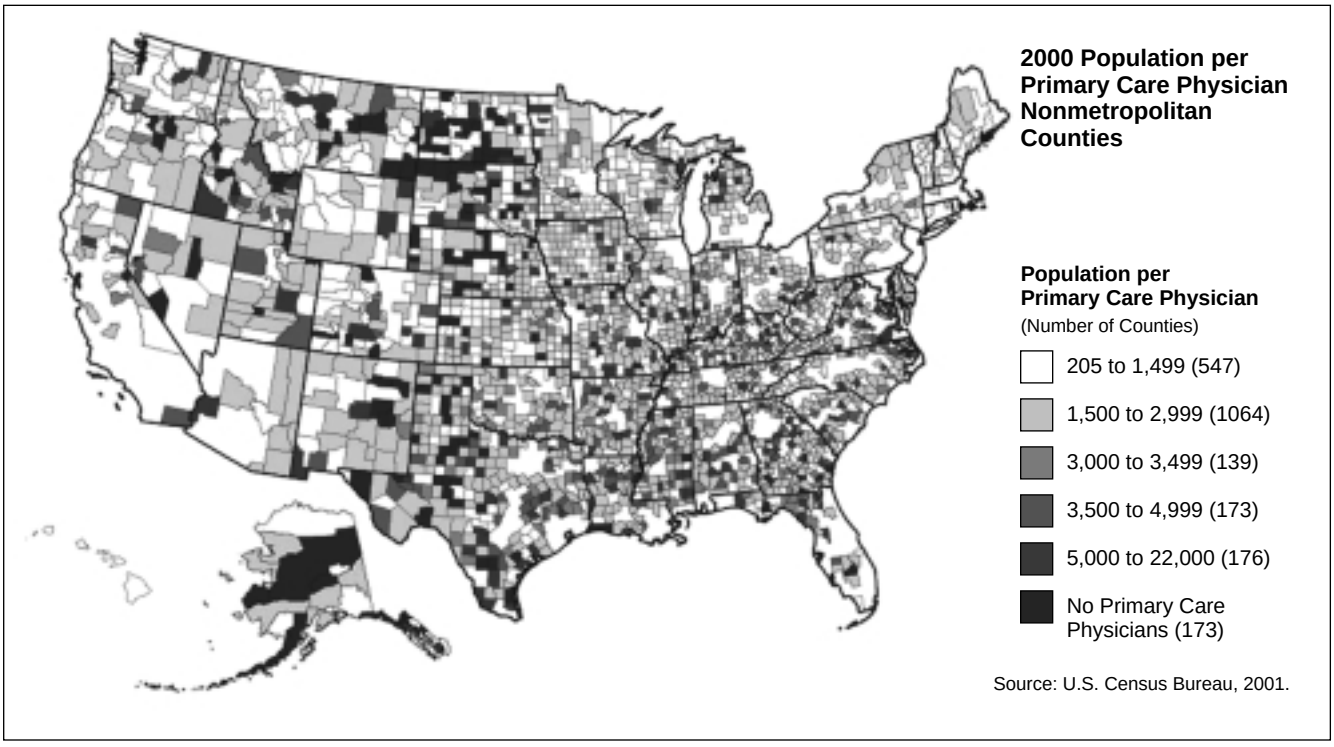
The map shows the disparity across the ten Federal Health Districts as of 1999. It ranges from a low of 76 public-health workers per 100,000 people in the North Central area, including Chicago, Detroit, Cleveland, and millions across the six-state region, to 200 in the Northwest.

Put in the same staff terms as the ratio of people per primary-care physician, the declining public-health infrastructure of the nation can be seen in the drop down to one public-health worker per 580 persons today, as compared with one worker per 457 in the early 1970s. Public-health workers perform functions ranging from mosquito control, to disease surveillance, sanitation, food safety, epidemiology, childhood vaccinations, etc.

