Click here for Full Issue of EIR Volume 26, Number 25, June 18, 1999

If you get sick, will you have a hospital?

by Richard Freeman

For the past 15 years, and for the past five years in particular, America's health delivery infrastructure has been torn apart by the financier oligarchy's policies. As the worldwide financial disintegration enters a final eruptive phase, combined with existing lowered living standards and increased disease, the conditions have now been set for America's death rate to rise.

America's network of community and long-term care hospitals is being dismantled, brick by brick. At the hospitals which are still standing, services have been greatly reduced: Since 1980, the number of allowable days of inpatient care, per capita, has been cut by 50%. At many community hospitals, nurses are being fired. A large number of services that were previously provided on an inpatient basis at hospitals have been shifted to outpatient, ambulatory care, or emergency room bases; but then, emergency rooms are being closed.

Increasingly, an individual finds that even if he has the means to pay, no physical hospital structure may exist in his vicinity to obtain medical service. This is true in both rural areas and densely populated urban areas.

And, alarmingly, this is happening in America, a nation which, during the late 1940s through the early 1970s, possessed one of the world's finest hospital systems.

Two policies, implemented by the London-centered financier oligarchy over the past 15 years, are responsible for this gutting of America's medical system:

- The policy of "managed care," which now dominates the medical industry. The leading form of managed care is the health maintenance organization (HMO); also widespread, but less well-known, is the preferred provider organization (PPO). A majority of large HMOs are owned outright, or exist in the orbit of, insurance companies, such as Aetna Insurance. These HMOs apply concentration-camp accounting, siphoning and stealing profits out of the medical system at the expense of life. This is accomplished by chiseling or reimbursing at less than the true medical cost—shaving payments for surgical operations, reducing the time allowed for hospital stays, and/or refusing to pay anything for some expensive life-saving operations. As a result, the medical providers, such as hospitals, nursing homes, and doctors, which are reimbursed by HMOs at less than the cost needed to exist, either triage their medical service or, failing that, close down.
- The effects of the Balanced Budget Act (BBA) of 1997. This additional element was superimposed upon the longer-term downward spiral by the banker-run Conservative Revolution crowd in Congress. The sponsors of the BBA were Senate Majority Leader Trent Lott (R-Miss.) and then-Speaker of the House Newt Gingrich (R-Ga.). Strong backing is also reported to have come from Vice President Al Gore.

The BBA instituted deep budget cuts in programs that make substantial payments to hospitals: Medicare, the Federal program that provides medical assistance to the elderly and disabled; and Medicaid, the joint Federal-state medical assistance program for the poor. For the five-year period extending from fiscal year 1998 (which started Oct. 1, 1997) through fiscal year 2002, the BBA rammed through cuts in Medicare and Medicaid of $115.1 billion and $10.4 billion, respectively. For the following five fiscal years (fiscal years 2003-07), Medicare and Medicaid were axed by an addi-

© 1999 EIR News Service Inc. All Rights Reserved. Reproduction in whole or in part without permission strictly prohibited.

tional $270.4 billion and $37.4 billion, respectively. Thus, over 10 years, the combined cuts in the funding for the two programs is to be $433.3 billion. Approximately 65% of that sum—nearly $300 billion—is money for payments by the elderly and poor, mostly to hospitals, and some to nursing homes.

To a hospital system already crippled by HMO policies, the past two years of BBA have proved to be dangerous. In 1997, 44% of community hospitals' revenues came from two sources: 33% from Medicare, and 11% from Medicaid. Hundreds of hospitals located in areas serving a large number of elderly or poor, derive an ever-larger share of their revenues—between 50 and 80%—from Medicare and Medicaid. Many hospitals may not survive.

On May 28, a spokesman for the American Hospital Association, which represents 5,000 hospitals out of the roughly 6,500 in the United States, stated that, "given the reduced level of reimbursement, many hospitals which remain open are cutting back or eliminating services: obstetrics, care for the elderly, and so forth. *They are rationing care*" (emphasis added). This is outright medical triage.

The present report will first look at the take-down of America's health and hospital system infrastructure, including hospital beds, many hospital services, and nurses, and will then assess the superimposition of the Balanced Budget Act onto this downward-spiralling process.

Take-down of hospital infrastructure

A first approximation of the state of the U.S. hospital system begins with the number and availability of hospitals, hospital beds, nurses, and emergency room access. This, most emphatically, includes the amount of time that patients, once admitted to a hospital, are permitted to stay there. HMOs and insurance companies are attempting to move them out the hospital bed and out the door with indecent haste.

