Dire Shortage of U.S. Hospital Beds

by Marcia Merry Baker

April 17—To understand the threat to civilized life itself, which Lyndon LaRouche has identified the current economic breakdown crisis to be, you need look no further than the hospital crisis in the United States.

The rate of closings of U.S. hospitals and downsizing of related treatment logistics, has reached the stage of a public health emergency. In Los Angeles, New York City, and other metropolitan areas, emergency rooms are swamped and, at best, are resorting to "boarding" patients in the ER, because there is no "room upstairs" to admit people for proper care. In rural areas, families must drive "several counties over," to find medical services. As of now, almost no region could handle even a severe flu season, let alone a pandemic. Instead of hospitals functioning at 80% of bed-use-capacity—which allows for emergencies and orderly scheduling—many are straining at 100%, with waiting lists and dislocations. Moreover, come July 1—the financial half-year point—many more hospitals are due to shut or downsize.

This contraction in the public hospital system reflects the financial crisis of hospitals, resulting from reduced and delayed payments from private and Federal insurance; from the rise in charity cases, increased costs of operation; and predations of for-profit hospital outfits, spurred on by the HMO-era deregulation of medical care.

This hospital and beds shortage was acknowledged only secondarily, over the past six weeks, in the series of two White House health reform summits and five field hearings, the last of which was in Los Angeles on April 6. For example, a Pennsylvania Congresswoman, Allyson Schwartz (D), said there was no place in the northeast quadrant of Philadelphia to have a baby in a hospital! A Missouri Congresswoman, Jo Anne Emerson (R), said that 28 rural counties in her district lacked

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Philipsburgh Area Hospital, in Pennsylvania, was closed in April 2006. A recent decision was made not to reopen it, despite the serious lack of emergency room care available to area residents.

the workforce and facilities to treat their populations. medical infrastructure. Nursing association representatives emphasized the nationwide shortage of nurses and training staff.

Instead of addressing these kinds of physical infrastructure problems, the health summit talk was steered to curbing costs by digitizing records and delimiting treatment. The oft-repeated pledges of support for "access" to health care, and for making the U.S. medical system "sustainable," were especially ironic. First, if all 48 million uninsured Americans had the means to show up tomorrow to access care, they couldn't get it, because the physical system doesn't exist to deliver it. Second, current and proposed Federal policy is undermining, not sustaining, what is currently in place to provide medical and public health care.

However, President Obama issued an Executive Order on April 8, to create a White House Office of Health Reform, and another such office in the Department of Health and Human Services, for the purpose of developing ways to reform U.S. health care, along the lines of e-records and behavior modification of doctors and patients—what Newt Gingrich et al. term "evidence-based treatment," under the excuse of saving money. The Executive Order text offers general blather: "Reforming the health care system is a key goal of my Administration. The health care system suffers from serious and pervasive problems; access to health care is constrained by high and rising costs; and the quality of care is not consistent and must be improved, in order to improve the health of our citizens and our economic security."

In practice, this perspective is exactly in line with the behaviorist economics approach currently dominating the policy advice to the Presidency. (See box.)

Localities Battle for Hospitals

In contrast to the Federal health "reform" initiative, leaders on the state and local level are waging rearguard battles to retain and even expand physical infrastructure, especially public hospitals. With this kind of commitment, the U.S. health-care system could be readily built back up again, as long as there were a context of needed financial and economic-revival emergency measures taken on the national and international levels, to re-create a growing economy.

The U.S. national health-care system, centered on public hospitals, was originally built up under the "Hill-Burton principle," referring to the 1946 National Hospital Survey and Construction Act, sponsored by Sens. Lister Hill (D-Ala.), and Harold Burton (R-Ohio). This bipartisan, nine-page law mandated Federal and local cooperation to ensure that in every county, a beds-per-thousand ratio of licensed hospital beds would be provided to the populace, at modern standards. At that time, it was 4.5 beds per 1,000 persons in urban areas and 5.5 in rural.

A central part of this Hill-Burton approach is that the community hospital is the hub of regional networks of health services, involving public health, sanitation, defense against epidemics and disasters, education, and research. This was carried out over the 1950s-1970s period. Then began the take-down process. The number of community hospitals in the United States fell from nearly 7,000 in the mid-1970s, to barely 5,000 in 1999, and today, stands in the range of 4,897. The annual *U.S. Statistical Abstract* no longer even provides the total or by-state listing of the number of public hospitals in the United States! The lawmaker or citizen is instructed to purchase such data from the American Hospital Association.

