# $R_x$ for Rebuilding U.S. Health Care: Hill-Burton Hospital Principle

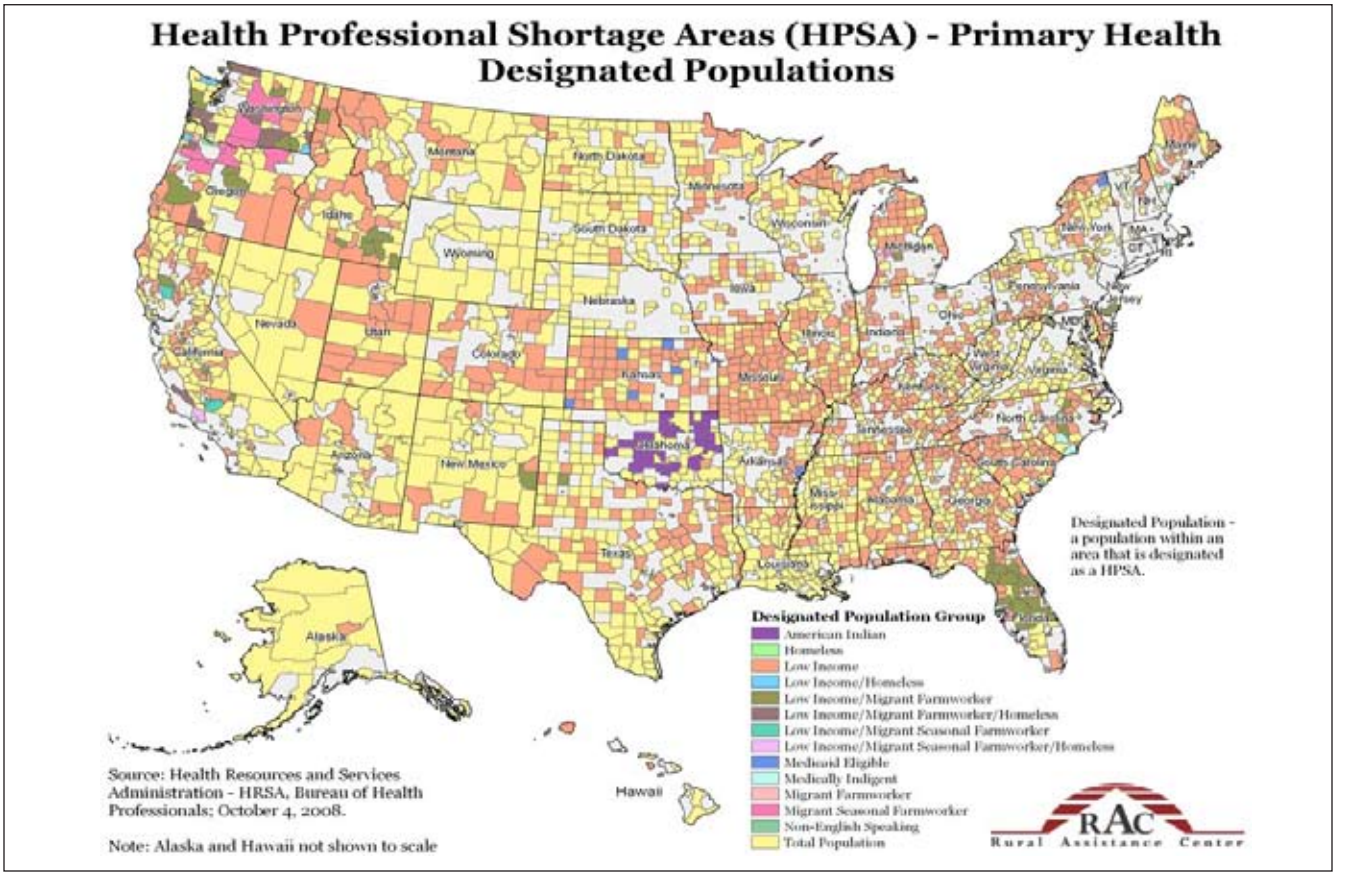
by Marcia Merry Baker

March 6—If the 48 millions of Americans now without health insurance were to go for needed medical attention tomorrow, there would be no way to deliver health care to them. The physical means don't now exist. The U.S. medical system today is characterized by dramatically substandard ratios of hospital beds, diagnostic facilities, and public health services, per capita. This also means that the nation lies wide open for new and resurgent disease outbreaks, despite all the blather about Homeland "Security" measures.