However, as important as the hospital system is, it is only one part of what constitutes the health of a nation. A nation must provide citizens with clean, disease-free water, sewage removal, and decent housing. These three types of infrastructure were essential to breaking the grip of disease in every American city in the period 1880-1930, especially in the ghettoes and urban tenements, where disease flourished. There must be electricity (to power many things, including the advanced EKG and CT machines), and adequate food supply to maintain proper levels of nutrition. There must be a decent standard of living, and provision of vaccine-inoculation programs, in particular, for the very young and very old. There must be basic scientific research. There must also be hospitals, doctors, nurses, and so on. This is an interconnected package; there cannot be just one or two parts of it. The problem in the United States, is that so many other parts of the infrastructure of the health of a nation are also breaking down.

To focus on the hospitals in the United States, let's look at the community hospitals, which comprise 81% of all hospitals in the nation. The American Hospital Association, which represents them, defines community hospitals as "all non-Federal, short-term, general, and special hospitals whose facilities and services are open to the public." This excludes: long-term care hospitals, such as hospitals for tuberculosis and other diseases which require long-term care; Federal hospitals, which are largely Veterans Administration hospitals; and psychiatric hospitals.

Table 1 shows the condition of hospitals for the 15 states with the highest rates of hospital shutdown in the nation (ranked from the highest percentage of hospital shutdown). In 1985, the United States had 5,732 operational community hospitals. By 1996, the latest year for which figures are available, the United States had only 5,134 hospitals, a loss of nearly 600 hospitals, or 10.4% of the total. In the 1985-96 interval, Massachusetts lost 21.4% of its hospitals; Texas, the nation's second-most populous state, and Michigan, the nation's eighth-most populous state, lost 15% of their hospitals. These 15 states with the highest rate of hospital shutdown, contain 58% of the U.S. population; the hospital shutdowns occurred in the states with the highest population concentrations.

Table 1 also shows that in 1985, the U.S. community hospitals possessed slightly more than 1 million beds. By 1996, they had only 862,400 hospital beds, a decrease of 138,238 beds, or a loss of 13.8%. Six states listed in Table 1 lost one-fifth or more of their beds.

The most extreme case of the loss of hospitals and hospital beds is the state of Massachusetts. In 1980, Massachusetts had 110 hospitals; today it has 77, a decline of 30%. **Figure 1** shows the beds in Massachusetts. In 1980, Massachusetts community hospitals had 24,237 beds; by 1999, they had 14,599. According to testimony presented on May 20, 1999 to the Massachusetts state legislature, prepared by Alan Sager and Deborah Socolar of the Boston University School of Public Health, by the year 2005, Massachusetts community hospitals will have only 12,000 beds. If that trend holds true, then in the quarter of a century since 1980, Massachusetts will have lost 50% of its hospital beds. The Sager-Socolar testimony is titled, "Massachusetts Should Identify All the Hospitals Needed to Protect the Health of the People."

Table 2 shows that in 1985, the nation's community hospitals had a ratio of 4.19 beds for every 1,000 Americans; in 1996, this ratio was 3.25 beds for every 1,000 Americans. This decline by 22.4% between 1985 and 1996 is very steep. To get an idea of the risk this exposes the nation's population to, we can compare today's ratio of beds per 1,000 persons to the objective standard set by the Hill-Burton Act of 1946.

Hill-Burton—named after its sponsors, Sen. Lister Hill (D-Ala.) and Rep. Harold Burton (R-Ohio)—specified a survey of the nation's hospitals and a state-by-state census of hospitals and beds, on both a rural and urban basis, and it set

TABLE 1
Community hospitals closed and beds eliminated, 1985-96

	1985		1996		Change 1985-96			
					Number Shut Down		Percent Shut Down	
	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds
Massachusetts	112	25,892	88	18,000	24	7,892	21.4%	30.5%
Texas	480	66,061	408	56,300	72	9,761	15.0%	14.8%
Michigan	193	37,546	164	28,800	29	8,746	15.0%	23.3%
Tennessee	145	25,230	124	20,600	21	4,630	14.5%	18.4%
Illinois	238	54,925	205	40,700	33	14,225	13.9%	25.9%
Minnesota	165	21,933	142	17,600	23	4,333	13.9%	19.8%
Washington	103	13,173	90	11,100	13	2,073	12.6%	15.7%
Alabama	129	19,703	113	18,700	16	1,003	12.4%	5.1%
New York	259	78,986	227	72,100	32	6,886	12.4%	8.7%
California	479	83,232	420	75,700	59	7,532	12.3%	9.0%
Missouri	141	25,734	125	21,500	16	4,234	11.3%	16.5%
Louisiana	145	20,190	129	19,300	16	890	11.0%	4.4%
Ohio	197	47,500	178	36,900	19	10,600	9.6%	22.3%
Oklahoma	118	13,692	108	10,800	10	2,892	8.5%	21.1%
Pennsylvania	241	56,221	223	47,000	18	9,221	7.5%	16.4%
U.S. total	**5732**	**1,000,688**	**5134**	**862,400**	**598**	**138,288**	**10.4%**	**13.8%**

