End HMOs and Rebuild the Hill-Burton Hospital System

by Marcia Merry Baker

May 16—If a nation in the midst of an economic crisis, with unmet medical needs, decided to reduce spending on health care, decrease the number of hospitals, and cut treatment, what would you think about its government's intention? Premeditated murder?

That is precisely what the Republican Nixon Administration did in 1973, with the support of Democrats, when it initiated the "health maintenance organizations" program—a for-profit, cost-cutting medical intervention, as a foot-in-the-door to replace the existing, workable U.S. public-health and hospital system. Over the next decades, the HMO system has had its intended outcome: undermining U.S. medical infrastructure to the point of today's health-care crisis.

Now the Obama Administration, with its Nazi-doctor health-care "reform" campaign, intends to do more of the same. This plan must be stopped dead, before it begins to kill. We must ban and terminate HMOs of all forms. The HMO system was imposed on U.S. health care; it can be removed from U.S. health care.

The U.S. health-care system is now entering a state of public-health emergency, as measured in physical-economic terms of falling ratios of care-delivery capacity per capita. It is far below requirements of beds-per-thousand, medics-per-100,000, and equipment availability. Public hospitals are closing or downsizing at crisis rates. The logistics are no longer in place to handle even a "normal" flu season, let alone a pandemic.

This medical infrastructure crisis is the result of allowing 28 years of "managed care" looting of the health-care system, and implementing the collapse of the ratios of infrastructure that had been built up over the 1946-1970s period under the Hill-Burton Act. Hill-Burton, the 1946 Hospital Survey and Construction Act (named for its sponsors Sens. Lister Hill [D-Ala.] and Harold Burton [R-Ohio]) was committed to mandate and fund hospital-centered care logistics for all citizens.

In 1973, the HMO-enabling act against the Hill-Burton system was signed into law by President Richard Nixon, as the Health Maintenance Organization and Resources Development Act. This Federal policy shift allowed private financial interests to interpose themselves between citizens and their providers of health care. In the guise of being care "managers," these financial interests could profiteer by delimiting the care patients received and the amount of compensation given to hospitals, doctors, and others. In this way, the private financial interests presided over the takedown of infrastructure.

In 1993, when the Hillary Clinton White House health-insurance initiative merely threatened to rein in their looting, it was smashed. Over the ensuing years, even Medicare and Medicaid were opened up for "managed" care rake-offs.

Today, the looters are inside the White House, in the persons of Larry Summers, Peter Orszag, Dr. Ezekiel Emanuel, Nancy-Ann DeParle, and others (see accompanying article). There, they are dictating how to continue the HMO looting rights, even to the point of death, under the banner of "saving money" by health-care "reform." Citizens are receiving Hitler-era "reasons" for why they must accept drastic medical cutbacks, sickness, and death. For example, you must forego what is called "wasteful, excessive treatment," during your end-of-life months.

President Obama has proclaimed this Nazi medicine/health "reform" his top goal. Congress, so far, is acting in lockstep, under the direction of Sens. Max Baucus (D-Mont.), and Charles Grassley (R-Iowa), to whip up comprehensive reform legislation by this June.

Lyndon LaRouche has repeatedly led the charge against the HMO wreckers, and in support of an updated Hill-Burton approach. In 1992, the Democrats for Economic Recovery/LaRouche in '92 committee issued a

EIRNS/Steve Carr

Hill-Burton built up the U.S. hospital system from 1946-73. Then the HMO profiteers began shutting it down. This closed hospital is in Oshkosh, Wisconsin.

25-page pamphlet, "Solving the Health Care Crisis," against the HMOs. In 1996, LaRouche led a campaign under the banner, "'Managed Health Care' Is a Crime Against Humanity." In 2000, LaRouche's political action committee issued a national 16-page dossier titled, "Ban the HMOs Now! Before They Get You and Yours," providing draft legislation to revoke the HMO enabling acts. Now it is a matter of life and death for the nation.

Hill-Burton Infrastructure Build-Up

Near the end of World War II, on Feb. 26, 1945, Sen. Lister Hill told the Senate, that there must be a "long-range, scientifically planned health program … to the end that scientific health care is readily available to all our people.…" The prerequisites, he said, include "adequate hospital and public health facilities." Part of Hill's concern was "the shocking fact that nearly 40% of our young men of draft age were found to be physically unfit for military duty."

