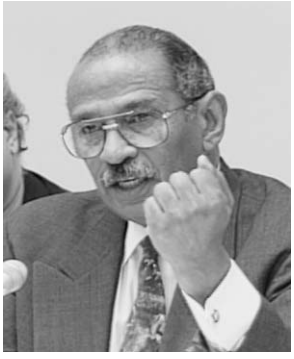
U.S. Rep. John Conyers

Convening of the Briefing: March 22, 2001, 12:00 noon



Good afternoon, everyone. Great to have all of you here; I had no idea that we needed a larger hearing room. . . .

I'm glad everyone is here today, I'm happy to welcome you here to the Rayburn Building. As you know, I've been working on health care for many years, and as a matter of fact, about three Congresses ago I introduced the single-payer universal coverage bill, and I have ever since, because it's my belief that ultimately the only way we're going to get out of the health-care problems which continue to aggregate, is to have a universal system of coverage that covers everybody, regardless of their ability to pay.

It's the only way you can deal with prevention, it's the only decent thing an industrial nation can do to deal with health-care problems, which should not have to turn on how much money you or your family earns, or what kind of health insurance policy you're carrying, or the moods or whims of whatever particular administration might be prevailing in Washington or somewhere else. And so it's in that spirit that I continue to inquire into one very important area about this subject matter: and that is, what do you do with public hospitals that operate for people who don't have the means, otherwise, to get the kind of health care that they deserve?

And so it's in that spirit that I welcome all of you here today for us to examine this issue, not only from a local perspective, but from a national perspective as well. And so, I have a number of other comments that I will be able to intersperse into this subject matter, but this was a request that I am honoring, that wanted to tell me about the circumstances here in the District of Columbia.

Now we do understand that the Congress itself per se is not able to intervene under the prerogatives of home rule into D.C.'s business. As a home rule supporter and proponent, one who supported—and still does—statehood, and certainly voting rights representation for those that you send to the halls of Congress, I am very sensitive to that, and I do not want to imply any "overpromises" about us coming together to share this very important information.

I also want to welcome all of my friends that have come from a longer distance, who are with us here today. Among others we have Harold James, of the National Black Caucus of State Legislators, who is a member of the Pennsylvania House of Representatives. We're very delighted to have you here, sir. (applause).

So, we're trying to examine this phenomenon of the problems of public hospitals in the United States, and it's in that spirit that we're happy to have all of you make statements, as truncated as possible so that there can be as much discussion as we can get to. We have a number of people who are submitting written statements, which we will be very happy to receive into the record: including Dr. Will Horsley of the Boston Regional Medical Center; Dr. Henry B. Foster, the former Surgeon General-designate and former Special Health Counsellor to President Clinton; that of Dr. Jocelyn Elders, the former Surgeon General of the United States; also from Michigan State Rep. LaMar Lemmons; from former State Rep. from Michigan Ed Vaughn; and, from the Cardiology Center of Northwest New Jersey, Dr. Paul Goldfinger. And so we're collecting all of these, checking all the ideas, and trying to—as constructively and as seriously as we can—evaluate all of the circumstances that are involved in this very important part of health-care delivery.

So with that, I am going to invite the vice president of the National Association of Public Hospitals, Lynne Fagnani, to start this conversation that we're having today. Welcome.

Lynne Fagnani

'The Health-Care Safety Net Is a Fragile Thing'

Thank you, Congressman.

My name is Lynne Fagnani, I'm a vice president for the National Association of Public Hospitals and Health Systems. I've submitted a written statement, that describes NAPH's position on what's happening in the District right now, and puts it into context, in terms of what's happening around the country, but I'd like to speak to you today as a private citizen if I might, because I heard some news earlier this week that I found very upsetting, and I don't think it's been profiled very much in the story of what's going on right now.

The demise of D.C. General doesn't just affect the poor and uninsured in this city who may not, unfortunately, have

the political clout to change what's going on: it affects every single resident of this city.

Earlier this week, Washington Hospital Center announced that it might be forced to close its Trauma Center if D.C. General shuts down. I'm sitting here today because of Washington Hospital Center's Trauma Center. Two and one-half years ago I was run over by a car in the Pentagon City Price Club parking lot, and was helicoptered to Washington Hospital Center, where they saved my life. I had a broken back, a broken hip, most of my ribs were broken, my lungs were collapsed, and I'm lucky to be here, and I owe it to Washington Hospital Center's trauma team.

I'm sure you would hear similar testimonials from people treated in the emergency room at D.C. General, G.W., and any other emergency room around this city. The health-care safety net is a fragile and delicate thing. No specialized service like trauma care can exist in isolation from the rest of the system. When one trauma center closes, it has a serious and damaging domino effect on other trauma centers in the system. I don't understand why the elected officials and citizens of this city have not been more vocal about what's happening at D.C. General. Any of us sitting in this room or anywhere in this town, could be the victims of a car accident, chest pains, or an act of violence. Where will we go, if the trauma center—or the trauma system—in this city crumbles? And why aren't these questions being asked and addressed by the elected officials in this city? Thank you.

Written Statement: My name is Lynne Fagnani, vice president of the National Association of Public Hospitals and Health Systems. NAPH represents over 100 of the nation's largest urban safety net hospitals and health systems, and advocates on their behalf on the Federal level, to assure organizational and financial strength and to safeguard their ability to provide health care to all, regardless of ability to pay.

NAPH is here today to describe the situation of safety net hospitals such as D.C. General, and their critical role in delivering health care to low-income populations, the uninsured, and the community at large. NAPH member hospitals and health systems, along with community health centers, public health departments, and other community providers, form the core health-care safety net in this country—defined by the Institute of Medicine as providers who maintain an "open door" policy, treating all regardless of ability to pay; and who provide a substantial share of their patient care to uninsured, Medicaid, and other vulnerable populations. Let me share a few key facts about NAPH members that help define their safety net role:

Bearing the Greater Burden

- NAPH member hospitals provide 82% of their services to low-income Medicaid (34%), Medicare (21%), and uninsured patients (27%). This payer mix means that not only are they important health-care resources for low-income communities—these hospitals are uniquely reliant on support from Federal, state, and local governments to provide care. Policy in any of these levels of government has a profound impact on these hospitals.
- They provide high levels of inpatient and outpatient care in their communities. In 1998, NAPH members provided an average of 15,639 admissions per hospital, almost 150% higher than the average for all hospitals in the country. They also provided 28 million outpatient visits in 1998, which is an average of over 300,000 visits per hospital, over three times the level provided by all hospitals in the country. Less than 20% of these visits were provided in the emergency room, with significant amounts of primary and specialty care provided in on- and off-site community settings.
- Safety net hospitals are important providers of specialty services in their communities, including emergency and trauma care, burn care, pediatric and neonatal intensive care, psychiatric care, and HIV/AIDS care. In 1998, NAPH members represented only 17% of hospital beds in communities where they are located, but provided 42% of all Level I trauma care, 59% of all burn care, 29% of all pediatric intensive care, and 24% of all HIV/AIDS services in their communities. These services are vital to the entire community.
- Safety net hospitals train our nation's physicians, nurses, and other health-care professionals. In 1998, NAPH members trained 16% of all residents in the country, and 9% of all other allied health professionals.

D.C. General: Good Samaritan

What is happening to safety net hospitals? The prestigious Institute of Medicine released a report last year that described the health-care safety net as "intact, but endangered." Safety net hospitals are facing a number of trends that jeopardize their viability:

- The number of uninsured patients seeking care from them has been increasing. The percent of uncompensated care provided by all hospitals has been 6% of costs for the last two decades. For NAPH members, the amount of uncompensated care as a percent of total cost increased 21% between 1993 and 1998. Twenty-nine percent of costs were uncompensated among these hospitals in 1998. *D.C. General has the dubious distinction of being one of the top ten highest providers of uncompensated care among safety net hospitals in the country.*
- Care is shifting from inpatient settings to outpatient settings. NAPH members experienced an 11% decline in inpatient care between 1993 and 1998, and an increase of 17% in outpatient care during this period. This trend is ominous for safety net hospitals because much more outpatient care is uncompensated than inpatient care. Forty-two percent of outpatient visits were to uninsured patients, as compared to 26% of inpatient discharges in 1998.
- Safety net hospitals are experiencing the effects of competition in the health-care marketplace from other providers.

All hospitals have been facing declining margins from commercially insured patients. As Medicaid reimbursement improved during the 1990s, particularly compared to other payers, hospitals that previously avoided treating Medicaid patients began competing with traditional providers of care for these individuals. NAPH members lost 24% of their share of Medicaid inpatients during the 1990s. Frequently these hospitals have been left with higher-cost, and more-difficult-to-treat Medicaid patients. In addition, as they have lost Medicaid patients, they have lost reimbursement from the Medicaid Disproportionate Share Hospital (DSH) program, which finances care to the uninsured and underinsured.

• Reductions in governmental support from Medicare and Medicaid have had a significant impact on safety net hospitals. In particular, the Balanced Budget Act of 1998 reduced Medicaid and Medicare Disproportionate Share Hospital (DSH) payments dramatically. In the BBA-relief bill signed into law last fall, the Medicaid DSH cuts were postponed for two years; however, they will go into effect in 2003. Medicaid DSH finances 34% of unreimbursed care at NAPH hospitals, with state and local subsidies financing 39% of unreimbursed care.