Against this reality, it is insane to talk of "reform" of health care by squeezing payments due hospitals, staff, and facilities; such cutbacks are only serving profiteering claims from layers of HMO-type insurance, and financial entities which have tapped into the U.S. healthcare multi-trillion-dollar "income stream" over the past 30 years of deregulation.

What is required is to begin a drive to bring U.S.

FIGURE 1
**Health Professional Shortage Areas (HPSA), Primary Health Designated Populations**



public health and medical core ratios of staff and infrastructure up to modern standards for a productive nation, and roll back the HMO-era practices and premises. An essential part of this drive is to undertake crash programs in science to lead disease-fighting efforts with breakthroughs in bio-chemical R&D and nuclear medicine.

The scale of mobilization required to rebuild the U.S. health-care and medical-science system, in turn, poses the necessity of restoring the industrial base of the nation, to provide the needed inputs, ranging from construction materials to precision medical instruments, plus staff training all along the line. This defines the core of what is urgently needed in a real "stimulus" program.

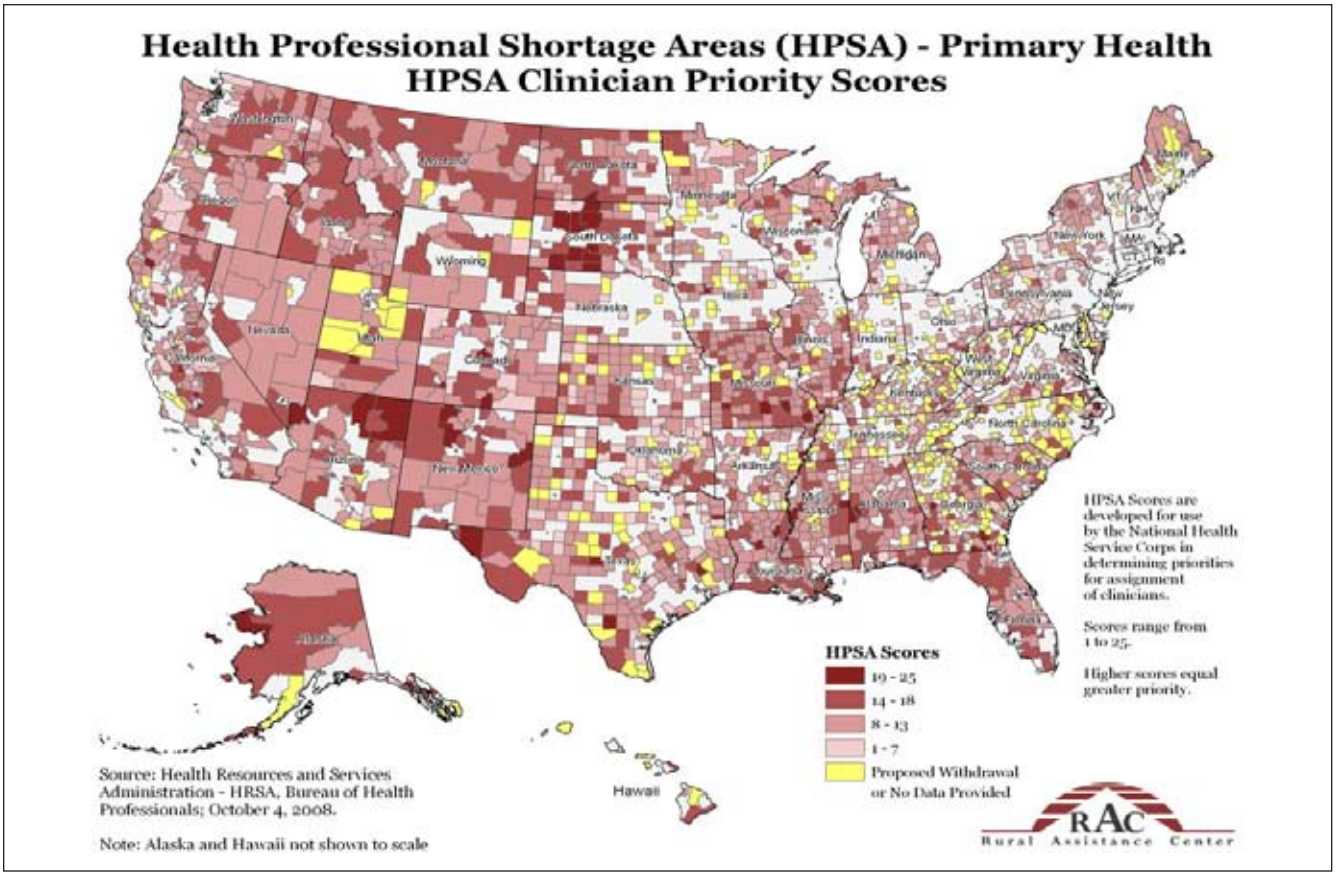
### 'Hill Burton' Hospital Principle

The rebuilding effort can best be done in the spirit of the 1946 "Hospital Survey and Construction Act," which, for 25 years, built up the hospital and health-care system to high standards and accessibility. The nine-page law, often called the "Hill-Burton Act," after the bipartisan co-sponsors of the Act, Sens. Lister Hill (D-Ala.), and Harold Burton (R-Ohio), mandated Federal and local cooperation and funding, to see that the goal would be achieved of having a community hospital in every county, to guarantee hospital care to citizens: in rural counties at a ratio of 5.5 beds per 1,000 (sparsely settled regions require redundancy); and in urban areas, 4.5 beds per 1,000.

The Hill-Burton concept sees the community hospital as the hub of regional networks of health services, involving education, public health, sanitation, defense against epidemics and disasters, and research.

At the same time that the Hill-Burton hospital construction boom proceeded—providing many of the 3,089 U.S. counties with their first hospital ever—public-health programs and applied medical R&D all but eliminated polio, tuberculosis, and other diseases. Pertussis (whooping cough) declined from a peak of

FIGURE 2
**Health Professional Shortage Areas, Primary Health HPSA Clinician Priority Scores**



156,000 cases in 1947 to 14,800 in 1960; diphtheria declined from 18,700 cases in 1945, to 900 in 1960. Mosquito control programs—including the use of the insecticide DDT, begun in 1940—were on the way to eliminating malaria and other mosquito-borne diseases.