Sources: American Hospital Association; *U.S. Statistical Abstract,* various years; *EIR.*

an objective standard of between 4.5 and 5.5 of general-use hospital beds per 1,000 Americans. The act also set standards for the needed number of long-term care and psychiatric hospital beds. Because the Federal government authorized money for hospital construction, most communities brought their beds per 1,000 population ratio up to the Hill-Burton objective standards during the 1970s. But today, not one of the 15 states listed in Table 2 reaches the Hill-Burton level. Today, the national average of 3.25 hospital beds per 1,000 Americans is 28% below the lower range, and 41% below the upper range, of the Hill-Burton standard of 4.5 to 5.5 hospital beds for every 1,000 Americans.

The insurance company-Conservative Revolution-HMO crowd continues to argue that the Hill-Burton standard no longer applies, and that the United States needs fewer hospital beds. That argument will be answered below. But, even if a slight reduction in hospital beds were possible, the steep drop in the number of beds bears no relation to the real needs, and represents a major threat to the nation's health. Many communities have been denuded of hospitals and hospital beds: The hospitals are either standing empty, or have been ripped down, in some cases replaced by shopping malls. In an emergency, this can mean the difference between a sick or injured person surviving or dying.

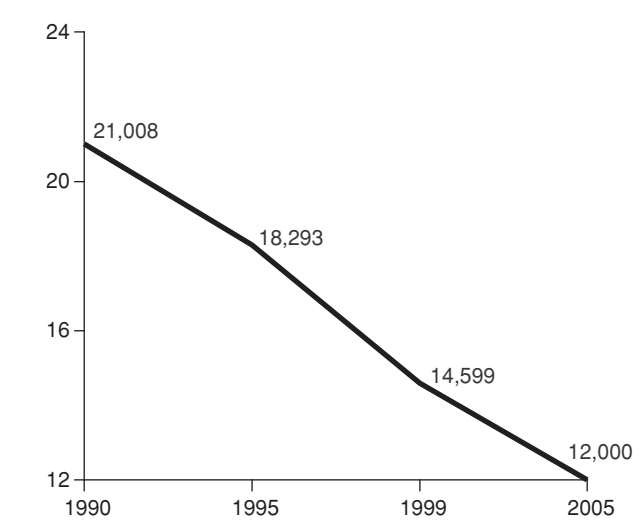
An extreme example of this is the Borough of Manhattan in New York City. In 1960, New York City had 154 functioning hospitals; today, that number is approximately 77. **Figure 2** shows the Borough of Manhattan, which has a population of 1.7 million, more than most cities in America. The map shows that in 1960, Manhattan had 78 operational hospitals. By 1995, this had dropped to only 33 hospitals (**Figure 3**). The significance of this can be seen by looking at the "goose

TABLE 2
Beds decline per thousand population

	1985	1996
Massachusetts	4.45	2.96
Texas	4.03	2.95
Michigan	4.13	2.96
Tennessee	5.29	3.88
Illinois	4.76	3.44
Minnesota	5.23	3.79
Washington	2.99	2.01
Alabama	4.90	4.36
New York	4.45	3.98
California	3.16	2.38
Missouri	5.11	4.01
Louisiana	4.50	4.45
Ohio	4.41	3.31
Oklahoma	4.13	3.28
Pennsylvania	4.74	3.90
U.S. total	**4.19**	**3.25**

Sources: American Hospital Association; *U.S. Statistical Abstract,* various years; *EIR.*

FIGURE 1
Number of hospital beds declines in Massachusetts



Source: Dr. Alan Sanger and Deborah Socolar of the Boston University School of Public Health.