Overall, many safety net hospitals around the country are facing serious challenges to their existence. D.C. General is facing the same challenges; however, its situation is exacerbated in a number of ways. As mentioned earlier, D.C. General is one of the highest providers of care to the uninsured and underinsured among NAPH members across the country. Unlike other safety net hospitals around the country, however, D.C. General's reimbursement from Medicaid and local government falls far short of this level of need. Local subsidy and Medicaid DSH cover half the level of uncompensated costs borne by D.C. General, as compared to what these sources of financing cover for NAPH member hospitals around the country. D.C. General provides one-third of all uncompensated care in the District, but receives only 14% of the District's Medicaid DSH funds (a funding allocation that is determined by the District's Medicaid program). *It is unlikely that any other provider of care in this city would be able to meet these financial burdens with the level of resources that the District has provided D.C. General.*

Many safety net hospitals are rising to the challenges they face by reorienting their delivery systems, reorganizing their relationships with local and state governments, and revitalizing their physical plants. Good models exist for the citizens of the District. Unfortunately, they require adequate financing, elimination of political interference, reorganization to limit the constraints and hindrances of "public" governance, and adequate capital.

We need to find ways to strengthen the health-care safety net in Washington so that its citizens are well served and no one is turned away. NAPH stands ready to help in any way we can as the city, its leaders, and its citizens work together to find the right solution [emphasis added—ed.].

Dr. Debra Hanania-Freeman

National Public Hospital Safety-Net Crisis

Dr. Hanania-Freeman is a Doctor of Public Health who resides in Baltimore, and is national spokeswoman for the 2004 Presidential campaign of Lyndon H. LaRouche, Jr.

I'd like to begin by thanking Congressman Conyers for facilitating today's deliberations on this most urgent matter. In addition to representing the good people of the State of Michigan, Congressman Conyers also serves as the unofficial dean of the Congressional Black Caucus, which has, so many times over the last years, served as the conscience of the United States Congress. And, so, his concern on this question should surprise none.

Yesterday, I had the privilege of moderating a seminar here in Washington, that was addressed by Lyndon LaRouche, who is not only the world's leading economist, but who is also seen around the world as the leading representative of the American intellectual tradition which resolved the crisis America faced in 1933.

I mention this, because Mr. LaRouche developed an irrefutable argument that the first 60 days of the Bush Administration—both by the Administration's actions and inactions—have pushed the world over the brink of the worst financial and economic crisis in modern history, and created a situation that he described as far more dangerous than the one that Franklin Roosevelt faced at his first inauguration, 68 years ago this month. And, in that context, he identified that the United States is at a crossroads: either our nation will go the way of Germany 1933 under the Nazis; or, it will re-adopt the commitment to the General Welfare clause of the U.S. Constitution, as FDR did in launching the new deal. The fight to save D.C. General Hospital, and indeed the fight for quality health care for all Americans, must be viewed in this context.

Since 1973, the operating policy of the United States has been an explicit commitment to the controlled disintegration of our economy, of de-industrialization, and of depopulation. As a willful, deliberate consequence of those policies, we face a full-scale health emergency both globally, and inside the United States.

Since 1973, over 30 new diseases have emerged worldwide, due in large part to the abandonment of the commitment

of the 1960s to the eradication of poverty, hunger, and disease throughout the world. Instead, as a consequence of the globalization policies of the first Bush Administration, we have "globalized" deadly diseases. The spread of AIDS, and the re-emergence of new, drug-resistant strains of old diseases, like tuberculosis, that we once had under control, endanger all of humanity. And, at the same time, the outbreak of BSE and of hoof-and-mouth disease, has placed the world's food supply in serious jeopardy.

Third World Health Profiles

Here in the United States, many of our urban centers have epidemiological profiles that are comparable to those of any Third World country. In the City of Baltimore, Almost 70% of children born, are born to unwed mothers under the age of 18. We have an infant mortality rate that is comparable to that of a Third World nation. Since most of these young women have absolutely no access to pre-natal care, we suffer a very high incidence of low birth-weight babies; babies born burdened not only by poverty, but by all the long-term risks that are associated. As best we can tell—and since there is still no comprehensive testing and reporting policy, it is hard to tell precisely—the rate of AIDS infection, as well as the incidence of drug-resistant tuberculosis, is on the rise. During the course of the last year, outbreaks of measles, encephalitis, and meningitis have forced the closing of schools or colleges. And, although Baltimore's epidemiological profile does resemble that of a Third World country, it is not all that dissimilar from the epidemiological profile of other American cities.

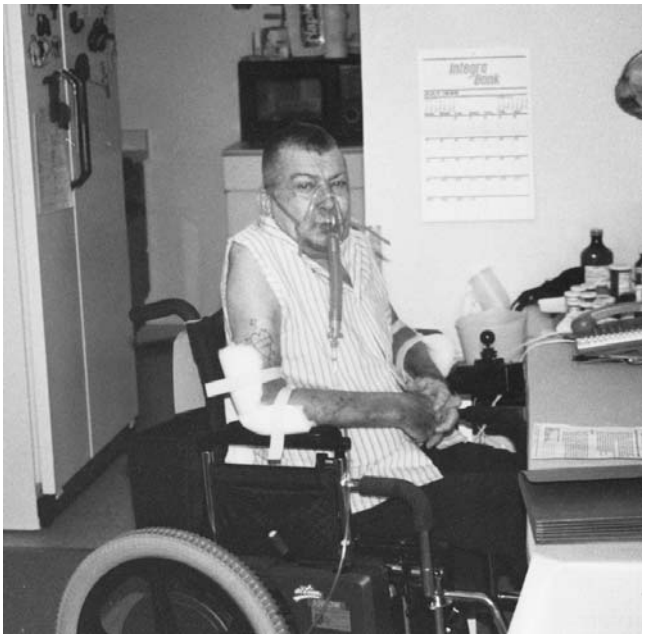
How do we provide health care for Baltimore's poor? Well, first let me say that Baltimore has the highest number of physicians per capita population of any city in the United States. However, we do not have a single public hospital. Three years ago, Prudential was awarded a contract to manage 80,000 Medicaid lives in Baltimore's inner city. It didn't come cheap. The contract was for $157 million. Over the course of the first year, the utilization rate was an unbelievable 18%! Why? When the contract with Prudential was signed, it was well known that the caregivers associated with the Prudential plan were all located outside the city. After they were awarded the contract, they made no attempt to sign up any inner-city physicians. So, 80,000 poor Baltimoreans, people largely without access to personal vehicles, and obviously without disposable income for cab fare (which would have been the only available means of travel to the suburban locations of physicians' offices, since we don't have much of a public transportation grid), were assigned to physicians located in the suburbs. And, Prudential essentially pocketed about $120 million, having rendered almost no service.

It is impossible to draw any conclusion other than the fact that we are witnessing the implementation of a policy that is consciously and deliberately designed to eliminate poor people, to proliferate disease, to increase infant mortality, and to lower life expectancy among citizens who have been deemed "redundant." And, if those responsible argue that they

The emergency trauma center at University of Maryland Hospital in Baltimore. The city has no public hospital.

didn't know this would be the consequence of their policies, my response is that—like those who were brought before the Nuremberg Tribunal at the end of the Second World War—they should have known. It is time to draw the line.

Access to quality health care is not a privilege, but a right guaranteed to every American under the General Welfare clause of the U.S. Constitution. And, as such, every American has the right to expect access to a full-service, fully funded public hospital. Keeping D.C. General Hospital open, restoring it to full capacity service, and indeed expanding and enhancing the services it offers to the largely poor population that it serves, by no means solves all our problems. But, it is an excellent place to start.



An emphysema patient thrown off state medical assistance by Pennsylvania Gov. Tom Ridge's 1998 cuts. The cuts were denounced as "criminal" by State Rep. Harold James; the Schiller Institute documented 55 lives lost or crippled as a result.

State Rep. Harold James

'Public Officials Must Be Held Accountable'

Representative Harold James was recently re-elected to his seventh term in the Pennsylvania House of Representatives. He is the former chairman of the Pennsylvania Legislative Black Caucus, and former President of the National Black Police Association.

Mr. Chairman, as an elected official in the Commonwealth of Pennsylvania, and as Region II chair of the National Black Caucus of State Legislators covering Pennsylvania and New York, and as a special assistant to the President of NBCSL, with regional and national responsibilities, I believe it is essential to the health, safety and welfare of my constituents, that D.C. General Hospital be restored to a fully funded, full-service public hospital.

I believe that the collapse of public health care has proceeded so far in this nation, including in my region of Pennsylvania, that a victory in the battle to save D.C. General is necessary as a national victory, to turn around that national collapse before more lives are lost, and before more innocent people suffer unnecessarily.

In southeastern Pennsylvania, the region which includes my legislative district in south Philadelphia, about 3,000 beds have been cut in the last five years by the 80 hospitals located there. Last year, these hospitals provided $400 million in uncompensated care, and most of them ended the year in the red. Close to 50% of the state's uncompensated care is concentrated in the Philadelphia area. The University of Pennsylvania Health System, which is the second-largest non-profit in the region, lost an average of $100 million a year from 1996 to 2000. In response, the System slashed its workforce by 20%, which represents a cut of 2,800 employees.

