The LaRouche program to restore health care

This summary of Lyndon LaRouche's health care policy was issued by Democrats for Economic Recovery, LaRouche in '92.

1) The prerequisite for restoring the U.S. health care system is to commit the nation to a program of building our way out of the depression. This requires federalizing the Federal Reserve, that is, transforming it into a national bank that would issue credit, in accordance with the American System economic principles of Alexander Hamilton, to revive the nation's collapsing water, power, transportation and urban infrastructure, while creating an initial 6 million productive jobs. This means ending once and for all the era of post-industrial madness, and necessarily includes a thorough restructuring of debt, including selected debt moratoria and cancellations.

2) A new Hill-Burton Commission shall be established to upgrade our health care system, to oversee the construction of new hospitals, medical centers, and long-term care facilities, and to equip them with the most advanced medical technologies. Hundreds of thousands of beds must be added, including those used for intensive care. Closed emergency wards and trauma centers must be re-opened, and new ones built. Public health services must be expanded and improved. All of these must be staffed by far greater numbers of doctors, nurses, and other professionals, necessitating an expansion of our nursing and medical schools.

3) We must launch an Apollo-style, crash research program to fight degenerative diseases and epidemics with the best technologies available, especially employing the frontier technology of optical biophysics to find a cure for the species-threatening AIDS virus and other infections now careening out of control.

4) Fourth, the federal government shall regulate health insurance companies to ensure full payment of medical expenses and complete medical coverage for policyholders, with premium prices based on an average cost for entire communities, not on an individual's "risk factors." Forms will be standardized, and bureaucratic paperwork kept to a minimum.

The federal government will also provide a safety net for those without insurance, through revamped Medicare and Medicaid programs and a new catastrophic health insurance plan funded by the federal government. This will enable the restoration of our network of public and private hospitals. As people go back to work through the millions of jobs that this program will create, more and more employers and employees will be able to afford health insurance at the same time that the growing state and local tax base will increasingly be able to absorb health care costs, thus decreasing and eventually ending these federal subsidies.

Medicare reimbursement rates for rural hospitals at 39.6% *less* than urban hospitals for identical DRG cases. HHS employed fraudulent methodology to understate rural hospital cost increases, and arbitrarily adjusted downward the rural wage index.

In 1988, the National Rural Hospital Association sued the federal government on behalf of 2,700 rural hospitals whose administrations called the DRG payments "unconstitutional." The suit, which charged that the DRGs jeopardized the ability of rural hospitals to provide community service, is still not settled. Although there were small rate increases to bring rural rates up to par with urban rates by 1995, the damage was done: Three-quarters of rural hospital closures left frail, elderly people in rural areas without access to hospital care. Scores of hospitals were left at financial risk of failure, and 7,456 more rural hospital beds were cut between 1983-85. After PPS successfully deprived a significant number of rural counties of their only hospital, the congressional General Accounting Office "studied" the problems affecting the survival of rural hospitals, and recommended that only a federal initiative targeting rural hospitals would help.

The fact is, providing hospital care in rural areas is associated with higher costs, just as treatment for some patients is higher than others. The United States, as a nation, has to accept that responsibility—not penalize communities for existing in rural areas by triaging their acute care facilities and decimating their economy.

Standing room only

Even more dramatic than hospital closures, is the *loss of hospital beds* in urban and rural areas. By 1988, community hospital beds plummeted below the Hill-Burton standard of 4.5 to 5.5 beds per 1,000 patient population. Many states sank below their 1940 level. Of course, population shifts out of rural areas, an increasing ability to perform surgeries on an outpatient basis, shorter hospital stays, and fewer admissions under PPS all contribute to the need for fewer hospital beds. However, the drive to cut beds out of the system has more to do with the ideological drive to "downsize" our capacity to deliver care, despite the increased demands hospitals face in treating the growing elderly population, victims of AIDS, the HIV virus, and tuberculosis. Glenn D. Hackbarth, deputy