FIGURE 2
Hospitals in Manhattan, 1960

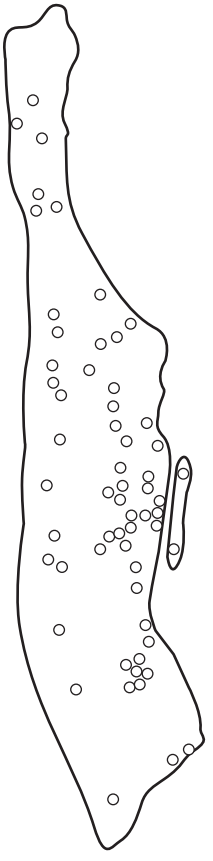
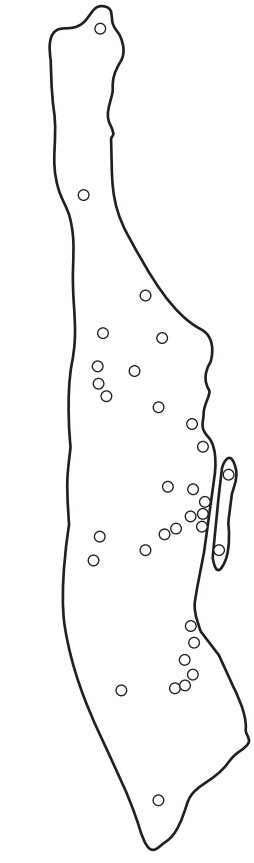


FIGURE 3
Hospitals in Manhattan today



neck" of Manhattan, which is the area north of 110th Street: In 1960, it had seven hospitals; today, it has only three significant hospitals. The area contains more than 450,000 people and many poor districts, such as Harlem, and some parts of Washington Heights. *More than one-half of the poor do not have a primary care doctor;* the only doctor they see is when they have to go to the hospital—yet, only three hospitals exist.

The same is true of many rural areas across the country, which have lost their only hospital.

The march of the HMOs

A health maintenance organization is a health care group plan. It is contracted for by a business that wants the HMO to cover its employees. In turn, the HMO pays a doctor a lump sum (called a capitation fee) to provide medical coverage for a patient for a year. If the doctor can keep the cost of covering the patient below the lump sum that the HMO pays him for treating the patient, the doctor can keep the difference. If the cost of treating the patient is greater than the lump sum that the HMO pays him, then the doctor himself must absorb the loss.

This method builds in a bias from the start: There is an incentive to keep the costs of treating the patient below the lump sum the HMO pays for covering that person. This principle of cost-cutting extends throughout the gamut of the HMO's activities: If it costs too much to send a patient to an expensive specialist—even though that is what is needed—discourage, or, in some cases, forbid, sending the patient to the specialist. If the patient can be moved, or forced out of the hospital earlier, by covering only part of the usual days required for a particular hospital stay, then do that.

This is the principle that some of the giant HMOs, such as Kaiser-Permanent and Aetna US Healthcare, have implemented (Aetna is one of America's biggest insurance companies). The concept of medicine has been turned upside-down. Instead of the goal being the well-being and survival of the patient, the goal is now the ability to build profits, by squeezing the profits out of the cash stream of the health industry. HMOs, with their cost-accounting practices, could offer lower costs for covering employees than the traditional health plans. For that reason, increasingly, employers began contracting with HMOs to cover their employees.

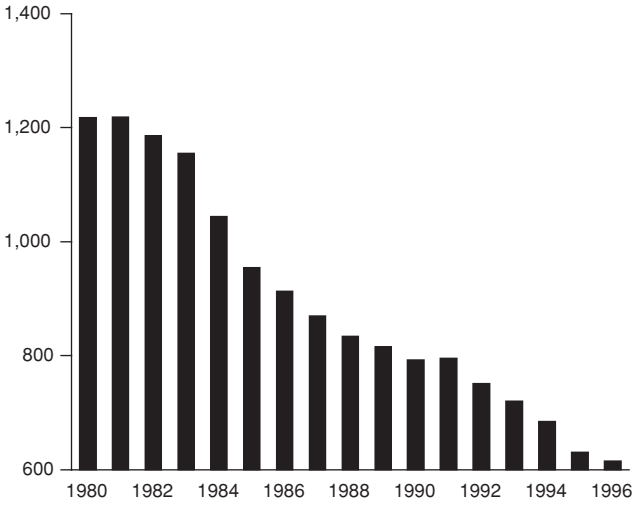
Table 3 shows that in 1980, only 9 million Americans were enrolled in HMO plans. Many of these HMOs were the old-fashioned type, which actually tried to provide reasonable health care. By 1985, there were 21 million Americans enrolled in HMOs, and by 1990, this figure rose to 33 million. By then, the leading HMOs were of the newer breed, which

TABLE 3
Enrollment in health maintenance organizations
(millions of Americans enrolled)

1980	9.1
1985	21.0
1990	33.0
1995	46.2
1997	66.8

Sources: *InterStudy Competitive Edge,* published by InterStudy, Minneapolis, Minnesota; *Satistical Abstract of the United States, 1998.*

FIGURE 4
Days of hospital care decline
(Care days per 1,000 persons)



Sources: U.S. National Center for Health Statistics; *Statistical Abstract of the United States,* various years.

expanded at a rapid rate by simply under-cutting the cost of all other health plans. In 1997, the number of Americans enrolled in HMOs jumped to 68 million, double its 1990 level.