We also had a traumatic experience with a massive bankruptcy of what was the largest non-profit health chain in Pennsylvania. The Allegheny health system controlled 14 hospitals, including 10 in the Philadelphia area, when it filed for Chapter 11 bankruptcy protection in 1998. This bankruptcy led to 1,700 layoffs of medical personnel in Philadelphia, and the closing of Mt. Sinai Hospital, which is located in my legislative district. Last year, the three top leaders of Allegheny were indicted by the state Attorney General, charged with looting over $52 million from charitable endowments.

Mr. Chairman, these are the consequences of allowing the principle of greed to supersede the principle of the General Welfare established in the U.S. Constitution. These are the consequences of political actions by the Congress and state officials, that trample on the General Welfare, by cutting medical care for the poor, elderly and disabled.

Pennsylvania Cuts Cost Lives

I believe that public officials must be held accountable for these consequences. In 1996, when Pennsylvania Gov. Tom

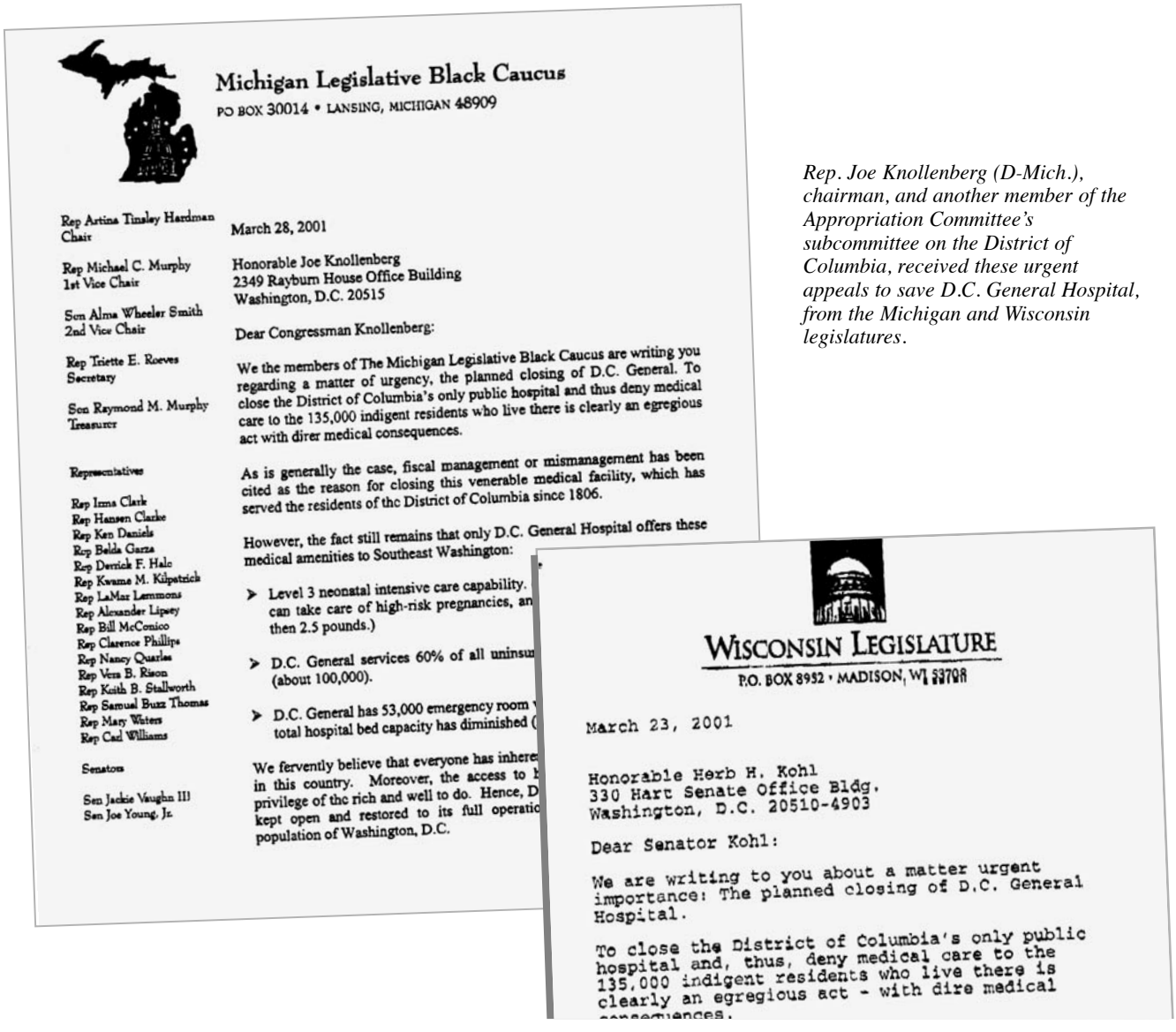
Ridge rammed a bill through the legislature, cutting off tens of thousands of poor and disabled people from state medical assistance, I, and many of my colleagues, denounced it as a criminal act, on the floor of the State House. The Schiller Institute assisted me in compiling case studies of 55 deaths, injuries, and threats to life that resulted from Ridge's budget cuts. I would be happy to make these case studies available. I understand that in any given year, approximately 70,000 people visit D.C. General, and that over 100,000 Washington residents have no medical insurance.

Where will these people go? Even the *Washington Post* has been forced to admit that there is no answer to this question.

Last year, 10,000 people were admitted to D.C. General—where will these people go? Last year, 50,000 people visited the Emergency Room at D.C. General—where will these people go? Last year, over 100,000 people visited the clinics connected to D.C. General—where will these people go? Fifty-five percent of the care at D.C. General is uncompensated care. This compares to 15% uncompensated care at the other area hospitals. Again, the question to ask: Who will care for the poor and uninsured? Where will these people go?

There is a standard we have to apply for every elected official, as well as to the D.C. Mayor and City Council, the Control Board, and the Federal City Council, among others, who are responsible for the policies being imposed on this city. That standard is adequate, accessible, quality health care for *all* Americans, regardless of their financial ability.

Let us establish this standard in the case of D.C. General Hospital. Let this be the time and place where you take the necessary leadership, and help the American people rise up, and demand accessible, quality health care for all Americans.



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March 28, 2001

Honorable Joe Knollenberg
2349 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Knollenberg:

We the members of The Michigan Legislative Black Caucus are writing you regarding a matter of urgency, the planned closing of D.C. General. To close the District of Columbia's only public hospital and thus deny medical care to the 135,000 indigent residents who live there is clearly an egregious act with direr medical consequences.

As is generally the case, fiscal management or mismanagement has been cited as the reason for closing this venerable medical facility, which has served the residents of the District of Columbia since 1806.

However, the fact still remains that only D.C. General Hospital offers these medical amenities to Southeast Washington:

- Level 3 neonatal intensive care capability. can take care of high-risk pregnancies, an then 2.5 pounds.)
- D.C. General services 60% of all uninsu (about 100,000).
- D.C. General has 53,000 emergency room total hospital bed capacity has diminished (

We fervently believe that everyone has inhere in this country. Moreover, the access to h privilege of the rich and well to do. Hence, D kept open and restored to its full operatic population of Washington, D.C.

WISCONSIN LEGISLATURE

P.O. BOX 8952 • MADISON, WI 53708

March 23, 2001

Honorable Herb H. Kohl
330 Hart Senate Office Bldg.
Washington, D.C. 20510-4903

Dear Senator Kohl:

We are writing to you about a matter urgent importance: The planned closing of D.C. General Hospital.

To close the District of Columbia's only public hospital and, thus, deny medical care to the 135,000 indigent residents who live there is clearly an egregious act - with dire medical

Rep. Joe Knollenberg (D-Mich.), chairman, and another member of the Appropriation Committee's subcommittee on the District of Columbia, received these urgent appeals to save D.C. General Hospital, from the Michigan and Wisconsin legislatures.

Charlene Gordon, RN

'In Order To . . . Promote The General Welfare'

My name is Charlene Gordon, I'm a registered nurse, and I have worked for D.C. General Hospital for 18 years and I have loved every year. As a nurse, I am an advocate for the patients. I believe that they must all have access to safe, quality health care, and D.C. General is at the forefront for that. As a member of the District of Columbia Nurses Association, *we agree with and support* the American Medical Association, the National Association of Public Hospitals, the American Public Health Association, the D.C. Medical Society, and the D.C. Hospital Association, that D.C. General is to be a *full-service, fully funded, public hospital for all*. The District of Columbia citizens are on the eclipse of a new dimension of medical care. The question is, for whom is health care going to be granted?

For over 195 years, the District of Columbia General Hospital (DCGH) has been there for the needy, the uninsured, and the underinsured. All the District residents were welcome and never refused care. Now it appears that this is in jeopardy.

The Doctors Community Healthcare Corporation, which was awarded the bid to D.C. General Hospital, proposes to clear away most of the clinics we have on the grounds of D.C. General Hospital and transfer them to Greater Southeast.

With more than 170,400 people visiting the ER and our clinics yearly—and in that number, over 55,000 visit the ER alone, with 15,000 being ambulance-driven, and 40% of that needing to have 24- to 48-hours observation, and 300 of that actively come in as CPR in progress—the Doctors Community Healthcare Corporation is going to leave a 23-hour inpatient unit at D.C. General Hospital and is planning on other hospitals accepting those patients still in need of care after 23 hours. Do we need a reality check?