By the mid-1970s, the Hill-Burton goal of 4.5 beds per 1,000 was nearly reached as the national average. Intervening laws furthered the approach: Amendments to the Hill-Burton Act in 1954 authorized funds for chronic-care facilities; in 1965, the Medicare and Medicaid health insurance programs were begun.

Then came the downshift, in line with the 1970s policy turn towards deregulation, privatization, and globalization. On Dec. 29, 1973, President Richard Nixon signed into law, with bipartisan support, the "Health Maintenance Organization and Resources Development Act," which, along with follow-up laws, ushered in the era of deregulation of health-care delivery, to the point where today, over 2,000 hospitals have shut down. Likewise, core public-health functions have been drastically reduced; hundreds of counties now have next to no programs at all. One of the most dramatic examples comes from the nation's capital.

In Fall 2001, the Washington, D.C. metro region could barely cope with the anthrax attack, given that its leading community hospital, the 150-year old D.C. General—a 500-bed, full-service facility with a pathology laboratory and isolation wing—had been shut down only months before, by direct action of Congress.

## Hospital Systems Decline

The number of community hospitals in the U.S. fell from nearly 7,000 in the mid-1970s, down to barely 5,000 in 1999, and today, stands at 4,897. The ratio of licensed hospital beds per 1,000 citizens has dropped from 4.5 in the 1970s, down to 3 today.

The false "alternative" to full-service hospitals, has been presented in the form of clinics. The Obama Administration's "American Recovery and Reinvestment Act" is letting out $155 millions for 126 clinics. These are useful in themselves, but no substitute for hospitals and hospital networks. Even worse, there are those proposing that "doc-in-the-box" operations should supplant hospital systems, in order to offer cut-rate care as a pretense for real health insurance.

Look at the emergency situation on the state level. In New Jersey, in 2007, three acute-care hospitals closed, and five more filed for bankruptcy. On Feb. 18, the New Jersey Hospital Association released the results of a survey over the past two months, reporting that of the 37 of the state's 74 acute-care hospitals that responded to the survey, 27% had a drop in cash reserves, and were making drastic cuts in staff and services. Clinics associated with the hospitals were also cut. This is the nationwide pattern.

In March, in Dallas, Texas, the 95-bed Renaissance Hospital shut; the parent company declared Chapter 11 bankruptcy in 2008. In New York City, two hospitals closed on March 1: Mary Immaculate, and St. Johns Queens, after Caritas Health Care, Inc. filed for bankruptcy in February. In Pennsylvania, on March 5, the 40-bed Brownsville Tri-County Hospital closed, after 93 years. It is 30 miles southeast of Pittsburgh.