The HMO expansion of the past 15 years has set the geometry for the health industry: all health plans, regardless of whether they are HMOs, must buckle under to the strict cost-accounting method, which callously reduces medical coverage. Those parts of the health industry that have resisted this current have usually failed and gone out of business.

During the 1990s, the HMOs have "cherry-picked" the best business, and, through their methods, profits could be enlarged by cutting down services, closing departments, and firing nurses. But, predictably, with each successive year, such cuts have become harder, and the "easy" profits have become harder to come by. According to a survey by Weiss Ratings, Inc., which evaluates HMOs and financial institutions, in 1997, there were 57% of all HMOs in financial difficulty. While some HMOs may be overstating their difficulties, the problem is that if some HMOs were to fail, millions of Americans would be left without health coverage.

Reinforcing the HMOs' cost cutting has been the growth of the large for-profit hospital chains, such as the notorious Tennessee-based Columbia/HCA, which have become bloated by slashing costs through layoffs and so on. Columbia/HCA has two bankers on its board: T. Michael Long, a partner of Brown Brothers Harriman & Co. investment bank; and Carl Reichardt, retired chairman of Wells Fargo bank. It also recently added to the board J. Michael Cook, former chairman and CEO of the Deloitte & Touche accounting firm. Columbia/HCA owns and operates 300 hospitals and health care facilities, with 60,000 beds, most of them in the United States.

Reduction of patient days

A critical outcome of the Auschwitz-style accounting practices of the HMOs, and the insurance and financial industries which control them, has been the reduction of the number of days that patients are allowed to stay in hospitals. HMOs set limits on how many days of stay in a hospital they will pay for: Every day over that limit, must be paid for by the patient, or, in the case of the poor, by the hospital. It required the threat of national legislation to make HMOs allow mothers, after childbirth, to stay two days in the hospital, instead of the *one day* that the HMOs were insisting on. The HMOs have a list of the number of hospital days allowed per illness, and often doctors must spend precious time arguing with the HMO to get additional—and necessary—days of stay for patients. For example, one HMO recommendation is that someone who gets a leg amputated below the knee leave the hospital in 2.5 days. HMOs and the insurance industry are also putting blocks on allowing patients to be admitted as inpatients.

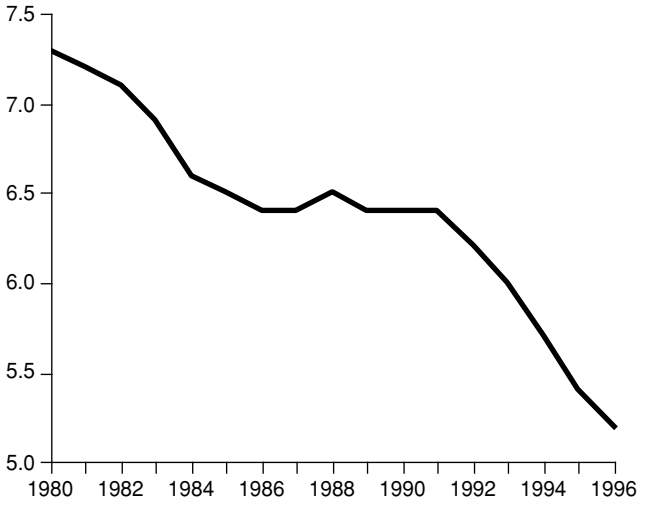
This picture is presented in **Figure 4,** which shows the number of inpatient care-days per 1,000 of Americans—in other words, the average number of days citizens are in hospitals receiving inpatient treatment. In 1980, there were 1,217 inpatient care-days per 1,000 people; in 1996, this had plummeted to 604 inpatient care-days per 1,000 people. In other words, *patients are permitted only half the amount of time today in hospitals as they were in 1980.* The HMOs and insurance companies save a bundle on this.

Figure 5 shows the average length of inpatient stay, in days: a decline from 7.3 days in 1980, to 5.2 days in 1996. Thus, if one is fortunate enough to make it into a hospital as an inpatient, one is moved out more quickly, often with life-threatening haste.

