Shutdown of Community Hospitals Portends Near-Term Health Disaster

by Marcia Merry Baker

Aug. 7—The fastest way to kill people who are sick is to close their local community hospital. That is what the Health Maintenance Organization (HMO) policy has done in the United States since the 1980s. Now, in the midst of the accelerating breakdown crisis, which itself is feeding the spread of a deadly flu pandemic, that hospital-closing policy is about to lead to a rapid increase in the death rate, including in the United States.

The Obama Administration health "reform" will, if it is permitted to go through, disastrously accelerate this process. The behavioral Nazis devising the policy have declared their intention to wrench "savings" out of the Medicare and Medicaid budgets, much of which goes to paying hospitals. Already, as of 2007, community hospitals had a $32 billion payment shortfall, relative to their costs, for treating Medicare and Medicaid patients, and the Obama plan would reduce payments much more, in the name of "incentivizing" "effective" care.

The community hospital is the baseline health-care resource for the country, and particularly for the uninsured, Medicaid, and Medicare recipients. In 2007, these hospitals cared for 121 million patients with emergency needs, performed 27 million surgeries, and treated 35 million inpatients. With tens of millions of Americans having lost their jobs and health insurance since 2007, the strain on hospitals has gotten much worse.

However, the nation is in the process of losing these community hospitals, along with specialty hospitals, and vital hospital beds, every day. The peak of the buildup of hospitals under the 1946 Hill-Burton policy, which set a standard of 4.5 to 5.5 beds per 1,000 persons, was in 1980. That year, there were 5,904 community hospitals, spread across most of the 3,000 U.S. counties, providing their populations with the desired standard. But, by 2007, the number of community hospitals had shrunk to 4,724, a 20% decline, and only 3 out of the 50 states had anything approaching the required beds-per-1,000 persons ratio.

In order to face the worsening pandemic, not to mention, address the general health needs of the American population, it is the Hill-Burton policy that must be revived. Lyndon LaRouche has outlined the necessary program: 1) cancelling the HMO law; 2) reviving Hill-Burton; and 3) instituting the single-payer system—all in the context of the bankruptcy reorganization required by the fatal bankruptcy of the current financial system. In addition, there must be an emergency infusion of monies to the states, in the range of $150 billion, by early September at the latest, to fill the holes in services being created by collapsing revenues and state budgets.

We summarize here some of the recent testimony and warnings on the disastrous decline of the U.S. community hospital network.

Start with the Military

Of the 36 Army base medical centers, fully 26 cannot meet the needs of the military right now, according to a late 2008 Army survey, reported by *USA Today* (July 31-Aug. 2 weekend edition). "Army records show that 26 of its [36] medical centers, hospitals and clinics are unable to meet Pentagon standards requiring that 90% of patients get routine care appointments within seven days. Those are the worst results since the start of the wars in Iraq and Afghanistan. That's a 13% increase from 2006 in the number of medical facilities unable to meet the standard. . . .

"The Army doesn't have enough doctors to provide care both to families and soldiers at home and to those in combat," according to those in charge, including Gen. George Casey, Army Chief of Staff; Col. Ken Canestrini, who is in charge of improving the situation; and Col. Jonathan Jaffin, director of Health Policy and Services, for the Army Surgeon General, Lt. Gen. Eric Schoomaker. Among the stopgap measures, Schoo-

Michael Heckman/Illinois Corps PAO

Military hospitals are among the most seriously endangered. Of the 36 Army base medical centers, fully 26 are unable to meet the needs of U.S. soliders. Shown: Carl R. Darnell Medical Center, Ft. Hood, Texas.

maker has authorized 12 medical centers to hire more primary-care physicians, and has ordered that soldiers and families may go to off-base care centers, even if it costs more.

The on-base medical center at Ft. Bragg, for example, has "not met the routine care standards since 2005. Bragg is home to the 82nd Airborne Division and special operations forces that have been fighting in the two wars constistently."

To go "off base" for medical treatment, means in many localities, to seek care in communities already short of hospitals and facilities.

Shutdowns Proceed

Meanwhile, the rapidly worsening net loss of beds and staff in the U.S. medical-care delivery system proceeds. For example:

• **New Orleans, La.**. On Sept. 1, the New Orleans Adolescent Hospital (NOAH, which also serves adults of any age) is set to close, which among other things, will shut down the city's only public hospital with a dedicated mental-health unit (with 35 beds). At present, the city has only 170 inpatient beds for the mentally ill, located at seven hospitals—way down from 400 such beds at 10 hospitals, four years ago.

• **Syracuse, N.Y.**. In the nearby town of Hamilton, the Community Memorial Hospital will close its baby-delivery unit as of Sept. 1, because of financial constraints and lack of obstetricians. Women will have to go to the more distant facilities in Utica, Syracuse, Oneida, and elsewhere. The physician shortage in Upstate New York is bad, and is acute in the Mohawk Valley, where the supply of doctors fell 4%, between 2002 and 2006, according to the Center for Health Workforce Studies at the State University in Albany.

• **Toledo, Ohio**. On Sept. 1, the Toledo Hospital will shut its Drug and Alcohol Treatment Center, which has operated both in- and out-patient services. The 20 staff members are seeking work at other facilities in the ProMedica Health Care System. The patients are being referred to a 42-bed facility in the region, operated by Arrowhead Behavioral Health, a company based in Tennessee.