The Veterans Administration nationwide hospital system—in the forefront of many medical advances, from prosthetic therapies, to electronic records, to successfully battling MRSA—is being downsized to far below what is required to meet the needs of former servicemen, and their extended community.

## Staff, Public Health Shortages

Many hallmark features of a modern health-care system are declining, for example, cancer-screening services per capita. This goes along with the downsizing or loss of hospital-centered webs of medical-care delivery. For example, the number of counties without mammography equipment is increasing.

Public health-care capacity has likewise been reduced below even minimum levels required to deal with mosquitoes, vermin, and other pests; monitor and deal with disease outbreaks; maintain sanitation; conduct vaccination programs, etc. No concerted effort was mounted to contain West Nile Virus when it first appeared. Lyme Disease—carried by ticks thriving in suburbanized environments—has spread to epidemic proportions in several areas, where the landscape has been de-structured by the now-collapsed McMansion boom. Denge Fever is resurgent in the Americas.

As of 2000, the total U.S. public health-care workforce numbered 448,000, which was 50,000 fewer than in 1980. Looked at per capita; in 1980, there were 220 public-health workers per 100,000 U.S. residents; but in 2000, this had fallen to 158 per 100,000.

Of the total public-health worker roster today, fully


EIRNS/Stuart Lewis

*Since 1973, when Nixon signed the HMO Act into law, over 2,000 U.S. hospitals have shut down. A few months before the anthrax attack in Washington, D.C., in 2001, D.C. General Hospital—a 500-bed, full-service facility (shown here), with a pathology laboratory and isolation wing—had been closed, by direct action of Congress.*

23%, or 110,000 of them will be at retirement age by 2012, but new ranks are not being trained up in the required numbers. In December 2008, a report on the crisis was issued by the Association of Schools of Public Health (www.asph.org).

The shortage of nurses exemplifies the general situation of understaffing in the U.S. medical-care delivery system across the board. At present, there are about 2.5 million nursing jobs in the country. The Bureau of Labor Statistics predicts that each year—without a major expansion of health-care delivery—an additional 233,000 nursing positions need to be filled. However, in 2007, only 200,000 candidates passed the Registered Nurse licensing examination. Thousands of nurses leave the profession each year.

## White House Summit: 'Money,' Not Medicine

At the "White House Forum on Health Care Reform" March 5 in Washington, aspects of this shortages picture came up only secondarily. Instead, the theme was on "money," not the state of the physical economy. President Obama called for focusing on today's "exploding health care costs" in his opening remarks to the 120 attendees. This is in line with the new Administration budget proposal for a fund of $634 billion, intended to lead to universal health insurance, through "money-saving" ideas, and cost-cutting. Obama called on the Summit to discuss ways to provide medical care for the 48 million Americans lacking health insurance, as a "fiscal imperative" as well as a "moral" one. He wants legislation by the end of the year.

The ensuing Summit discussion then dwelt mostly on specific proposals for cost-suppression and incentives for cutting expenses while inducing people to "live healthy." There are advocates demanding deadly "evidence-based" and "outcome based" methods of coercing medics to use only mandated lists of symptoms and treatments, instead of judgment and science; the enforcement is to come from threatening to not pay them.

However, a few notable exceptions to this venality came from participants who gave accounts of how the lack of medical-care facilities and staff in their areas—and lack of infrastructure generally—mean that health care is just *not available* for millions of Americans right now, whether or not they have health insurance. Examples:

• **Missouri:** Rep. Jo Anne Emerson (R) said that her district has 28 rural counties, where many cannot get medical treatment, because it isn't there to be had. This is typical of rural counties cross country, where there is a "workforce shortage," and "decaying rural health-care infrastructure." There aren't enough doctors, nurses, and other staff. We "need to fix and build rural health-care infrastructure." Furthermore, people can't travel the distances to seek care. "We don't have public transportation at all.... Unless you are a senior [potentially eligible for van service] you have no public transportation."

• **Pennsylvania:** Rep. Allyson Schwartz (D) said the situation is now the same in many urban and suburban areas. In half of her own 13th C.D., "you can't have a baby!" In northeast Philadelphia, they no longer have obstetrical services at the hospitals. Sure, she said, "You can go somewhere else to have your baby—if you can get there!"

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