It is becoming more apparent as time rolls by, that the killing of D.C. General was not decided yesterday. The Doctors Community Healthcare Corporation needed a pawn to do the actual stabbing, gutting, and killing of a hospital, D.C. General. And they have been very active from the '50s to present. The slow eroding of the hospital is witness to that.

D.C. General Hospital is the highest-rated hospital in the District of Columbia. JACHO, the national accrediting agency for all of the hospitals in the nation, gave D.C. General a rating of 100, then took six points off because of the deteriorating facility. Even with the rating of 94%, D.C. General remains the highest-rated hospital in the District of Columbia. (applause).

Trauma, Bio-Hazard To Close

Don't let the terminology fool you. The Community Access Hospital is a large clinic that is going to be open 24 hours a day. It will have smaller clinics. It will not have inpatient services to our Wards 5, 6, 7, and 8. It will not have a Level 1 Trauma Center, which is for motor vehicle accidents, gunshots, stabbing wounds, primary treatment of burn victims, or any conditions that would need emergency trauma treatment.

Washington Hospital Center, Howard University Hospital, and D.C. General are the only Level 1 Trauma Centers in the District.

The Bio/Chemical Hazardous treatment disaster area will be closed. The remaining treatment areas are strategically located at G.W. Hospital and Walter Reed. To maintain this area, you must have inpatient service, and this is going be eliminated.

Why do this? Consider the fact that D.C. General is right next to Interstate 295 and next to wards that have the highest homicides and gunshot wounds in the city. Major trauma [care] could no longer be provided. D.C. General's new CEO, Mr. Barch, proposes a secure, trustworthy bid for the hospital, called the PBC2 Urban Healthcare Campus, along with the Doctors Community Healthcare Corporation from Scottsdale, Arizona. His bid was not selected—and you can all refer to Mr. Barch's plan, it's on my second page, I've submitted it all to the members.[1]

This plan could all be done while operating within an allocated budget; earning increased revenues; operating efficiently and effectively; providing quality health care to the District's insured and uninsured residents.

So why did Mayor Williams give DCHC, which is Doc-

1. The Barch plan would include a Level 1 Trauma Center, Emergency Room, and Urgent Care Center, as well as a Women's Health-Care Center, a modern birthing facility, and a Senior Wellness Center. A new medical campus, including mental health, long-term acute care, substance abuse services, Federal/D.C. Partnership, Community Health Centers to partner with non-profit Clinics, Unity Health to Focus on 330 Status, Primary Care, Medicaid Manned Care. School nurses in the public schools, including charter schools, will emphasize health education, preventive medicine, immunizations, and screening. Services will include enabling social services, nutrition, care management, mobile health vans, and home visitation; expand Community Health Programs; provide long-term acute care, substance abuse and mental health care. "Centers of Excellence" would be established to assist patients with management of chronic diseases that disproportionately affect African-American and low-income city residents. A new strategic partnership would be formed with Howard University's Cancer Center, Howard University Hospital, and Howard College of Medicine, as well as other organizations, such as the National Institutes of Health. Our physicians will organize into a corporation for the purpose of delivering specialty care.

tors Community Healthcare Corporation, the bid to a public hospital, the District of Columbia General Hospital? Realtors indicate the property D.C. General sits on is valuable.

Be mindful that Washington Navy Yard, which is near the hospital, is bringing 5,000 jobs to the area. Even if Baltimore is selected to host the 2012 Summer Olympics, a full-service hospital will be needed there. Change is good, so why can't we compromise and have both?

Ms. Eleanor Holmes Norton, the District's Delegate to Congress, once championed the cause of civil rights for all; your constituents are looking for you to step up to the plate and say, stop this! (applause)

Conyers: Okay, that was your last riff, my lady. Okay? Last riff.

Gordon: Will you help us, please? Do *not* privatize our public hospital. *Yes,* you can help! Congressman, you can help, too. Please call the Control Board members and tell them to stop this potential loss of lives, and bloodshed and needless deaths of our residents who don't quite fit the bill of the fortunate like you do.

Stop trying to kill D.C. General, but give CPR and breathe back *life* into these walls of caring, love, and devotion. Remember what our Preamble says: *Promote the General Welfare,* not demote. Thank you. (applause)

Dr. Michal Ann Young

'We Serve Both the Haves And the Have-Nots'

Dr. Young is on the Medical and Dental staff of D.C. Health and Hospitals' Public Benefit Corporation. She is director of neonatology—care of newborn and premature babies and their mothers—at D.C. General Hospital

Congressman Conyers, thank you for the opportunity to place these issues before you—but we need you to talk with the [Financial] Control Board that this Congress put into place. It appears that it is leading the fight to dismantle D.C. General Hospital (DCGH) and the public health system, and will then get to slide away in September or October 2001 and leave us with a disaster on our hands.

The Medical and Dental Staff of the PBC is resolute in its stance, which is—that the community we serve needs and deserves a full-service hospital that includes a substance abuse unit, obstetrics, and pediatrics, with a Level 1 Trauma Service joined to a network of comprehensive primary-care community clinics. The mandate for the PBC is to provide care for any resident of the District of Columbia. Many envision those individuals as the indigent, the immigrant, the working poor, the underinsured, and the uninsured. However, the community we serve is larger than that, and consists of both the haves and the have-nots.

On nearly every occasion that the Washington Redskins played in RFK Stadium, we treated a suburban white male for a heart attack. Any concert or community gathering in the Stadium or at the Armory finds the hospital available and providing care—ask the young lawyer struck by lightning while on her cell phone; she would not be alive today. We were there for the child attacked by the pit bull before he was stable enough for further transfer to Children's Hospital. We were there to rescue the unborn child of the pregnant woman who lost consciousness and subsequently her life when she drove into the Anacostia River. My point: The leading cause of death in America, and in our community, is accidental and traumatic injury; and with trauma, minutes count. We must be prepared to manage it. To design a health-care system—particularly in our community where 40% traumatic injury occurs—that does not plan to optimally address trauma, is short-sighted and will cost lives.

DCGH is strategically located to address all the medical needs of this community, as well as the nearly 1.5 million workers, visitors, and residents who transit this jurisdiction nearly every day.

Our strategic location, in addition to the trauma services we provide, is why the Department of Defense determined that we would be one of only two civilian hopsitals in this jursidiction that they outfitted with decontamination units. What that means is, that this equips us to handle attacks on civilian populations with weapons of mass destruction like biological (anthrax, Ebola virus), nuclear, and chemical warfare—similar to the incidents that occurred in the subway in Japan. We need to preserve trauma services in this community. Ironically, we sit in the more populous part of the city, while the remaining trauma centers are located in the Northwest. The cost to bring the Emergency Medical System ambulances up to adequate service levels to service the District, and then do the multiple transfers that will be required if we are not there—15,000-plus runs annually—is estimated to be around $40 million. That amount, coupled with the proposed cost to lease beds from other hospitals, are funds that could be used to build a new, streamlined, full-service public hospital.

What Will Be Lost

The nation's capital should be the shining example of what public health networks could be—DCGH and our com-

munity clinics can be like other public hospital systems in which their community has *invested,* and they have been transformed with the goal to treat all patients: like Cook County Hospital in Chicago, Orlando General Hospital in Orlando, Florida, and Jackson Memorial, managed by a public trust in Miami. Closer still are Prince Georges Hospital and Inova Fairfax—both public county hospitals whose communities vested them with visions for excellence and greatness; and we can be that, if someone has that picture for us. With new management, newly implemented information systems, and reconfiguration of services, we were poised to fully embrace comprehensive, integrated care, when the Mayor decided to go in yet another direction.

If those in power are determined to make a lesser decision and dismantle DCGH and the public health system, this is what will have to be absorbed:

- *Adult admissions*—10,000 yearly—4,000 of which are estimated to be uninsured.

This includes 24 critical care beds in our NICU, CCU, and SICU, which are 110% occupied. Currently all hospitals with critical care beds are running at 90-100% occupied. This means that even if you can transport the patient to another hospital, they will lie in that hospital's emergency room, because no critical care beds are available.

- *Code yellows*—that's life-threatening surgical emergencies—1,500 of them annually, 200 of which must be in an operating room within 10 minutes; they will not survive the extra 7 to 10 minutes required to transport them past DCGH.
- *Pediatric services*—There are 7,000 pediatric ER visits annually. We are currently Level 2 Trauma for children as well as providing emergency and inpatient services for children. The American Academy of Pediatrics has stated unequivocally that pediatricians, not emergency medicine physicians, should be the provider caring for emergently ill children. There are no plans for pediatric emergency services in what is being proposed for this city. It will result in a diminution of care for children, and we have the most populous area.

Previously, when we were mandated to downsize by 554-plus personnel, we were trying to see if some of our services could be absorbed by other institutions, and we met with Children's CEO, CFO, CMO, and the Director of PICU—and before we could speak, they asked us not to close our pediatric emergency room, because it would result in a delay in care; and children deserved competent services close at hand. And yet our great powers have decided to accept a plan that has no such planning in it. The plans that have been put forth by Greater Southeast and accepted by this administration will result in a substantial diminution in the quality of care for children in this area of the city.