And then comes the flu . . .

Meanwhile, responsible public officials are looking ahead to the disaster over the horizon—when the expected Fall flu pandemic hits. Public health leaders from California, New York City, and Maryland testified about their fears during a hearing of the House Homeland Security Committee on July 29. They described how their capacity was stretched "to the limit" during the Spring outbreak of A/H1N1. Health officer Mark Horton, M.D., M.S.P.H., added, "There is no way we could have sustained this. . . . I am very concerned about this for the Fall. . . ."

States and localities are now in the throes of still further reductions in their public-health capacity, given the budget-slashing underway since the start of the new fiscal year July 1, under impossible conditions of revenue collapse. But, at the same time, they are trying to step up "pandemic readiness"!

In Pennsylvania, the state has managed to purchase 19 mobile "medical surge" trailers, with 50 cots each, and eight portable hospitals, with 50 beds each, but the net gain is reduced by the loss of pre-existing beds from the closure or downsizing of local hospitals, reductions in Veterans hospitals, etc. This crazy pattern prevails across the country. Last year, 12,000 public-health worker jobs were eliminated in the United States.

On Aug. 5, nurses demonstrated in Sacramento, Calif., to protest the lack of protective equipment to provide them safety during their care for flu patients. A week earlier, the first death of a nurse occurred in the state, due to A/H1N1.

The Administration sent only their number-two-level deputy secretaries from the Health and Human

Services and Homeland Security departments to report to Congress on the hearing topic, "Beyond Readiness: An Examination of the Current Status and Future Outlook of the National Response to Pandemic Influenza": respectively, William Corr and Jane Holl Lute. These officials played down any deficiencies in the U.S. hospital/public health delivery system, by instead focussing on "collaboration" between agencies, "communication," etc.

They also spoke of the $350 million in Federal grants for preparedness aid, now going out to the 50 states and the territories—a paltry sum, given, for example, that, to properly protect New York City alone, a bare minimum of $70 million will be required this Fall, which they don't have (this was in the New York City testimony), and for full protection from a severe episode, $0.5 billion is needed.

The Administration spokesmen actually left the hearing chamber at the end of their panel, without bothering to listen to what the state and local officials had to say.

Dr. Horton spoke afterward, on the second witness panel for the July 29 hearing, which was chaired by Rep. Bennie Thompson (D-Miss.). Horton and two other government officials, Thomas A. Farley, M.D., commissioner of New York City's Department of Health and Mental Hygiene, and Richard G. Muth, executive director of the Maryland Emergency Management Agency, reported on their experience from this Spring's A/H1N1 outbreak, and their preparations for the Fall. In addition, Colleen M. Kelley, President of the National Treasury Employees Union, called for Federal action to provide A/H1N1 protective gear for customs, border, airport, and other key front-line Federal personnel. The following are indicative specifics from their testimony.

Surge Capacity

The California Department of Public Health has stockpiled supplies and equipment for 21,000 "alternate care site beds" being lined up by local health departments, but Dr. Horton describes the overall process as "an overloaded health-care system" statewide.

In New York City, an advance-planning effort is underway for bed space and equipment. Dr. Farley reported, "During the peak of the pandemic this past Spring, some hospital emergency departments were overwhelmed. Many emergency departments saw a 200% increase in the number of patient visits. To deal with overcrowding, some hospitals created additional space by setting up a tent outside of their emergency departments or used outpatient clinic space to allow those patients with influenza to be quickly separated from others. . . ." Now, a bigger surge is ahead.

Personnel

Every state and city has big "personnel gaps." Dr. Farley testified that, "the steady erosion of funding the last few years hinders our ability to maintain progress and retain the critical workforce needed to respond to the unique risks and public health emergencies in New York City. . . .

"The primary source of support for the preparedness infrastructure in New York City, the [Federal] Public Health Emergency Preparedness Cooperative Agreement through CDC, has steadily decreased since 2002, dropping approximately 26%." Other Federal programs have also dropped, especially a 25% reduction in New York City's allocation under the 2004 Cities Readiness Initiative program. Farley testified, "And we have been advised that we will receive another 25% reduction in the next grant year. . . ."

Dr. Horton of California asked Congress for "additional investment in the public health workforce, including epidemiologists, microbiologists, and laboratorians to ensure enough scientists are on the ground to identify and monitor the spread of disease."

Supply Lines

In California, where the first two U.S. A/H1N1 cases were identified April 17, and by July there were 3,200 reported cases, and 537 hospitalizations, Dr. Horton said, "We experienced an early and inexplicable collapse of the private industry pipeline for antivirals and masks, which, if not resolved, would have rapidly depleted our stockpiles. The resolution required Federal intervention, as the suppliers were national companies. . . ." This must be worked on "more closely . . . to ensure supply-chain reliability."

California's network of 26 local public-health laboratories tested over 14,500 specimens over a four-month period, "compared to a typical volume of 2,000 in a regular influenza season," but they came within hours of shutting down because of a shortage of reagents. Lab capacity must be expanded, with reliability in supply lines.

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