"We have neglected public health for decades," was the simple evaluation by Paul Kuehnert, Executive Director for Public Health Emergency Preparedness for the State of Maine, given at a March 22 press conference by the Rural Health Policy Institute. Given this infrastructure deficit, plus the effects of states slashing their budgets in recent years to attempt to deal with the economic breakdown crisis, the combined result of Medicaid and Medicare cuts will be a guaranteed public-health disaster in the near future.

FIGURE 8

Ratio of Population per Primary Care Physician in Rural Counties, 2000

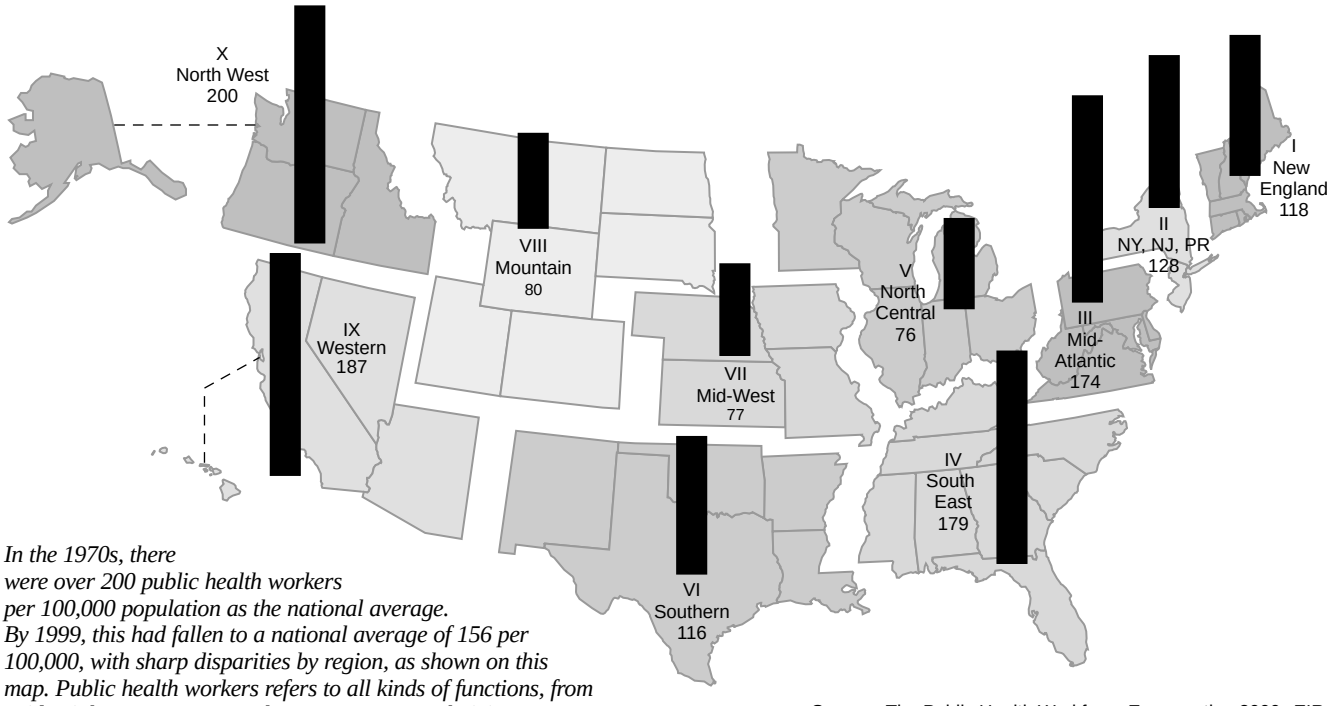


Source: U.S. Census Bureau, 2001.

FIGURE 9

Public Health Workers per 100,000 Population, in 10 Federal Health Districts, 1999

(Number per 100,000 Population)



In the 1970s, there were over 200 public health workers per 100,000 population as the national average. By 1999, this had fallen to a national average of 156 per 100,000, with sharp disparities by region, as shown on this map. Public health workers refers to all kinds of functions, from epidemiology, to pest control, county nurses, technicians, etc.

Source: The Public Health Workforce Enumeration 2000; *EIR.*