- *Care of incarcerated men, women, and youth*—both outpatients, inpatients, and delivery services.
- *Evaluation and review*—of all forensic patients brought by the various uniformed services, i.e., MPD, Park Services, FBI, Immigration, etc. We do it without cost, that's our oversight, but who is going to absorb that when our doors are closed?

The 243 active, courtesy, and volunteer members of the medical and dental staff, consisting of physicians, dentists, oral-maxillo-facial surgeons, podiatrists, and allied health practitioners, ask that you support our request to continue to have the privilege to serve this community with a new, streamlined, full-service hospital that is fully integrated with our community centers. We remain ready, willing, and able to serve any District resident. (applause)

Dr. Edith Rasell

'The Whole Health-Care System Is in Crisis'

Conyers: I'm pleased to introduce the doctor from the Economic Policy Institute that has worked with me and the Congressional Black Caucus on formulating national health-care policy, she's with us today, Dr. Edith Rasell. Let us welcome her.

Edith Rasell: I have really appreciated hearing the testimony of the folks here that know firsthand what's going on with D.C. General, but I wanted to say a couple words to put this in context with what's going on in the nation as a whole. And I don't think I need to tell anybody here that the whole health-care system is in a crisis, and what we're seeing here with D.C. General is maybe just one tip of many mountains that are sticking out of this crisis.

We know that there are about 43 million people that are uninsured; about 10 million of those folks are kids, most of these are people that work—in fact, about two-thirds of all the uninsured are workers or family members of workers. We've got another 30-40 million people that have insurance, but it's inadequate insurance, and doesn't cover really important things that they need to have to be healthy, so we've got a major problem here; and not only that, the folks that do have insurance, know that they could lose it at any time if they lost their job, got laid off. We have a recession coming on. We're probably going to see these numbers of uninsured people rise. So we've got a major problem here, of which what we're seeing in D.C. is only a piece.

Health Care Is a Right

But we've also got to remember that the problem is not lack of money. We spend more in this country than any other country. What we're looking at in D.C. right now is not—there's not talk here about saving money, right? I mean, what they plan to do is pay this for-profit corporation about twice what the D.C. General and the clinics at D.C. General are paid to operate as a public hospital; and instead, the services and the money are going to go to a for-profit entity whose first responsibility, which they'd be the first to tell you, is to their shareholders, not to the public, and I think that's another incredibly troublesome aspect to this.

When we have seen privatization in other places, there are, very, very commonly, problems with accountability, with holding these folks up to do what they're supposed to be doing, and there's problems with oversight, and I think we can expect to see those kinds of problems in the future if this move goes ahead.

We live in a wealthy country. We live in a wealthy area—the problem's not money; we know that President Bush has plenty of money—he wants to give it back to us!—we spend more money on health care than any other country, so it's not a matter of too little money, it's a matter of how we want to spend it, and what we think is important.

And I just want to wrap this up by saying, the health-care system—and now I'm speaking for myself—I think reflects the social issues, the larger social issues that we see in the country. The problem with poor people, people of color, people that don't have good jobs, being devalued, and—you know, health care is a right, we can go back to what we heard from the Declaration of Independence; we're all in this together, and we all ought to be getting health care just like anybody else.

I just want to note: Two days ago, Congressman Conyers introduced a bill, the Working American Families Access to Health Care Act (applause), and if this bill were passed, everybody that today is uninsured, would have insurance, and so that's a goal that I think we all can work for. Thanks. (applause)

Dr. Abdul Alim Muhammad

'We Represent Thousands And Thousands More'

Dr. Abdul Alim Muhammad is the founder and director of Washington's Abundant Life Clinic, and Health Minister of the Nation of Islam.

Conyers: Dr. Abdul Alim Muhammad, who came to us and brought this matter to our attention with such persuasiveness that it led to us coming together this afternoon. We're delighted he's here, and we now turn the podium over. (applause)

Dr. Muhammad: I want to first thank you, Mr. Congressman, for your sensitivity and compassion on this issue, and in fact your entire stand. I could spend the three to five minutes that I have, in showing appreciation for what you have done, because this is an issue that, as you see, resonates quite widely throughout the Washington, D.C. community, and these are people from all walks of life, they come in all colors, all faith groups, you know, some are rich, some are poor, but they are all united in their solidarity with this issue of saving D.C. General Hospital. (applause)

I'm a local physician, not affiliated with D.C. General Hospital professionally, but there are some issues that are so important that they transcend one's personal interests. And I think that's why most of the people who are here this afternoon, are here—and they represent thousands and thousands more, who would be here to show their support for D.C. General Hospital. I guess in one sense, I represent an ad hoc coalition to save D.C. General Hospital, and if you're a member of that ad hoc coalition, would you please raise your hands? (applause)

So the feeling is strong, it runs deep, it's broad. We have a Mr. Michael Barch here, who's the CEO of D.C. General Hospital (applause), and he, like so many others, has shown amazing courage in this issue, because he convened a meeting of those who support the hospital, and as a result of those efforts, we understand that they're trying to fire him, simply because he wants to foster the kind of dialogue that's going on in this room. And so he needs our support in what he's trying to do to keep D.C. General Hospital alive and well. (applause)

Determined To Win This Fight

You know, most of the important points have already been made. And you have already heard the mantra of the coalition to save D.C. General Hospital. Our mantra is, Full Service, Fully Funded, Public Hospital. And it has to be in the budget!

And the reason that the coalition has adopted that as its mantra, is because we know that this is going to be a very long, complicated fight. Anything that involves the District of Columbia, by the very nature of the District, is going to be very, very complicated. This is a local community, but it's also the national capital. It's also an international capital. So it gets very, very complex, very, very involved, and we know there are going to be proposals and counterproposals galore,

but at the end of the day, when the dust settles, we want a full-service, fully funded, public hospital that's in the D.C. budget!

Now, we're like the hometown rooters, and we know it's a national issue, an international issue, but we're like the rooters for our hometown team; and we are looking at the scorecard of people in this country who seem to be the enemies of public health. If we look at the record over the last 15 years, we notice that about 1,500 hospitals around the country have been shut down, and so the other side on this issue is looking at the same scorecard and they saying that "we're winning, 1,500 to 0," because, generally speaking, citizen groups do not win these fights. But we in the District of Columbia, we are determined to win this fight. Because we realize (applause) it's more than just several hundred jobs involved, it's more than just the citizens of the District of Columbia. As has already been said, the District of Columbia should serve as a model for the rest of the country, it should serve as a model for the rest of the world; and if we cannot defend public health in the District of Columbia, then it means public health is in danger everywhere. And so that's how important this fight is, and we really thank you.

Just finally, let me just say that, you know, there's been a change in our culture over the last 15 or 20 years. When I was in medical school—I graduated in 1975—at that time, medicine was still a profession. Now, it has become an industry; it has become a commercial enterprise, and there are people who are trying to run health care in this country who are looking at the bottom line.

We Are Our Brother's Keepers

But the bottom line is not the bottom line, in health care. The bottom line is what we just witnessed here a few minutes ago [when a woman fainted and had to be taken out for assistance—ed.]. We never know when an emergency will occur. But we do know this: that we always have to have the capability to respond, and that when you start to degrade the health-care system, the public health system, then that means that we no longer have the ability to intervene where necessary to save valuable lives. So the bottom line, if you will, with health care is human beings, human life. It is sacred, and we have a solemn obligation under the Constitution—under God, for those of us of faith, under God (applause)—we declare, we absolutely declare, that we *are* our brother's keeper, and that we *are* obligated to be there to take care of one another. We can only prove our service to God by our service to humanity, because God has nothing that He needs from us. I mean, He has everything, but we prove our faith by our service to one another.

And so there are some questions about the process as it has unfolded that need to be answered. Some of those questions have already been raised. If it's not about saving money, then what is it all about? I mean, if you're going to pay a private group twice as much as you're willing to pay the public doctors and the public workers who have been on the frontlines for so long, then what is it really all about?

Is it really an issue of land use? Because we've seen the plans of the National Capital Planning Commission, that they want to take the land that the hospital is on and develop it with condominiums and hotels and marinas and parks and all kinds of things of that nature. Is that what it's really all about? And if it is, we say, "You can put your condos someplace else, but leave D.C. General Hospital alone." (applause)

We had a conversation this morning with Miss Alice Rivlin of the Control Board, and I was shocked to find that her defense of the Control Board's action in regard to D.C. General Hospital, her defense of it is no better than the defense of others who have tried to make sense out of something that just simply doesn't make any sense. When we look at D.C. General Hospital, it has often been remarked that this is the last option of the poor and the downtrodden. And that's part of the truth, but it is also the saving grace of the other hospitals in the city. It's like the linchpin; D.C. General is like the keystone in an arch, and if you remove that keystone, then the whole arch collapses. And so it just simply doesn't make any sense. The professional organizations that are represented here who have spoken on this matter, make it very clear that the Mayor and the Control Board and everybody else who wants to shut down D.C. General Hospital—they are doing it against professional medical advice, and the citizens are saying, you're also doing it against common sense and decency.