Yet the battle to retain the local public hospital is

front-page news, and a life-or-death issue across the nation. Here are some of the updates, as of the time of the White House health care summitry, which all but ignored them.

Eastern States' Crises

New York: In the borough of Queens, two hospitals closed on Feb. 28, St. John's and Mary Immaculate. Now the remaining Jamaica Hospital and Forest Hills Hospital are overfull. Borough President Helen Marshall toured their emergency rooms in March and reported, "The whole floor was just people on those gurneys. They were packed together, one next to the other, and all down the halls. There were at least 20 that were waiting to be admitted, but there were no beds. There was just no space." She called it "a public health crisis." The *Queens Village Times* has begun a series of articles, "Hospital Closings Leave Borough in Triage."

New Jersey: Kessler Memorial Hospital closed March 12 in Hammonton, Atlantic City.

Pennsylvania: Northeastern Hospital in Philadelphia is to close on July 1. There is a furor over this. Its emergency room treats 50,000 patients a year, and the hospital delivered 1,800 babies last year. "I think people will die because they won't get to an emergency room in time, and there won't be good follow-up care," said the head of the intensive care unit.

In the western part of the state, in Aliquippa, an Ohio River town, the 96-bed Commonwealth Medical Center closed in December 2008, terminating most of its 200 jobs.

Virginia: The in-patient bed shortage in the Norfolk-Hampton Roads region, but also nationwide, was the focus of warnings by the *Virginia Pilot* newspaper in March 2008, quoting Dr. Francis Counselman, chairman of the Emergency Medicine Department of Eastern Virginia Medical School. The paper described the national practice of "boarding" patients in the ER. "Patients arrive at the ER, are diagnosed and need admission. But instead of being sent on to the intensive care unit, the psychiatric ward, or just a regular hospital bed, they get stuck. They can wait for hours, even days, in an emergency department before getting to a hospital bed."

"I have patients who ask me, 'Why won't you let me upstairs?'" said Counselman, who practices at Sentara Norfolk General Hospital." He tells them, "There are no beds to put you in."

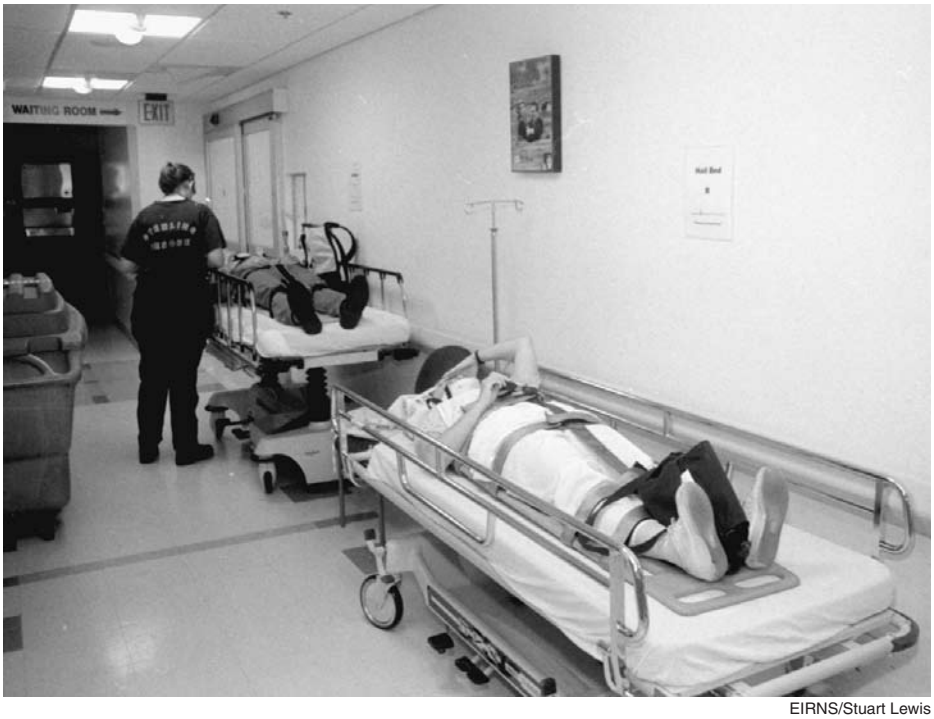
OMB's Orszag: 'Reform' Behavior To Cut Costs