FIGURE 5

Average length of hospital stay is cut

(days)



Sources: U.S. National Center for Health Statistics; *Statistical Abstract of the United States, various years.*

The HMO-Conservative Revolution attempts to defend this policy by asserting that the occupancy rates of hospitals were down, and that this meant that fewer hospitals were needed. They argue that the improvements in medicine have outmoded the Hill-Burton standards and that, therefore, such standards should no longer be adhered to.

There have, of course, been improvements in medicine and medical technology. Several medical procedures, which previously required invasive surgery, can now be carried out with non-invasive or less invasive procedures. This includes, for example, several types of operations for appendectomies and hernia, which no longer require deep incision operations, but can be performed on an outpatient basis. The patient can be discharged on the same day, and does not require a stay in the hospital. But in other cases, medical advances have *increased* the need for hospital stay. For example, today, hip replacements are easier to perform, and more people have them, whereas 30 years ago they were relatively rare. This has increased the need for hospital and long-term care stay for hip-replacement patients.

Improved medicine provides only part of the answer to why, since 1980, the number of care-days that patients have been permitted in hospitals has been slashed in half. If an HMO or insurance company will only give limited hospital coverage, then sure enough, the time a person spends in the hospital will fall, and this pushes down the occupancy rate. That is, if the coverage for hospital stays is reduced—or if patients are refused hospital admission—then the hospital occupancy rate will be lowered. Indeed, the occupancy rate is often a direct consequence of HMO cost-cutting policy. Yet, the same HMO will complain that there are too many beds.

The HMOs' track record makes clear, on a deeper level, what is really happening.

In their haste to push patients out the door, HMOs and insurance companies are responsible for deaths. In Loudoun County, Virginia, four years ago, an elderly woman was forced out of the hospital by her health insurance plan, after being allowed to stay only the stipulated few days for treatment of pneumonia. A few days after being discharged, she died—a death that would not have occurred had she remained in the hospital.

Furthermore, HMO cost-accounting practices, by cutting payment allowances to hospitals, increase the pressure on hospitals to cut costs, and, for example, to fire competent RNs, replacing them with unlicensed technicians and aides who have very little training. In a case that made national headlines, in November 1996, Christ Hospital in Cincinnati, Ohio settled a suit for $3 million, in which an unlicensed technician missed all of the warning signs of a post-operative infection in a hysterectomy patient, Rebecca Strunk. As a result, Mrs. Strunk died.

HMOs are focussed on what each doctor can bring in as profit, to the point of discouraging the treatment of the poor. In the March 24/31, 1999 issue of the *Journal of the American Medical Association,* Peter Cunningham et al. issued the findings of a study titled "Managed Care and Physicians Provision of Charity Care." The report found that doctors whose incomes depend most heavily on managed care plans, such as HMOs, or who work in areas with a high level of HMO penetration, provide either none or only half the hours of uncompensated charity care for the nation's indigent, compared to physicians with no involvement with managed care. HMOs in some cases, actively discouraged doctors from treating the indigent.

According to a class-action suit brought by the Foundation for Taxpayer and Consumer Rights, which represents thousands of present and former members of the Kaiser-Permanente, the HMO violated California's laws regarding patient care. Kaiser-Permanente is a giant HMO, with more than 9.1 million members in the United States, of whom 5.6 million are in California. The suit reported what Dr. John Vogt, Kaiser's Texas regional resources management director, instructed Kaiser managers in a 1995 seminar. Vogt said, "We need to get from 300 [hospital days per 1,000 patients] to 180 days, and do it in less than two years. . . . We're basically online to getting [to] 180 days by 1996."

And how do you cut the number of patient days in half that quickly? Vogt proposed that Kaiser dump its chest-pain protocol (which saves lives by early identification of heart attacks), because the protocol "tripl[ed] our hospital days."

As these few examples demonstrate, once one sees the HMO and insurance company practices of reducing patient-days in the hospital up close, it confirms that the reduction of patient-days in hospitals is mostly explained by the implementation of the financiers' strategy to skim profits at the expense of lives of citizens.

Other infrastructure: emergency rooms and nurses

Other remaining vital infrastructure of the health and hospital system is being scuttled. For many poor and lower-income individuals, the point that they first meet a doctor is usually in the emergency room of a hospital. But now, the emergency rooms are being closed. This has started in pockets across the country, but especially in California, the state where the HMO industry has one of the highest rates of penetration. A significant reason for the closings is the growing trend, especially in parts of California, for the HMOs to either delay or not reimburse the hospitals for the costs of emergency room treatment of patients (see article, p. 38).

