

that were the forerunners of today's "managed care." Abramson left to start US Healthcare, Inc., with \$3 million in start-up money in the form of loans from the federal government. In 1981, Abramson discarded the non-profit status of US Healthcare, and in 1983, transformed it into a publicly traded company.

The results have been extremely lucrative for Abramson. US Healthcare became the fifth largest HMO, with nearly 1.8 million enrollees by January 1995; in 1995, it had \$380.6 million in profits on \$3.6 billion in revenue. The Sept. 22, 1995 *New York Post* reported that Abramson, founder and chairman of US Healthcare, was paid \$3.85 million in salary and bonuses in 1994, and by September 1995, held company stock options worth \$1.8 million and 1.88 million shares worth \$63.2 million. In addition, US Healthcare paid \$800,000 in salaries and bonuses to his two daughters and a son-in-law. One of Abramson's benefits was that the company paid the \$405,177 premium for his life insurance.

The same year, the U.S. government paid \$178.4 million to US Healthcare for its Medicare enrollees, and another \$62 million for Medicaid enrollees.

'US Healthcare is a bank'

One Wall Street analyst, who reviewed the financial position of the company, noted holdings of \$1.13 billion in liquid cash and short-term securities, and exclaimed, "US Healthcare is essentially a bank. They are a bank!" The analyst said that the company's 13.15% profit rate on \$2.876 billion in premium revenues was "three times the average for computers and peripherals, three times apparel, more than two times chemicals and mining and food."

According to the *Post*, Abramson was the sixth best paid HMO executive that year. The average cash and stock awards to top executives of the seven biggest for-profit HMOs, the *Post* calculated, was \$7 million in 1994. The eighth best paid HMO executive in 1994 was Steven Wiggins, founder and CEO of Oxford Health Plans, who was paid \$857,000 in salary and bonuses, and had \$35.5 million worth of stock options. He also held 1.372 million shares of Oxford, worth \$97.2 million.

In April 1996, it was announced that US Healthcare would merge with Aetna Health Plans, the 11th largest HMO, to become the third largest HMO, after the Blue Cross and Blue Shield system, and Kaiser Permanente. The payoff for Abramson is staggering—almost \$1 billion in cash and Aetna stock, one of the largest financial payoffs ever given an individual in a single transaction.

According to a July 19, 1996 filing with the Securities and Exchange Commission, Abramson holds 15.755 million shares of US Healthcare stock, each share of which Aetna will exchange for \$34.20 in cash; 0.2246 shares of Aetna common stock; 0.2246 rights to Aetna common; and 0.0749 shares of Aetna preferred C stock. At a market price on Oct. 7 of \$70 for Aetna common, and \$73 for Aetna preferred, Abramson will receive: \$247.66 million worth of Aetna com-

mon, \$86.14 million worth of Aetna preferred, and \$538.85 million in cash. Abramson will receive more, if Aetna's stock price goes up, and depending on what the value of the rights is.

Time magazine on April 15, 1996 reported that 14.5¢ of every dollar US Healthcare takes in goes to administration, and another 10.5¢ goes to profit, "an interesting contrast to the 2¢ of every Medicare dollar that goes to administrative costs." Thus, only 75¢ of every dollar paid to US Healthcare, actually goes for medical care.

But as HMOs reach the saturation point of signing up only healthy people, and more of their enrollees become elderly and require more costly care, profit margins are being squeezed. That makes Wall Street decidedly unhappy. In mid-September, Salomon Brothers advised clients: "We expect the HMO industry will undertake a number of steps to reduce the higher medical costs that have plagued the industry this year."

Expert Testimony

If nurses are fired, patients will die

The following testimony, by Laura Gasparis Vonfrolio, was delivered on Sept. 12, 1996 at a hearing of the Pennsylvania House of Representatives Committee on Health and Human Services. Vonfrolio has been a nurse for over 20 years, holding positions from staff nurse to tenured professor of nursing. She is currently editor of Revolution—The Journal of Nurse Empowerment, a national nursing journal, and travels throughout the United States lecturing to over 40,000 nurses annually. Vonfrolio made the testimony available to EIR, which we have excerpted below.

I am very concerned about the delivery of health care. It is said that when health care becomes a primary threat to quality patient care, advocacy by necessity must move from the bedside into the political arena. . . .