And so we thank you, Congressman Conyers, we thank you for your leadership on the issues of health over the years, we thank you for the introduction of the legislation that would give all of us health insurance, but having health insurance won't mean a doggone thing at all, if they shut all the hospitals down. (laughter, applause)

Dr. Walter L. Faggett

'Access To Quality Care Must Take Precedence'

Walter L. Faggett, MD, is Vice-President of the Medico-Chirurgical Society of the District of Columbia.

We, the physician members of Medico-Chirurgical Society of the District of Columbia, are going on record in support of maintaining an integrated community-oriented primary

care system at D.C. General Hospital. Med-Chi feels very strongly that continued services in support of inpatient acute-care, a Level 1 trauma service, psychiatric care/substance abuse, and graduate medical education programs are critical to efforts to improve the health status of D.C. residents.

Residents of the District of Columbia have some of the worst health-care indices in the country. Heart disease, cancer, stroke, alcoholism, infant mortality, and AIDS afflict our residents at alarming rates. An improved health-care delivery capacity at D.C. General Hospital is one of the critical elements we believe must be present to reverse the current trends, especially in Wards 6, 7, and 8.

We in Med-Chi believe that, at a minimum, a new 150-bed inpatient acute-care hospital is needed to provide access of quality care for the patients being served. While we recognize that there may be an abundance of hospital beds in the District of Columbia, the area serviced by D.C. General Hospital suffers from no such surplus. Eliminating the presence of inpatient care beds at D.C. General Hospital will adversely affect the health status of those residents most in need of hospital services. The patients traditionally served by D.C. General Hospital have less access to quality health-care services than most other district residents. Maintaining the presence of D.C. General Hospital is critical to maintaining access to health care for these underserved residents. Access to quality care must take precedence over profit motivation. The transportation needs of this patient population will be greatly increased in absence of the availability of D.C. General Hospital.

The continued presence of Level 1 trauma services at D.C. General is critical to preventing additional loss of life due to trauma, especially for residents in Wards 6, 7, and 8. While we recognize that there may be a surplus of Level 1 trauma units in the city, no such abundance exists in the area serviced by D.C. General Hospital. Eliminating the presence of a Level 1 trauma service in this area of the city will result in delays in residents being treated for their injuries, which will have an adverse impact on patient care outcomes. We agree with the Washington Hospital Center concern that existing trauma units will be overwhelmed with uninsured patients in absence of the D.C. General trauma unit.

The provision of psychiatric services, including substance abuse, at D.C. General Hospital, is another critical element in improving the health-care status of District residents. Once again, we are talking about a population which has had diminished access to medical services, including mental health and substance abuse services. It is critical that such services continue to be provided at D.C. General Hospital during this transition period.

'We Physicians Are Coming Forward'

One aspect of D.C. General Hospital that has not received the attention it deserves, is its graduate medical education program. Over the years, D.C. General has served as the training grounds for a significant number of physicians. Many of the members of the Medical Society, which is 116 years old, received their residency training at DCGH. The expertise gained by residents and fellows in DCGH's teaching program has provided the springboard to valuable and significant contributions by minority physicians to the field of health worldwide. Minority medical graduates face diminished access to residency training. Maintaining graduate medical education programs at D.C. General Hospital is critical to having a well-trained cadre of health-care professionals available to provide health services to the underserved residents treated by D.C. General Hospital.

We, the physician members of the Medico-Chirurgical Society, can be a valuable resource to the District government, and we are concerned that we have not been asked to assist in this critical community health-care issue previously. At this time, we're here, and we are coming forward and will continue to participate in the resolution of this problem to ensure that our patients have access to quality health care in a seamless integrated health-care system which includes wellness and preventive health capacity in addition to primary care.

Dr. Henry Williams is the President of Med-Chi and may be reached at (202) 347-4170. Dr. Walter Faggett may be reached at (202) 487-0542. We will be available, and again, we appreciate your time Congressman Conyers, and your support of this effort.

Barbara Lett Simmons

'This Issue Is About Real Estate, Not Health Care'

Barbara Lett Simmons is a well-known leader in Washington, D.C.'s Democratic Party; she was the District's Democratic Elector, pledged to Al Gore, who cast a blank ballot in the Electoral College, to protest the fraud of the 2000 election.

Simmons: I want you to know this man was my Congressman from age about 18; it was while I was in college. (laughter)

Conyers: Just a moment, strike that from the record—I don't want that to go any further, and not go out of this room. Good to see you, Mrs. Simmons.

Simmons: All right, thank you very much. But [Congress-

man Conyers's] courageous and sensitive act, of the legislation he introduced, is not new. He is not someone who joined the human race recently. He has been there all the time. And there's no point in me reading to you the facts that you've heard over and over and over again. I want to say, it delights me to associate myself with the remarks of the good doctor who immediately preceded me.

This issue is about real estate, people—make no mistake about it. It is not about health care, it is about *real estate*. It's the same bottom line that was there about our Board of Education reorganization, where the Mayor can dictate what [school] buildings will be closed, and become condos, as well. Now I think we've got to be honest, and you've got to look at the facts of the matter, people. You can engage in denial, you can put your head in the sand if you want, but the reality is that there are two specific categories of people who are carrying on their backs the burdens of all of those industries in this city, which are needed by the people: that's poor people, and old people. And you need to be aware that when you address every issue in this city, is it good for the general public? Is it good for old people? and if you don't walk away with a resounding affirmative, Then you know for whom it *is* good. It's very simple.

Time To Show Some Courage

And we have to—folks—stop always assuming that everyone is about something noble and wholesome and good. What did Dr. Muhammad tell us? He said, medicine is an industry. If you really understand that, you would know the very company that is proposed to take over D.C. General, already has five states who are litigating against it; no place have they a hospital two or three years after their purchase where services are given to the people. In other words, medical services are *not* the interest of that body, and their own record proves it to us. All we have to do is be honest enough to look at it and have courage enough to articulate it, instead of hiding those facts from the general public.

We need to look at to whom they gave money in the campaign. Look at the people on the Hill who received the maximum amount of money—oh, hi there, Dr. Wilson! Because I know he does that kind of research, and I know all of you, and it's a shame, we are preaching to the choir here about these issues, because you folks do know it and I know that the Congressman knows it, or he wouldn't have introduced the legislation.

Folks, it's time for us to show some courage. The courage that says, yes, I know that the paycheck is being held by this man, but what is right is right, and has to be explained, has to be articulated. And that's why we've got to keep our presses working, so that the truth can get out, because you can't expect those who are colluding in this issue to actually share the facts of the matter for the general public. That will not happen, and that is being naive.

May I just say in conclusion, I'm delighted to be here and associate with the worthiness of this cause. The proposal that the several Council members have come up with, merits consideration, merits implementation—and why we have someone with a blind spot that says, "Anything that's good for the people of D.C., I'm against that, I'm the leader, and if they don't like what I do, they know what they can do." Folks, *you* know what we can do, we can draft someone for Mayor in 2002. (applause)

Conyers: Okay, Mrs. Simmons, you're very welcome, you concluded your remarks at exactly the right time, because this is not a political meeting, and your normal shy, demure demeanor has not gone unnoticed this afternoon.

State Rep. Erik R. Fleming

'Closing D.C. General Would Hurt the Nation'

To Chairman Conyers, Members of Congress, Ladies and Gentlemen:

My name is Erik R. Fleming and I am a member of the Mississippi House of Representatives from District 72. I have served in the House since 1999, representing approximately 25,000 people.

One of the issues that are important to my constituents is quality health care. My district is considered the most affluent African-American district in the State of Mississippi. Yet, I know there are a significant number of people in my district that are not covered by health insurance.

In fact, according to the most recent statistics, a 1997 survey by the Urban Institute, there are some 476,000 Mississippians that do not have health insurance. That's around 17% of the state's population.

I believe the District of Columbia has an estimated rate of 27% uninsured, some 150,000 people. Of the number of patients that D.C. General treats, 55% of them are uninsured.

However, instead of having a discussion concerning the expansion of D.C. General and how their medical expertise could help my state handle its health crisis, there is a move afoot to close the doors of this institution, an institution of

health care which has been a beacon of hope on the Anacostia River, since 1804.

I am here to recommend to all who would hear this testimony that closing D.C. General Hospital would exacerbate the problem of health care in this city and in this nation. Use Mississippi as an example.

In 1987, it was recommended that the state's three eleemosynary, or charity hospitals should be closed. That recommendation came from a Louisiana physician hired as a consultant by the state's Performance Evaluation and Expenditure Review, or PEER, Committee.

The PEER Committee report (#184, 2/17/87) suggested that there were 13 alternate ways to treat indigent citizens of Mississippi, including taking the money that was used to fund the hospitals, and putting it into the Medicaid system. The theory was that the $3 million the Legislature appropriated to the hospitals, could be turned over to Medicaid, which would generate more jobs and give the state a return of $12 million for health care.

According to the state's Eleemosynary Board that oversaw the hospitals, the amount of care the three hospitals provided with $3 million, was worth about $25 to $30 million a year. Therefore, instead of seeing a windfall of $9 million, contended the board, it would be a potential loss of $27 million in available health care.

Despite passionate arguments against the action, the State of Mississippi closed its three charity hospitals by June 30, 1989. One of the other alternatives cited in the PEER report, was that citizens could continue to sue the University of Mississippi Medical Center (UMMC, in Jackson) hospitals under the [1946] Hill-Burton mandates [requiring hospital bed per-capita coverage].

