'Managed health care' kills: a case study of Philadelphia

by Marcia Merry Baker

On Sept. 12, the Pennsylvania State Legislature House Committee on Health and Human Services heard testimony in Harrisburg, on the hospital care crisis in the Commonwealth, because, in particular, of the low ratio of trained nurses to patients in hospitals. The witness, Prof. Laura Gasparis Vonfrolio, a nursing expert, reported specific incidents from Philadelphia hospitals which indicate the extent of the problem. Her testimony is excerpted below.

The context for the dangerous lack of nurses, is the 25-year-long takedown of the U.S. health care system, by a process of shutting down or downsizing hospitals, clinics, and other facilities, and staff.

For approximately the 20 years over 1950-70, the U.S. health care system had been built up, on principles embodied in the 1946 Hill-Burton Act ("Hospital Construction Act"), the nine-page federal law that mandated building community and specialty-bed hospitals to make certain that all Americans had access to care. Hill-Burton set standards of about 4.5 or 5.5 community hospital beds per 1,000 people, depending on the population density of the region; and more beds for specialty use. As a national average, this standard was achieved by the early 1970s; other public health essentials (e.g., the national anti-polio campaign) were likewise provided in the spirit of Hill-Burton.

Then, over the 1970s, this commitment to public health, and the provision of staff and logistics to deliver care, was abandoned, with the shift to "post-industrial" policies. Federal deregulation furthered the growth of "managed care" swindles, in which a for-profit agency (mostly set up by the international insurance cartels—Prudential, Aetna, Metropolitan Life, etc.) created health maintenance organizations, or HMOs, that racked up huge profits by enrolling millions of people who had no alternative, and coercing doctors and hospitals to limit the care given. Membership in HMOs grew from 5 million in 1980 to 60 million today.

The direct and indirect effects of "managed care" cost-cutting have been devastating. A study reported in the Oct. 1, 1996 *Journal of the American Medical Association,* shows that the poor and elderly enrollees, directly suffered the effects of care denied by the HMOs. Since 1991—at the instigation of the George Bush administration—the HMOs have been allowed to take Medicaid and Medicare patients.

The indirect effects of cutting care include cutting the logistics base of delivering medical care. From 1980 to 1993, some 675 community hospitals closed, mostly in rural and inner-city areas. Many remaining hospitals cut back services.

TABLE 1
Philadelphia County death rates, 1992-94

Deaths per 100,000	Philadelphia County Average, 1992-94	Pennsylvania 1992-94	U.S.A. 1993
Cause of death			
Total resident deaths	724.7	504.9	514.0
Cardiovascular	232.4	184.2	181.8
Heart disease	189.0	150.3	144.7
Stroke	32.8	24.6	26.4
Lung cancer	54.0	37.9	39.3
Breast cancer	28.6	23.4	21.5

Source: "Health Profile, 1996, Pennsylvania Counties," Division of Health Statistics and Research, Pennsylvania Department of Health, Harrisburg, 1996. The death rates shown are based on the per 100,000 standard (1940 U.S.) population, using direct method.

Hospital beds decline

The situation in Philadelphia is representative of many once-great U.S. urban medical centers, which have been turned into disaster zones. We provide a few reference facts:

In 1985, Philadelphia County still had 50 hospitals. By 1991-92, six had closed, leaving 44; in 1993-94 there were 42 hospitals. The number of "set up and staffed" hospital beds was likewise going down, falling from 8,550 in 1991-92, to 8,035 the next year. Over 1995-96, the downsizing continued, and the "de-staffing" per bed, in which the ratio of nurses to patients in the hospital declines, got even worse.

Officially, the ratio of beds per 1,000 population in Philadelphia dropped from 5.5 in 1991-92, to 5.3 in 1993-94, and would have fallen further, except that the county's population itself is declining. While this bed ratio does not look so bad, note that thousands of Philadelphia bed-days are used by out-of-state or out-of-county patients, coming to the city for treatment at the remaining prestigious Philadelphia medical specialty centers.

Table 1 shows that the death rates for major causes are higher for residents of Philadelphia County than in the rest of Pennsylvania and the United States as a whole.