On Aug. 13, 1946, Law 725, known as the "Hill-Burton Act," went into effect, as an amendment to the existing Public Health Service Act. Only nine pages long, the Hill-Burton Act mandated Federal and local cooperation and funding, to achieve the goal of having a community hospital in every county, and to guarantee hospital and related care to all citizens. In rural areas, the mandate was a ratio of 5.5 beds per 1,000 (sparsely settled regions require redundancy); and in urban areas, the ratio was set at 4.5 beds per 1,000. During the initial years, 1946-50, 600 new general hospitals opened, with an average of 40 hospitals added per year through the mid-1960s.

At the same time that this hospital construction boom was providing many of the 3,089 U.S. counties with their first hospital ever, various public-health services and applied medical R&D programs were expanded. Polio and TB were all but eliminated, and other diseases were reduced. By the mid-1970s, the Hill-Burton goal of 4.5 beds per 1,000 was nearly reached as the national average. Amendments to the Hill-Burton Act in 1954 authorized funds for chronic care facilities, and, in 1965, the Medicare and Medicaid health insurance programs were begun.

'Managed Care' Imposed

Then came the shift. In February 1971, President Nixon called for establishing health maintenance organizations, following a "cost containment" script provided by international financial circles which, in the same period, succeeded in imposing a series of globalization-serving measures. These included deregulation of utilities, privatization of traditional government functions, and international floating exchange rates—all intended to undermine national economies, while yielding loot for the financial circles.

An excerpt from the secret Nixon White House tapes reveals how the President was briefed in 1971 by Presidential counsel John D. Ehrlichman, to back "these health maintenance organizations like Edgar Kaiser's Permanente thing." Ehrlichman said, "Edgar Kaiser is running his Permanente deal for profit. And the reason that he can … do it, I had Edgar Kaiser come in to talk to me about this, and I went into it in some depth. All the incentives are toward less medical care, because … the less care they give them, the more money they make … the incentives run the right way."

On Dec. 29, 1973, the new law allowing pilot-project HMOs went into effect. Democratic Sen. Ted Kennedy led the bipartisan support.

Over the next 20 years, more laws and court decisions furthered the spread of "managed care." The 1973 act gave a grant of $375 million for pilot HMOs, under the nominal excuse of "cost containment." In 1975, this funding was expanded, overriding President Ford's veto, and it continued until 1981. In 1976 and 1978,

Congress gave HMOs more freedom of operation, including leeway to refuse to pay for certain treatments.

HMO enrollment grew steadily, using the inducement of lower premium rates. In 1978, there were 168 HMOs in operation, with 6 million enrolled. By 1990, there were 652 HMO plans, covering 34.7 million people; in 1996, 60 million. Today, an estimated 154 million people are enrolled in managed care; of these, 109.7 million are in PPOs (preferred provider organizations) and 44.3 million in HMOs.

Corporate Health Control—and Profits

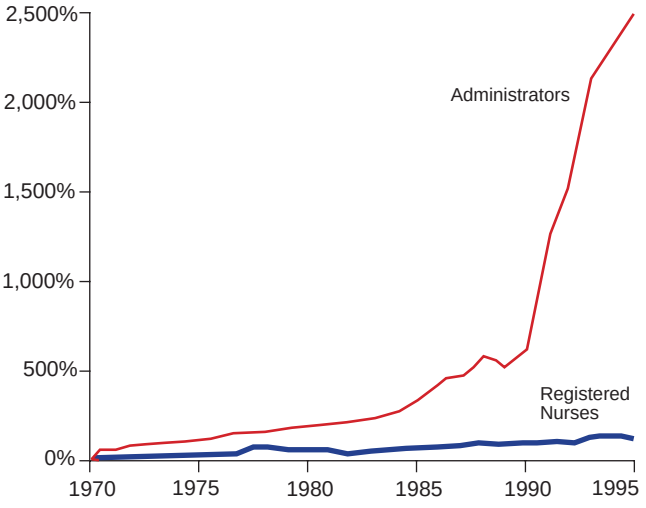
The 50 largest HMO companies control 60% of the managed health-care market. The top five of these, according to *Fortune*, for 2009, are UnitedHealthGroup ($81 billion in revenue); Wellpoint ($61 billion); Aetna ($31 billion); Humana ($29 billion); and Cigna ($19 billion). Behind these companies stand echelons of the very same financial institutions now stealing tax money through the TARP and other bailout swindles.