There is a redesigning in the delivery of health care in the name of profit. Hospitals are initiating a radical de-skilling of nursing, concealed under phrases such as "patient-driven health care," "patient-focussed care"—and giving unlicensed personnel titles such as "patient care assistants" and "patient care technicians." These are labels cleverly designed to give the appearance of improving care, when they in fact are about improving profitability.

Hospitals are restructuring, downsizing, rightsizing, in order to provide a cost-effective delivery of health care at the expense of patient safety. According to a June 1995 Hospital



Nurses demonstrate in Washington, D.C., May 10, 1996. "When health care becomes a primary threat to quality patient care," says Vonfrolio, "advocacy by necessity must move from the bedside into the political arena."

Council Survey, 85% of the CEO respondents indicated cost containment as the main reason to restructure. Within the hospital care setting, profit has consistently been given a higher priority than patient safety and quality of care as reported in an August 1996 study.

It is important to note that this redesign of patient care is *untested*.

Hospitals are relying on two strategies to cut costs: substitute cheaper labor for RNs [registered nurses], and increase their work responsibilities. Not long ago, it was common for RNs to constitute 90% of the hospital-based work force involved in direct patient care. Health-care institutions are reducing nurse staffing and altering their mix of nursing staff by utilizing smaller percentages of RNs, even when the care for more acutely ill patients with fragile conditions requires more hours of professional nursing care.

Nursing care can quite literally mean the difference between life and death. This is well documented by Dr. Prescott's study, along with a considerable amount of literature on nurses' impact on hospital mortality rates. Hospitals with a higher proportion of RNs had lower mortality rates, in addition to shorter length of stay and decreased cost in care.

Replacing licensed registered nurses with unlicensed personnel is dangerous, and results in an increase in patient complications, infections, readmissions, and death. This is documented with a multitude of studies.

In a May 1996 study by *Revolution—The Journal of Nurse Empowerment*, 74% of those surveyed indicated that their hospitals have replaced RNs with unlicensed personnel; 90% indicated that the decrease in the number of RNs at the bedside

resulted in a decrease in the quality of care; 46% indicated that they saw an increase in patient readmissions; 72% indicated an increase in incident reports of errors and patient accidents; 64% indicated an increase in infection rate.

And a July 1996 *American Journal of Nursing* 1996 Survey showed that there has been a 42% increase in patient complications, a 37% increase in medication errors, a 22% increase in patient injuries, and 57% felt that nursing care was not up to their professional standards.

Outline of current problems

1. The inappropriate use of unlicensed assistive personnel [UAP], and inadequate training given to individuals;
2. Insufficient levels of RN staffing to provide safe care and oversight for unlicensed personnel;
3. Cross-training of inappropriate and ill-prepared people;
4. The use of float nurses with insufficient orientation;
5. Inadequate patient assessment;
6. Mandatory overtime and increased workload and responsibilities of RNs; and
7. Medication errors, which will increase by replacing RNs with unlicensed personnel. In December 1994, the *Journal of the American Medical Association*, in an article by Dr. Leape, states that approximately 180,000 patients die each year from iatrogenic injury, the equivalent of three jumbo jet crashes every two days.

While we are on the subject of airplanes, would you board a jet if you knew that the highly trained and educated mechanics were replaced by unlicensed personnel with only 2-3 weeks training? . . .

Then why would we expect patients to enter into a hospital that had replaced their licensed, registered, professional, and educated nurses with unlicensed personnel? A hospital, an environment full of sophisticated equipment, complex monitoring devices, potent life-sustaining medications—and unlicensed personnel to care for patients.

Nurses have/had the ability to always evaluate a patient in comparison to how they were ten minutes ago, one hour ago, two hours ago. Nurses make decisions, minute-to-minute decisions, that are life-saving.

... Probably the one activity nurses do better than any other profession is monitoring. Monitoring means to post a vigilance, a constant surveillance. ... Fragmentation of care does not allow nurses to do this critical assessment—fragmentation caused by replacing RNs with unlicensed personnel. ...

Nurses are uniquely capable of combining all the complex elements that contribute to healing. Nursing care is a powerful force in helping patients get well. I don't know of any profession where one can so deeply walk into another person's life and potentially make a difference; it is such a privilege. Don't take that away from us, don't take that away from our patients. ...