Peter Orszag, director of the Office of Management and Budget, held forth on changing peoples' health behavior to save money, in an April 16 NPR interview. "We want to constrain costs and move towards a more efficient system," he said. "We pay for more care rather than better care," therefore incentives are needed to make doctors give fewer tests and get patients out of the hospital faster. (As if HMOs don't already provide incentives for doing just that!)

When he was challenged by the incredulous interviewer, that what he was actually doing was encouraging doctors to give less care, Orszag responded, "not necessarily less care, but higher-quality care," which is supposed to be made possible by better information as to what works and what doesn't for particular diagnoses.

As director of the Congressional Budget Office from 2007 to 2008, Orszag led a major effort to apply behavioral economics to health-care policy. Last October, he delivered a lecture at Harvard Medical School entitled "New Ideas About Human Behavior in Economics and Medicine," which, he said in a blog-post at the time, would build on the "role of expectations, beliefs and norms" in health policy and medical science. "Setting default rules that are more in tune with the realities of human behavior in such diverse settings as doctors' offices and federal nutrition programs might help to improve a range of health outcomes," Orszag wrote, "from adherence of patients to their doctors' medication regimens to the proportion of Americans eating a healthier diet and exercising more."

—Carl Osgood



EIRNS/Stuart Lewis

Patients wait on gurneys for entry to emergency room services, in a hospital in Leesburg, Virginia. This photo was taken in 2001; eight years later, the situation is much worse across the country, as emergency rooms are overwhelmed with patients.

California

Los Angeles is in severe crisis. A report in the April 16 *Los Angeles Times*, headlined, "For Poor People, Recession Can Be Fatal," covered the factors placing unbearable pressure on the area's hospital emergency rooms. There are cuts in all kinds of services in L.A. County. The county public health system faces a deficit which will reach $1.2 billion by 2011. The collapse of the government safety net, when combined with growing numbers of people lacking health insurance, sends people to the ERs. Dr. Howard R. Krauss, president of the L.A. County Medical Association, said that emergency rooms are reeling from unpaid bills and a shrinking number of hospitals. This crisis is forcing many poor people—including those among the "new poor" due to recent layoffs, foreclosures, etc.—to postpone or skip medical care completely. The results of these decisions can be deadly. (See accompanying article.)

The Community Hospital of Los Gatos ceased all operations on April 10. It may be reopened after July 1, by the El Camino Hospital of Mountain View, but in the meantime, the emergency room at the Good Samaritan Hospital in town is getting more traffic.

A National Catastrophe

Nationwide, there are 22 children's hospitals run by the Shriners, a fraternal organization, which are in the process of being reviewed for downsizing, or in some cases, being shut down, after decades of providing highly specialized and free care. For example, in Greenville, S.C., the Shriners Hospital for Children—one of the top three in the nation—may close as of July 1. It is an 82-year-old facility, and vital throughout the region. In July, leaders of the Shriners Hospital group will meet to vote on whether to close down hospitals in Greenville; Shreveport, La.; Spokane, Wash.; Erie, Penn., and Springfield, Mass. This would eliminate at least 250 high-tech, licensed beds from the U.S. hospital system. In March, the Shriners voted to shut four of their eight research centers. Since their first hospital in Shreveport, the Shriners' facilities have been known for excellent medical work in polio, burn treatment, and orthopedics.

All kinds of programs are lost when the hospital-centered networks contract or close, ranging from teaching internships to diagnostics. One dramatic sign of medical treatment decline in the United States is the dramatic drop in simple breast cancer screening. There has been a 16% decline in mammography procedures from 2000 to 2008, falling from 43.9 million procedures in 2000, to 36.7 million in 2008. Over the same period, the number of licensed mammography machines declined by 13% from 9,910 sites in 2000, down to 8,670 in December 2007. Many counties now have no mammography screening at all. This was documented in a report released in March by the IMV Medical Information Division, which surveyed the 8,670 sites, both hospital- and non-hospital-based.