Nurses are under the knife. Under the financier/HMO-generated atmosphere of cost-cutting, many hospitals have cut back on the number of nurses, substituting for them nurses aides or untrained "technicians." Then, to cover for the nursing shortage, nurses are made to work mandatory overtime of up to 70 hours per week. A measure of this trend is the reduction of the number of registered nurses working at community hospitals, per 1,000 of the U.S. population. In 1993, there were 2.74 hospital-based registered nurses per 1,000 population; in 1997, there were 2.65. That is a decline of 3.3% in five years, which can already make a difference in the life or death of some patients. Were this ruinous trend to continue at the present reate, there would be a 10% to 15% reduction in hospital-based registered nurses per 1,000 of the population by the year 2005.

As dangerous as any one of these policies can be, it is their simultaneous occurrence—shutdown of hospitals and hospital beds, tossing of patients out of the hospital or denying them admission, reduction of hospital-based registered nurses, and so on—which is disassembling the integrated physical infrastructure of the U.S. hospital system and its attendant staff of doctors and nurses.

Balanced Budget Act

Into this downward-cascading process of the U.S. health and hospital system, Congressaionl Conservative Revolutionaries Trent Lott and Newt Gingrich, backed by Vice President Al Gore, dropped the Balanced Budget Act, which was signed into law in August 1997. The BBA was touted as "a solution to the funding crisis of Medicare." Its solution: Cut Medicare and Medicaid with a vengeance. Furthermore, while exacting this austerity, it instituted capital gains tax and estate tax cuts of several tens of billions of dollars for the benefit of the wealthy.

Because Medicare makes significant payments to hospitals, this is a direct assault on the hospital system.

Medicare is the Federally funded program that provides medical assistance to 38.3 million persons who are 65 years or older, or disabled; 90% of Medicare enrollees are elderly. Medicaid is a joint Federal-state program that provides medical assistance to 36.1 million poor and low-income persons. Eliminating double-counting, combined, these programs provide service to more than 70 million people.

The main effects of the BBA meat-axe, as noted above, are that for the ten fiscal years from 1998 through 2007, the total cumulative cuts are for Medicare, $385.5 billion, and for Medicaid, $47.8 billion, or combined, $433.3 billion.

To comprehend how these cuts will affect the U.S. hospital system, focus on the $115.1 billion mandated cuts to Medicare for the period from fiscal years 1998 through 2002. More than three-fifths of that $115.1 billion in cuts, or $71.2 billion, was previously earmarked as Medicare payments to hospitals. The $71.2 billion represents a 10.5% cut in the funding level that Medicare would pay to hospitals during this period. According to a study commissioned by the American Hospital Association (AHA), "The Balanced Budget Act and Hospitals: The Dollars and Cents of Medicare Cuts," the cut in Medicare payments will force profit-loss margins for the Medicare portion of operations at the nation's hospitals from negative 4.4% now to negative 7.8% in 2002, and possibly even lower. These are substantial loss rates.

These cuts will affect not just the Medicare portion of hospital operations, but the entire financial health of the hospital, extending harm beyond Medicare patients. A spokesman for the American Hospital Association reported that 33% of all payments to hospitals come from Medicare. Further, Medicaid constitutes another 11% of all hospital revenues. Together, Medicare and Medicaid constitute 44% of all hospital revenues, and both are being cut. For hundreds of hospitals, Medicare and Medicaid payments constitute 50 to 80% of revenues. Thus the Medicare and Medicaid income stream folds into the hospital's total pool of funds, from which they draw on in order to exist.

The BBA cuts are razing a hospital system that has already been withered by the HMO-insurance company policies, and, on top of that, by 30 years of post-industrial society policy in America. Here is a look at some of the casualties:

- *More hospital closing and cutbacks*. The South Shore Hospital in South Weymouth, Massachusetts has a Visiting Nurse Association, which serves 5,000 patients, many of whom are frail, elderly, and chronically ill. Medicare payments make up a large portion of VNA's revenues. The BBA cuts, already in effect for 18 months, had forced the South Shore Hospital Visiting Nurse Association to triage service: It has closed two satellite offices, laid off 50 employees, and reduced patient visits by 30%

• *The grinding up of the country's teaching hospitals.* The Association of American Medical Colleges estimates that between fiscal years 1998 and 2002, the losses for the nation's teaching hospitals could reach $14.7 billion. Teaching hospitals teach the next generation of doctors, conduct research, and also provide medical service to a large number of the poor.