Cost-cutting administrators are replacing nurses with individuals with no training and expertise in caring for the sick. They think a less expensive worker could do the job, when it is well documented ... that an all-RN staff in an acute care setting is the safest and most cost-effective nursing care delivery model.

Linda Aiken (1994) found that mortality rates among elderly patients were lower in hospitals that placed a high priority on nursing care. ...

The clinical evidence: Philadelphia

The following information was called into my office from nurses employed in Philadelphia hospitals:

Medical College of Pennsylvania and Hahnemann Hospital, which are owned by Allegheny University Hospitals Center (reported \$1.7 billion in assets): Fifty-six nurses complained of severely short staffing: an 18-bed stepdown unit with only two RNs, compromising and jeopardizing patient care. Patient receiving medication which was shut off by RN due to reaction. Techs turned it back on. Patient suffered kidney damage.

Lankenau Hospital: Twenty-one nurses complained of severe shortage of RNs. Hospital has replaced RNs with techs. Last week, a 52-year-old woman died due to lack of licensed personnel. Techs were observed improperly suctioning, drawing blood, speaking incorrectly to families. Patient admitted from ER [Emergency Room] after accident with possible concussion and to be closely observed. Initial RN assessment: patient oriented. UAP reports to one RN on a 40-bed unit. Patient is disoriented. Six hours later, patient [is in] severe distress, with cardiac tamponade. UAP reported throughout night that patient was okay.

Krozer Chester Hospital: Forty nurses called regarding the unsafe patient environment and unbearable nurse-patient ratios. Hospital poorly staffed. The hospital has replaced RNs with techs. C-sections [caesarean births] now have orderlies instead of RNs in the surgical suite to assist. It is important to note that patients that required emergency C-sections are the sickest, in a very life-threatening situation. The surgical step-down unit has an 8:1 ratio with only three days of orientation. The practice of floating nurses to areas foreign to practice is common.

Misericordia Hospital: Twelve nurses called. Replacing RNs with techs, and care is being compromised. RNs are stretched to the limit with IVs, meds, orders. No time to check what techs are doing, yet accountable for nursing care being delivered or delegated. A cross-trained UAP trained to record hemodynamic parameter from a swan ganz catheter, failed to report that the catheter was in a wedge position. Patient develops pulmonary infarction. This UAP (post-dietary person) received two weeks' orientation to the critical care setting, whereas an RN has two to four years of college, and six weeks of orientation requiring the RN to pass six competencies before practicing. Substituting quality training and education with a crash course results in patient deaths.

Temple University Hospital: Twenty-four nurses called. Dangerous conditions. Floating nurses to units foreign to specialty. Cardiothoracic telemetry (post-open heart unit), one nurse for 11 patients and very unsafe. Use of UAP to collect data, i.e., breath sounds, vital signs, and report abnormalities to RN. Patient with hip fracture developed subjective SOB. UAP reported findings and imparted a low degree of urgency. Patient arrested and expired due to fat embolus.

St. Marys Hospital: Eight nurses called. Very limited staff and unable to supervise techs. A tech thought the umbilical cord was intestines. Mother was hysterical and thought the tech was a nurse.

Pennsylvania Hospital: Twenty-six nurses called, stating that hospital is short staffed, for example, 9:1 ratio stepdown unit. Heavy medical floor with much direct total care needed. Unsafe, patients falling getting out of bed, basic needs are not being met, greater skin breakdown, more potential for med errors, labs are being missed, increased danger of patients with critical problems and no time for emotional support for patients.

Presbyterian Hospital: Eighteen nurses called in with complaints of severe compromise in patient care.

North Eastern Hospital: Eight nurses called. Floating to areas foreign to practice common.

Roxborough Hospital: Seven nurses called. Very unsafe nurse-patient ratios, one RN for seven patients in step-down unit.

Vencor Hospital: Ten nurses called. Deplorable, unsafe conditions. Seventy percent of patients are on ventilation with a 6:1 ratio.

Albert Einstein Hospital: Thirty nurses called to report replacement of RNs with techs and unsafe patient conditions.

Mercy Hanover Hospital: Six nurses called to report unsafe patient conditions. ICU [intensive care unit] 4:1 ratios. Floating floor nurses into ICU. Two deaths due to inadequate staffing in one week.

