Universal health care? Only if economy is revived

by Marcia Merry

The most commendable facet of the administration's health care reform package is, as taken from President Clinton's statements, the goal of providing universal health care to Americans. However, the proposed 3,000-page Health Security Act, and the congressional debate to date, fall far short of even grasping the physical and related means to meet that goal. At worst, measures are proposed to merely aid private financial interests, through federal budget-cutting and insurance maneuvers that will make the general economy, and health care delivery, even worse than at present.

In testimony submitted to the Senate Finance Committee on Feb. 9, *EIR* offered these three points for consideration in analyzing what is required: 1) The country is right now in a state of crisis in terms of public health care, essential infrastructure and the general economy. 2) The postwar "Hill-Burton Act" type of health care system, involving public and private collaboration, insurance arrangements, etc., is the model that should be used again. 3) To provide adequate health care, the physical means for delivery can come only from a rejuvenated economy, which, in turn requires national economic emergency measures.

These points are in sharp distinction to the prevailing "money only" standard for discussing health care reform.

Public health care crisis

The state of crisis in the general health condition of the nation can be seen in the resurgence of once-controlled infectious diseases, and the spread of AIDS. This has come about as general poverty increased, at the same time as the adequacy of vital services—safe water, sewage treatment, inoculation programs, good nutrition, adequate housing—has declined drastically. In the more or less contiguous parts of the eastern seaboard megalopolis, there are whole areas of poverty where people have been turned into hosts for the spread of diseases, and incubation of new mutations. An example of this is the spread of drug-resistant tuberculosis.

At the February meeting of the American Association for the Advancement of Science in San Francisco, researchers warned that common bacteria that cause pneumonia, children's ear infections, and other ailments, are evolving into forms untreatable by the standard medicines. Dr. Alexander Tomasz of Rockefeller University in New York City reported that before 1980, only a few cases were known where there was a resistance to penicillin by pneumococcus (responsible for pneumonia, and also for about 12 million doctor's office visits for earaches a year). But now, penicillin-resistant strains are appearing everywhere. The same process is under way with other bacteria.

Therefore, sanitation, good nutrition, medical research, and most importantly, universal care, are all the more essential.

Yet, while public health levels (sanitation, diet, inoculation) have declined, the availability of medical essentials for specialized treatment has also drastically declined. This is manifest in terms of numbers of hospital beds per thousand persons, equipment per thousand persons, trained personnel, etc. If tomorrow, all funding problems were suddenly solved, and people were told to go out and get what services or treatment they required, they couldn't get it, because it physically does not exist.

The physical health care delivery system in the nation has been "downsized" along with the general economy.

'Hill-Burton' standards of universal care

Following World War II, the standards of medical care and public health embodied in the 1946 Hill-Burton Act were

implemented in many parts of the country, with good results. Those standards are applicable today.

The guideline is, "If you need doctoring, you get it." This is for your good, and for the protection of the general population. Besides being disease free, we want to prolong life, so that wherever skills, wisdom, and inspiration may be had—in particular from the elderly—they are passed on for the good of society and future generations.

Look at what this means in terms of physical plant and equipment. The Hill-Burton standard for hospital beds was 12 per 1,000 people. Of this total, the recommendation is for 4.5-5.5 beds for "general" hospital purposes, plus 5 for mental hospitals, and 2 for chronic disease of all types.

During the late 1940s, through the 1950s and early 1960s, communities built hospitals with this standard in mind. The average of 12 beds per 1,000 people was maintained in many regions.

However, after about 1970, the turning-point period marking the decline in maintenance of essential levels of "hard" infrastructure systems (water, power, transport), the desired number of beds per 1,000 people fell below the 12-bed standard, and similar declines set in for all forms of "soft" infrastructure facilities (schools, libraries, as well as health care).

In 1972, the national U.S. average of beds per 1,000 persons was 7.6. By the late 1980s, this fell to only 5—less than half the standard adopted after the war. By January 1994, we had fallen further still.

Over the 1980s alone, 761 hospitals were shut down. The import of these declining numbers of beds per thousand people is *not* that outpatient care and healthier people have made beds redundant. Far from it. People just aren't getting care. There has been a movement to attempt to replace hospital stays by outpatient treatment. In 1972, there were about 219 million outpatient visits in the United States. In the late 1980s, this was up over one-third, to 336 million visits. The beds just aren't there to accommodate inpatient treatment.

Look at Germany in comparison to the United States. Today, Germany has more than 7.4 beds per 1,000 people, which is nearly double the average in the United States.

Moreover, the national average of beds per thousand conceals great discrepancies from region to region in the United States. In vast areas of the farm states, and such southern states as Alabama, for example, a pregnant woman cannot even expect to have hospital facilities within reasonable distance for the delivery of her baby. There is not 1 bed per 10,000 people.

In contrast, in northern Virginia—the commuter belt for Washington, D.C.—there are an average 11-15 hospital beds per 1,000 people, far above the postwar standard, and far above the rest of the country today. There is also 1 doctor for every 250 people. But this is the exception, not the rule. In the rest of the United States as of the late 1980s, there was only 1 doctor per 400 people. Vast parts of the United States have no doctors, as well as no hospitals.

This same type of physical standards per population should be used for evaluating the adequacy of providing all essentials of medical care, such as numbers of nurses, operating theaters, and advanced diagnostic scanning equipment.

Where do the beds come from?

The only way to support the medical system necessary for universal health care is to mobilize the general economy, creating the physical means and the tax base and supporting the skilled manpower to succeed.

Briefly, the steps required are:

1) Declare a national economic emergency for reasons of the manifest crises in unemployment, disease rate, infrastructure, and related crises.

2) Nationalize the Federal Reserve System, which for decades has backed speculative financial practices, at the expense of the physical economy.

3) Initiate a national infrastructure-building program, including inputs for an adequate medical care delivery system and public health system. These and related measures (such as imposing a tax penalty on derivatives trading and other speculation now destroying the economy), will in turn result in a demand for employment on the scale of 6-8 million jobs in productive activity, and set up a chain reaction of orders for bills-of-materials inputs that can resuscitate industrial life.

For example, look at the impact on the construction industry of carrying out the right health care "reform" program. Millions of new square feet of floor space need to be built. At present, the annual rate of construction of new hospital floor space, on a per capita basis, is 20% below where it was in the 1960s.

(A detailed analysis of the scope and rate of decline in the U.S. physical economy over the past 30 years, using the extensive *EIR* economic database, was published in *EIR* of Jan. 1 and Feb. 4, 1994.)

Who will pay?

When you "needed doctoring" in the period of the Hill-Burton Act hospitals, if you lived in New York City or other areas where the system worked well, you got what was required. Then it was figured out how to pay the bill. To start with, the number of weeks of wages needed to pay the bill of the average hospital stay in the 1950s was 1.2 weeks. Today, it is over 12 weeks and rising.

If you didn't have the means, the relevant people would figure something out in the course of meeting the community's needs. Private and public officials met periodically on such bills, on planning for future facilities, and other projects. Blue Cross/Blue Shield and some other plans did not cost an arm and a leg, and played a role.

With a functioning economy and tax base, this is the model that can and should work again.