Boston has some of the country's finest teaching hospitals; five out of the top eight private employers in Boston are teaching hospitals. Under the BBA, for the period from fiscal year 1998 through fiscal year 2002, Medicare payments to Massachusetts are scheduled to be cut by $1.7 billion, most of which would be payments to hospitals, and a good amount of which would be payment to Boston teaching hospitals.

Dr. Michael Collins, president and chief executive of Caritas Christi Health Care System, a seven-hospital group affiliated with Tufts University in Boston, told the May 6 *New York Times,* that the effects can be seen in research. In 1988, Dr. Collins said, it was still experimental for doctors to open blocked arteries by passing tiny balloons through them; now, they have a number of expensive new options (which options can become less expensive once they are developed further). These include spring-like devices called stents that cost $900 to $1,850 each; tiny rotorbladers that can cost up to $1,500; and costly drugs to supplement the treatment, which can cost nearly $1,400 per patient. "A lot of scientists are doing research on which are the best catheters and which are the best stents," Dr. Collins said. That research is now costing the Caritas Christi Health Care System $50,000 per month, and it is not getting back a nickel. Medicare funds, in part, have made that research possible. The cuts in Medicare funding, he said, will seriously harm research.

New York City is another center of teaching hospitals. New York Presbyterian Hospital, a leading teaching hospital, is expected to lose $320 million under BBA-stipulated cuts—more than any other hospital in America. Dr. David Skinner, chief executive officer of the hospital, reported that he has asked every department of the hospital to cut spending by 5%. "The so-called low-hanging fruit has all been picked," he said. "Something's got to give here. You look at where can you downsize departments that are losing money. . . . I don't want to say which ones because I don't want to unnecessarily panic the troops." The "money-losing departments" that are frequently cut are emergency rooms, outpatient clinics, psychiatric and rehabilitation departments, and maternity wards.

• *Devastating the nation's skilled-nursing homes.* As a result of the BBA cuts, a growing number of skilled-nursing facilities are denying admission to high-cost, high-maintenance patients, especially those who depend on ventilators or kidney dialysis. The May 26 *Wall Street Journal* reported that the Seattle-based Sisters of Providence Health System recently bought a prosthetic device for $3,750 for a patient transferred to the facility, who had a leg amputated below the knee. The patient stayed at the facility for six days. But Medicare would only pay $1,830 for both the stay and the prosthetic device.

The *Journal* also reported, "In another case, in New Jersey, an elderly woman taking expensive drugs for respiratory therapy, renal failure, and bed sores was ready for discharge from a hospital, but was denied admission by two nursing facilities on the same day. The hang-up was that her drug costs alone exceeded the Medicare reimbursement for her care."

In LaCrosse, Wisconsin, Tom Rand, administrator of the Bethany St. Joseph Care Center, a nonprofit nursing home, said he reluctantly decided late last year to close his ventilator-care unit to new patients. The reason: His new Medicare payment rate for ventilator-dependent patients was $170 a day, despite the fact that his costs typically ran two to three times that amount. "At that rate," Rand said, "it doesn't take very long to go bankrupt."

• *Repeal of the "Boren amendment."* The BBA also repealed the "Boren amendment," which required that states pay for nursing facility services under Medicaid using rates that are "reasonable and adequate." With the repeal, states were able to pay at a rate that is below that of reasonable and adequate. In turn, nursing homes might refuse, or make it difficult, to admit Medicaid recipients.

The coming devolution

Concomitant with the cuts in services, America, especially in urban areas, has experienced a recrudescence of disease. In Harlem, New York, the tuberculosis incidence rate had fallen to 80 per 100,000 in the 1980s; it is now back up to 182 per 100,000, which is half of what it was in the 1950s, when TB was considered rampant. The rise of diseases has pushed the U.S. health system to below its break-even point. The poor, the elderly, and the very sick are experiencing this first.

So far, as the oligarchy and its followers in the HMO industry and the Conservative Revolution faction—including balanced budget supporter Al Gore—have contended, the death rate in America has not zoomed up as a result of the BBA cuts or the shutdown of hospitals, beds, and nurses during the past 15 years. But there is a lawful limit to the breakdown process.

The lunatic policies of Federal Reserve Board chairman Alan Greenspan have put the world on the path for a 1921-23 Weimar Germany-style hyperinflationary blow-out. When that hits, it will intersect the destruction of America's health system, its falling living standards, increased disease vectors, and the collapsed physical state of the economy. The death rate will not rise incrementally, but rather will explode, in full realization of the Auschwitz polices that have been established.

Having lost its health system, America will pay the consequences.