Since that time, the U.S. Congress has *repealed* Hill-Burton. However, even if Hill-Burton were not repealed, those mandates would have expired by August of 2000. The community health centers do a fine job with outpatient care, but do not provide the trauma units or the in-patient care a hospital could.

Even more compelling than that, the number of patients seen by the UMMC has not drastically changed since 1985. In 1985-86, UMMC saw an average of 26,214 patients, while the three charity hospitals saw 10,272 pateints. In 1999-2000, UMMC saw an average of 26,196 patients, while the charity hospitals had been shut down for ten years.

Where did those 10,000 extra patients go? No one in the State of Mississippi knows, and that is the tragedy that is waiting to befall the indigent and the uninsured in the District of Columbia, if D.C. General suffers the same fate as our charity hospitals.

If a public hospital in the nation's capital closes for whatever invidious or nefarious reason, what hope is there for America to solve its national health-care crisis?

With that question, I thank the chairman for allowing me this opportunity to testify at this briefing.

Dr. Henry Foster

'We Have An Obligation To Keep This Facility Open'

Dr. Foster was nominated on Feb. 2, 1995 to serve as Surgeon General of the United States. He was the director of the Robert Wood Johnson Foundation for five years. His "I Have a Future" program received one of President Bush's "Thousand Points of Light" awards. Dr. Foster has been a board certified specialist in obstetrics and gynecology for almost 40 years. He currently practices and teaches in Nashville, Tennessee.

I commend the committee, and Congressman Conyers, for holding this briefing today on the "National Public Hospital Safety Net in Crisis: D.C. General Hospital in Focus." The threatened close down, or curtailment of functioning of D.C. General Hospital, would be a national tragedy, and parallels similar health disasters around the country. I support very strongly the effort to keep this hospital open as a full service hospital.

I would say, in fact, that we have an obligation to keep this facility available. When a public service—a crucial service, such as D.C. General Hospital—cannot be obtained through the free market society, then there is an obligation for us to provide that service. That is clear. The implications of closing this hospital will translate into adverse health care outcomes and, obviously, in the long run, this will have negative economic consequences. We have a moral obligation to keep this facility open—unless, and this is an important point—unless there are facilities that can meet these needs otherwise. However, from what I understand, the loss of this hospital as a full-service facility will create a void that will go unfilled. Therefore, as I said, I strongly support this effort in support of this hospital.

Now, we should also consider this issue from the standpoint of the national objectives of U.S. health care policy. A major objective of U.S. health care policy has been to close disparities in health care—this directly relates to the efforts of the Center for Disease Control (CDC) and the Department of Health and Human Services (HHS). This has been the stated national policy. Now closing this hospital will actually go in the opposite direction, of increasing health outcome disparities—and therefore, the opposite of stated national policy. We talk about getting rid of health disparities, but then consider doing something that is completely negative to that policy. Closing this hospital is, in fact, a contradiction to national policy, a mitigation of it, because it will decrease access and utilization of critical services.

There is much more I could say on this question, and its

"Save D.C. General" marchers head toward the Capitol to attend the Congressional briefing, following one of the rallies outside offices of the Financial Control Board and the Mayor.

implication for national health care policy in general. However, I will close my statement here. Again, I think our obligation as public and health officials is clear. D.C. General Hospital should remain as a full-service facility for the citizens of this community. If anything, the hospital should be expanded and improved—as should our national health care system in general. We are talking, after all, about life, and about death.

State Rep. Ed Vaughan

'We Need To Go Back To Hill-Burton Standards'

Ed Vaughan is a Former Michigan State Representative, whose district was part of Detroit. He was a leader of the campaign effort which won the Michigan Democratic primary for Lyndon LaRouche in March 2000.

I certainly want to congratulate Congressman John Conyers for calling the meeting in Washington on the issue of "The National Public Hospital Safety Net in Crisis: D.C. General Hospital in Focus."

I think it is terrible that there is contemplation of closing the hospital. It should not be closed. We have to remember that health care should be for the people and not for profit, and that whatever it takes to run the hospital should be provided, because the people in the district need sufficient health care. This is the nation's capitol, and the whole world is looking at America. For America to close the only general hospital it has in the District of Columbia, is a terrible affront to mankind.

Therefore, I certainly urge the Congressional delegation from Michigan, and the rest of the Congressmen and women around the country, to stand up and fight the closing of D.C. General Hospital. I commend the efforts of the LaRouche organization and the others in Washington, D.C. in fighting for this issue which affects us all, nationwide.

We have many of the same problems in Michigan. Fortunately in Detroit we have the Detroit Medical Center, and we have a large Veterans Hospital in Detroit, but we still have a crisis in health care here. It is much worse in other areas, but the issue is still here, and of course, some of the hospitals are not doing as well as they should—and I am thinking about some of the hospitals in the Detroit Medical Center, and I am thinking about some of the hospitals which are overcrowded with people who do not have health care, and cannot afford health care.

Health care has gotten out of hand in this country. Ironically, many small countries in the world have better health-care systems than America. I think we need to go back to Hill-Burton Standards to insure that health care is for everyone. A nation this large has no reason to not provide health care for all of its citizens.

So I urge the adoption of Hill-Burton standards, and I urge this nation to give health care to the people. Health care should

be for the people once again, and not for profit. It will benefit us all if D.C. General Hospital stays open, and we finally bring this question to the fore. Will we or will we not operate in the interest of the General Welfare of our citizens—in health, as well as in all issues confronting us today?

State Rep. Lamar Lemmons

Lamar Lemmons, III, is Second District State Representative of Michigan, and member of the Michigan Health Policy Committee.

On the issue of the proposed closing of D.C. General Hospital, and on the occasion of the March 22, 2001 Congressional briefing on "Public Health in Crisis, D.C. General Hospital in Focus," I am very disappointed and appalled at the prospect of closing another inner-city hospital. Making medical care facilities unavailable is tantamount to withholding health care, which is tantamount to genocide.

District of Columbia Medical Society

'No One in This City Should Sit Idly By'

Stuart F. Seides, M.D., President of the Medical Society of the District of Columbia (MSDC), issued the following statement regarding D.C. General Hospital.

Additional concerns and supporting data have come to the surface that solidify the Medical Society's serious concerns regarding the viability of the Control Board's plan to dismantle inpatient services at D.C. General Hospital.

The negative impact of the Control Board's plan will be far-reaching. Many of the 52,000 emergency department visits and many of the 15,000 ambulance arrivals that currently go to D.C. General will simply be shifted to the already-overcrowded but closer emergency rooms of the Washington Hospital Center, Providence Hospital, George Washington Hospital, and Howard University Hospital. We question the choice of supporting a system that depends upon a hospital that is far removed from the traditional catchment area of D.C. General, with the clear potential to shift substantial costs to the other, already financially fragile, community hospitals.

The emergency departments of the hospitals closest to D.C. General—emergency rooms that are already bottlenecked—will see the overall number of ambulance visits increase. In fact, for reasons yet to be understood, the number of emergency room visits in the city increased by nearly 17% in January 2001, as compared to the previous year.

In addition, no hospital can possibly develop, staff, and become an accredited trauma center in three months. The accreditation process itself takes at least a year. We are concerned that there is no interim solution to the trauma center issue. What plan is in place to serve the residents of Wards 6, 7, and 8 while a trauma center is being established to replace the one at D.C. General?

For centuries, physicians have adhered to the oath *primum non nocere*—"first, do no harm." It is against this standard that we must measure the Control Board's transformation plan for D.C. General Hospital.

We have the solemn responsibility to treat illness and save lives. We have yet to see a workable transition plan that would adequately do either. After months of study and dozens of meetings, it is clear to MSDC that the plan to eliminate the acute-care beds and/or substantially reduce hospital services at D.C. General will, in fact, cause harm to patients—harm to the patients of Ward 6, 7, and 8, as well as to the broader population of patients that are currently treated at neighboring D.C. hospitals.

We add our voices to those urging the Mayor and the Control Board to suspend the current deadline of April 2, and to establish a realistic timeframe for a careful re-examination of the alternatives for providing the desperately needed health care services that D.C. General now provides.

The Medical Society will continue to join others in calling for a transition plan that guarantees an increase, not a decrease, in health care services available to patients who have historically relied on D.C. General Hospital. No one in this city should sit idly by while health care services are likely denied to some of the city's most vulnerable populations. We will continue to advocate for our patients. We can do nothing less.

Dr. M. Joycelyn Elders

'Why Would We Even Consider Closing This Hospital?'

Dr. M. Joycelyn Elders is an American physician and government official whose effective advocacy for preventive medicine, especially for children and young adults, led to her appointment as U.S. Surgeon General during the first Clinton Administration. She served in that post for 15 months. Previously, Dr. Elders had been director of public health in Arkansas, beginning in 1987.

Thank you, Congressman Conyers, and others for holding this briefing on the crisis of the national public hospital safety net, with D.C. General Hospital as a focus.