The HMOs in Philadelphia

The major HMOs in the Philadelphia metropolitan region (including Bucks, Chester, Delaware, Montgomery and other continguous counties), as of the third quarter 1995, ranked by percentage of market share (of HMO enrollees), are:

1. U.S. Healthcare (HMO of Pennsylvania), 43%; Aetna, 8% (as of 1996, Aetna owns U.S. Healthcare)
2. Keystone East (Independence Blue Cross), 33%
3. Health Partners, 5%
4. Greater Atlantic, 5%
5. Oaktree, 3%
6. CIGNA, 2%
7. PruCare Philadelphia, 2%

U.S. Healthcare, Inc., based near Philadelphia, in the town of Blue Bell, merged earlier this year with Aetna Life & Casualty Co., in an $8.9 billion deal, to form one of the nation's largest HMOs. The new firm now accounts for well over 50% of all HMO enrollees in the greater Philadelphia region. HMO strategists now project that Philadelphia would "need" only 1.91 beds per 1,000 if 100% HMO "managed care" took over the "market." (Estimate from *Hospitals and Health Networks,* Oct. 5, 1994.)

U.S. Healthcare, Inc. makes big bucks

U.S. Healthcare, Inc. had an average return-on-equity rate of 37.4% over a five-year period, ending 1993, the highest for all HMOs in the nation. This reflects the aggressive HMO enrollment, severe cost-cutting, and limiting of care. The founder and chief executive of U.S. Healthcare, Inc., Leonard Abramson, is now one of *Forbes* magazine's 400 richest men in America. Abramson's total compensation from U.S. Healthcare, Inc. in 1994, for example, was $3.87 million. According to *Washington Post* coverage of the merger, the filing with the Securities and Exchange Commission shows that Abramson "will gain a $1 billion bonus as a result. In addition, Abramson has a $10 million, five-year consultant contract that does not call for him to work full-time." In describing the Aetna-U.S. Healthcare, Inc. merger, the *Philadelphia Inquirer* on April 2, 1996 noted, "The end result will be fewer players—hospitals, doctors and insurers."

TABLE 1
The top managed-care firms
(ranked by enrollment, as of Jan. 1, 1995)

	No. of plans	Enrollment (millions)
1. Blue Cross and Blue Shield Association	80	8.118
2. Kaiser Foundation Health Plans Inc.	12	6.666
3. United Healthcare Corp.	20	2.548
4. Prudential Health Care Plans Inc.	32	1.810
5. U.S. Healthcare	9	1.793
6. Humana, Inc.	16	1.754
7. FHP Inc.	11	1.753
8. Health Systems International Inc.	7	1.544
9. PacifiCare Health Systems Inc.	6	1.496
10. Cigna Healthcare Plans Inc.	37	1.282
11. Aetna Health Plans	24	1.230
12. Health Insurance Plan of Greater New York	3	1.131
13. Foundation Health Corp.	6	.942
14. Sanus Corp. Health Systems Inc.	5	.839
15. Group Health Cooperative of Puget Sound	2	.644
16. Metra Health	22	.640
17. Physician Corp. of America	5	.577
18. Harvard Community Health Plan	1	.570
19. Mid-Atlantic Medical Services Inc.	1	.543
20. Oxford Health Plans Inc.	3	.534
21. Healthsource Inc.	14	.510
22. Principal Health Care Inc.	16	.492
23. Coventry Corp.	4	.469
24. Henry Ford Health Care Corp.	1	.429
25. Heritage National Healthplan Inc.	2	.296

Source: The InterStudy Competitive Edge (Minneapolis, Minn.); cited in *Managed Healthcare,* December 1995.

'Managed care' boosts profits for insurers

by Anthony K. Wikrent

Among the top 25 "managed care" firms in the United States as of 1995 (**Table 1**), are some of the most prominent names in "Big Insurance"—Prudential, Aetna, Metropolitan Life, CIGNA—all part of the international financial aristocracy that has positioned itself to make huge profits by looting the economic base of the nation.

The system of health maintenance organizations (HMOs) evolved over the 1970s-90s, the 30-year "post-industrial" policy shift, as enabling legislation was rammed through favoring the financial interests behind HMOs. In 1988, private insurance companies were granted the right to directly own and operate "managed care" health services, instead of to run them through "fronts" and subdivisions. Then, in the 1990s, a wave of mergers and takeovers occurred among the giants in "managed care," creating even bigger, new companies, making profits off the managed care system of limiting medical treatment, bullying medics, hospitals, and nurses, and courting new enrollees.

Executives and stockholders of HMOs have been making a killing—literally. One of the most egregious examples of HMOs reaping riches while the Grim Reaper grins, is Leonard Abramson, who calls himself just a "former Philadelphia pharmacist." Abramson is the head of US Healthcare, Inc., which merged earlier this year with Aetna, to create the third largest HMO in the nation.

In the early 1970s, Abramson became the vice president for corporate development at R.H. Medical, Inc., a small company that managed hospitals. Abramson devised practices