Germantown Hospital: Sixteen nurses called in to report deplorable and unsafe patient environment with a 1:12 ratio on Med Surgery and Telemetry floor, and replacement of RNs with unlicensed personnel. Also a 1:8 ratio stepdown. Severe increase [in] infection rates. Diabetic patient: cross-trained UAP puts sugar on tray even though tray was clearly marked diabetic diet. UAP does acucheck; clearly not enough blood on pad, reading 80. Nurse rechecks blood sugar: 296.

Graduate Hospital: Fourteen nurses called to report a severe compromise in patient care with a 1:4 ratio in CCU [cardiac care unit] and a 1:7 ratio in cardiac stepdown unit.

Methodist Hospital: Eighteen nurses called regarding unsafe patient environment with a 1:10 ratio on telemetry unit. Clerks are taking a training course in patient care.

Solutions

I recommend to the health committee the following measures:

1. Return to established nurse-patient ratios.
2. Make nurse-patient ratios available to the public.
3. Make mortality and complications rates available to the public.
4. Make staffing mix available to the public.
5. Protect nurses who speak out about unsafe conditions.

The patient population in the hospital is far more ill than five years ago. Nurses can no longer count on finding numbers of easier or self-care patients whose reduced needs allow staff to concentrate on the needs of more acute patients. Nurses find that all of their patients are acute and in need of a great deal of care and close monitoring.

Based on these trends, the health care needs of the American people require more nurses to be available to provide high quality, cost-effective health care services.

There are not enough registered nurses providing direct care to patients, as a result of workplace redesign schemes that have intentionally limited the numbers and percentages of RNs utilized to deliver patient care, in a misdirected effort by institutions to save money.

The current bedside shortage is the result of short-sighted attempts to cut immediate costs as hospitals continue to cry poor despite their growing profitability.

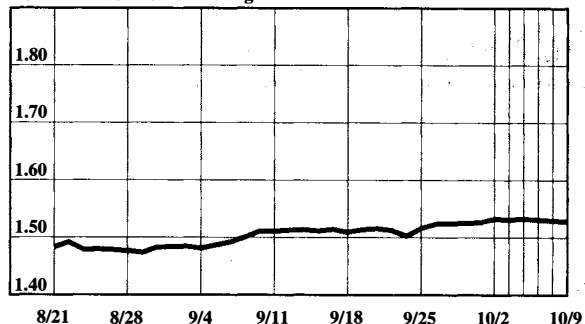
I believe that this trend toward decreased use of professional nursing staff poses a grave threat to the health and safety of the American people.

The hospitals are not neutral parties and should not be setting the parameters of this inquiry. It is the legislature, with advice from reliable, unbiased sources, that should be pursuing the facts in this situation and weighing them in a dispassionate manner for the greater benefit of their citizens.

Currency Rates

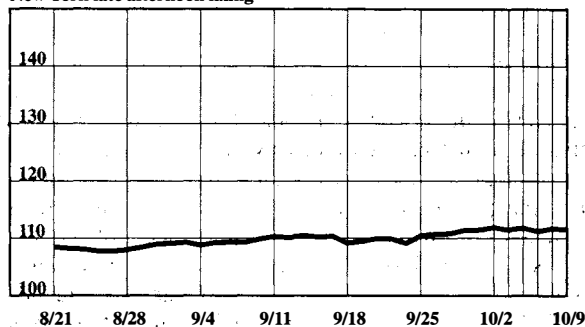
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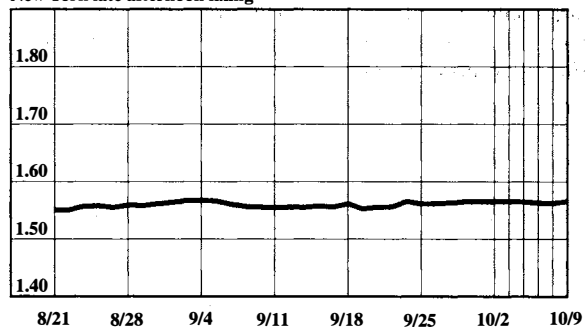
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New York late afternoon fixing



The British pound in dollars

New York late afternoon fixing



The dollar in Swiss francs

New York late afternoon fixing