EIR's John Hoefle reports that, "In a sample of active HMOs at present, six banks show up among the top institutional owners: Bank of America, Bank of New York Mellon, Goldman Sachs, J.P. MorganChase, Morgan Stanley, and State Street. Also on the list is Barclays, the British giant which received U.S. bailout money via the AIG backdoor-bailout scheme. The list of owners also includes the major money management firms FMR/Fidelity, Vanguard, Wellington, T. Rowe Price, Janus, as well as the giant TIAA-CREF teachers' retirement fund, and the big French insurance company, AXA.

"While these institutions individually typically own less than 15% of an HMO, and sometimes as little as 1%-2%, in the aggregate, they dominate. Take the case of WellPoint, which bills itself as 'the nation's leading health benefits company serving the needs of approximately 35 million medical members.' As of the end of 2008, 638 institutions owned 88% of its outstanding shares. The top ten owners included: Dodge & Cox, 15%; Vanguard, 8%; T. Rowe Price, 7%; Barclays, 4.5%; Fairholme, 4.3%; State Street, 3.9%; Barrow, Hanley, Mewhinney & Strauss, 3.9%; Capital Research, 2.6%; Fairholme Capital, 2.5%; FMR, 2.3%; and Goldman Sachs, 2.1%.

"WellPoint has a decidedly political board, to go with its financial ownership. The directors include: William "Bucky" Bush, the younger brother of George H.W. Bush; former U.S. Senator and Banking Committee chairman Don Riegle (D-Mich.); Susan Bayh, the wife of Sen. Evan Bayh (D-Ind.); and Sheila Burke, the former chief of staff to then-Senate Majority Leader Bob Dole (R-Kan.)."

FIGURE 1
Growth of Registered Nurses and Administrators, 1970-96
(percent growth since 1970)



Source: Bureau of Labor Statistics and Himmelstein/Woolhandler/Lewontin Analysis of CPS data.

Under the HMO system, administrative costs and profits zoomed up, while real medical care and infrastructure declined.

"Managing" care, in order to make profits, takes vast layers of personnel, time-consuming paperwork, and, of course, mega-salaries for top officials. **Figure 1** shows the sharp increase in the number of administrators in U.S. health care, contrasted with the number of registered nurses, from 1970 to 1995. The conservative estimate is that 30% of private "managed" health-care costs are for administration, and it may be as high as 50%.

In contrast, the administrative costs for the Federal Medicare program run at 2%. A 1990s Government Accountability Office study found that the United States could fund a single-payer national health program to cover *all* uninsured Americans simply with the savings in administrative costs.

In the 1990s, dozens of states passed laws against notorious HMO practices, because Washington refused to protect the public interest. States took rearguard actions to outlaw "drive-by" childbirth, and prohibit HMOs from rewarding doctors for denying expensive

treatments, and so forth.

Despite this, Washington consistently gave sweetheart deals to the financial crowd behind the HMOs, including entry into Medicare and Medicaid programs. The HMO Act of 1976 began to offer HMOs as an option under Medicare, and this was expanded in 1983. In 1997, came the Medicare "Advantage Plan" of managed care. On Dec. 8, 2003, Bush signed into law the "Medicare Prescription Drug Modernization Act," which began Medicare Part D "managed" prescription purchases in 2006. At the same time, government payments to non-HMO Medicare and Medicaid care providers have been cut.

The reality is, that the U.S. system of health-care delivery—based on regional networks of hospitals, anchoring programs of education, sanitation, and epidemiology, as well as screening and treatment—is falling apart, because of the economic crisis, and the cumulative impact of "managed care"/HMO swindles. State and local officials are fighting rearguard skirmishes to keep the doors open. The number of community hospitals has fallen from nearly 7,000 in the late 1970s, at the culmination of the Hill-Burton drive, down to under 5,000 today. The national average ratio of beds-per-1,000 persons has dropped from 4.5 in the 1970s, down to 3 today. Hundreds of counties have lost their last community hospital.

The lack of medical emergency rooms is now itself an emergency. From 1992 to 2003, the nation's emergency departments decreased by 15%, while over the same time period, millions more people have been seeking emergency room medicine, according to the American College of Emergency Room Physicians. Public-health services, diagnostics, and all kinds of other programs are likewise in sharp decline. For example, mammography X-ray procedures have dropped 16% from 2000 to 2008, falling from 43.9 million procedures in 2000, down to 36.9 million in 2008. The number of certified mammography screening sites has dropped 13% from 9,910 in 2000, down to 8,670 in 2008.

There are staff shortages of all kinds. 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. It has not improved since then.

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