D.C. General Hospital is a hospital that has served a community, and an underserved population for a very long time. This hospital has served in times when nobody else would. They have many health disparities of concern—such as teenage pregnancy, AIDS, TB, poverty, health illiteracy, and so forth. No one has gone out there to provide this population with the primary health care to reduce mortalities and morbidities. So why close the only source of care, and promise primary care to an underserved, under-educated population in apparent need? Everything posed by the closedown of this hospital contradicts national health goals, and common sense.

For instance, one of the three major health goals for the year 2010 is to have 100% access and 0% disparity in health care. The other two goals are to have every American have the best possible health that they can. And the third is that every American have access to primary preventive health care.

The idea of these health goals began in a 1979 report of the U.S. Surgeon General. This practice of establishing health objectives in coordination with state, local, and national government health professionals continues today.

Higher Mortality, Shorter Lives

I urge you to consider the suggestion of closing D.C. General, and then compare it to the health goals for the year 2010.

"Healthy People 2010," established in 2000, included a new objective to "Eliminate Racial and Ethnic Disparities in Health." This initiative came from the simple recognition of the reality of health conditions in the United States. In a 1998 radio address, President Clinton announced that the nation would eliminate—not narrow—the considerable long-standing racial disparities in health status by the year 2010. For instance, in infant mortality: African Americans and Native Americans have the highest death rates in the nation. In adult mortality: In 1997, overall mortality was 55% higher for black Americans than for white Americans; life expectancy was still 7.1 years shorter for black males than for white males in 1997; and again, in 1997, the age-adjusted death rates for the black population exceeded those for the white population by 77% for stroke, 47% for heart disease, 34% for cancer, and 655% for HIV infection.

Part of the discussion of disparities included access to health care facilities. This access includes: *provider access, financial access, transportation access, and cultural access*. I noted this in a recent address to the Congressional Urban Caucus (June 28, 2000): "[Our health care system] is not equitable, and certainly not universal. Consider the statistics—1) We have more than 44 million people who have no health insurance, including more than 18% of our non-elderly population; 2) 42% of the uninsured population consists of minorities; 3) 80% of the 44 million uninsured people work every day, or live in families in which at least one member works every day; 4) 56% of the uninsured earn less than 200% of the poverty rate, and many more are underserved by our health-care system. Our population is growing older, living longer . . . and have more chronic disease and disabilities. Our medical technologies have improved . . . however, not all of our citizens are recipients of our progress. Barriers include *provider access, financial access, transportation access, and cultural access*."

Medical staff and supporters in Berlin, Germany, demonstrate against the forced closing of that city's best-known public facility, Moabit Hospital. Demonstrations have spread to five German state capitals.

I emphasize the last sentence, because the closing of D.C. General Hospital—a hospital that has long served the inner-city urban population of the district; a hospital that serves the uninsured; a hospital that serves a minority community—is exactly a hospital we would not want to close if we are serious about these national health objectives, and national concerns. Why would we even consider closing this hospital? What would we substitute for the provider access, financial access, transportation access, and cultural access?

U.S. Is 54th in Fairness

The World Health Organization recently released a book comparing the United States to all the industrialized countries. They said we have the best resources, but our system is very

unfair—it is number 54 in "fairness."

In this report, WHO carried out the first-ever analysis of the world's health systems, using five performance indicators: 1) Overall level of population health or disability or "Adjusted Life Expectancy" (DALE); 2) Health disparities within a population; 3) Health system's responsiveness to the needs of the population; 4) Distribution of responsiveness (Rich vs. Poor; Goodness vs. Fairness) and 5) Distribution of financial burden (who pays?). Using these criteria, it was found that the United States stood at #1 in spending 14% of its gross domestic product; #37 out of 151 countries according to its performance; #72 in its performance on health level (DALE); and #54 in fairness.

Let me repeat: #54 in "fairness."

Hospitals are being closed all over America—to make what was once a primarily non-profit vocation a profitable enterprise. But is this fair? By cost cutting analyses, the cheapest care is no care. Or, the most expensive pediatric care is for

Rep. Holmes Norton Spills the Beans

This release was issued by EIRNS on March 27.

In an informal meeting held with constituents on March 22, D.C. Congressional Delegate Eleanor Holmes Norton revealed that Oklahoma Republican Rep. Ernest Istook, Jr., of the House Committee on Appropriations, had threatened to jail Mayor Anthony Williams, as well as members of the Washington, D.C. City Council, for keeping open D.C. General Hospital, the District's only public hospital, through a set of operating loans.

Istook allegedly made the threat in the Summer of 2000, while he was chairman of the D.C. subcommittee of the Appropriations Committee, which has power over the D.C. budget.

Confederate-thinking elements in the Congress, had sought to force the closing of the hospital by allocating only a $40 million subsidy to it, when it was known that the hospital's operating expenses well exceeded $75 million. Further, it was known, that one of the major factors in deficits run at the hospital, was the tardiness in reimbursement of D.C. General *by the U.S. government* for tens of millions of dollars in Medicare and Medicaid payments due for services rendered!

Employing the financial accounting methods of Hitler's Economics Minister Hjalmar Schacht, Istook follows in the footsteps of Newt Gingrich, cutting the "financial consumption level" of the hospital, in much the same way that the Nazis cut the food consumption levels of the victims of the concentration camps to starvation levels. His stated plan: If elected officials, or even the Congressionally-appointed Control Board, *still* attempt to keep the hospital services open in the District, use *direct police-state methods and indict them*. In this way, the Gingrich theory of "Conservative Revolution" is to be combined with the Himmler-like "resettlement method" of handling the District's African-American population, known in D.C. as "Negro Removal." If the hospital leaves, the people will leave as well, or die.

Triumph of the Will?

In the official record of Congressional deliberations on the hospital, from July 25, 2000, ominously entitled "Political Will and Fiscal Will," Representative Istook chastises the City Council, the Financial Control Board, and the Public Benefit Corporation, which runs the D.C. hospital system, for using "a facade of 'loaning' money to the PBC. . . . The greater threat to public health in the District is not the potential closing of D.C. General Hospital, but in letting it continue to siphon off precious health-care dollars. . . ."

The Committee's majority report continues: "Just as bad as the financial failure is the failure of *political will* to address this problem. The Committee is disappointed that officials have preferred to procrastinate and spend, *rather than risk the unhappiness of the political constituencies involved in PBC and D.C. General Hospital*." "Political constituencies" is a Confederate euphemism for the African-American electorate and inhabitants of Washington, D.C.

According to Delegate Holmes Norton, in that same July, Istook met with Mayor Williams and members of the Council, and told them that they had committed felonies by extending the funds to keep the hospital open; that he would seek jail for them, if they did not rectify the situation; and that if the law allowed "some loophole"—that is, if, in fact, the D.C. government *had* the right to make such an arrangement—he would make sure the loophole were closed, and that the elected officials were thrown in jail.

In effect, Representative Istook was speaking for the Gingrichite, outright fascist view, that the defense of the general welfare of the population would be subjected to *police-state* measures of repression.

In her discussion with constituents, Holmes Norton confirmed this outlook by the Stone-Age Republicans. She stated that the intent of Istook was to write the closing of D.C. General into the year 2001 Appropriations bill as a precondition for any release of funds to the District. The following is a paraphrase of Holmes Norton's account of

a child born too little, too soon—a premature child, a possibly deformed child. Would we propose infanticide . . . to save money? Is this fair? . . .

It is true that the most expensive medical care is emergency room care. For many people, that is all they have, and the only place that they can be seen. However, we must fully solve that problem before we consider depriving people of that solution.

D.C. General is a hospital that serves more than the poor. It is a major trauma center. And hospitals in other areas of the country—serving wealthy and poor—are overburdened and shut down by the American health and economic crisis. We must solve this problem nationally. I call on Congress to consider what must be done to provide quality health care to all Americans. The immediate step, and the focus of this briefing, is to support D.C. General Hospital as a full-service, expanded hospital. The second and immediate step, is to move quickly to save the American health care system as a whole.

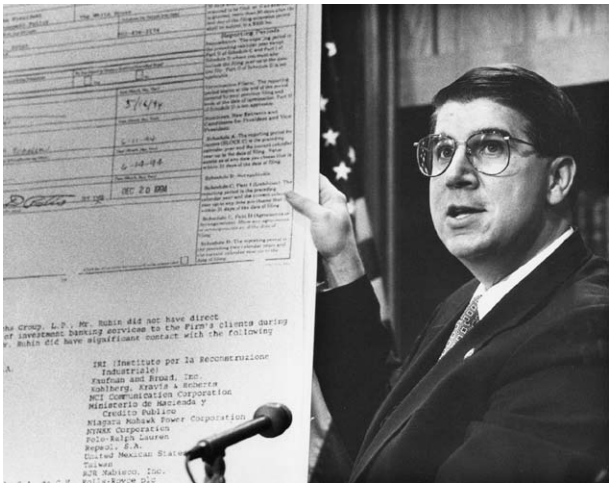
a meeting, which also included Alice Rivlin, head of the D.C. Control Board:

"I came to the meeting for one reason only, and that was to keep him [Istook] from writing into the Appropriations bill that D.C. General Hospital *had to be closed* for the District to see a penny of their budget. That's what he was going to do and I stopped him. It was the only reason I got involved. Williams wasn't going to do sh—. That's the only reason why. Ask anyone here. If it is a D.C. bill, Eleanor doesn't intervene. It has been my policy for ten years to leave it to the Mayor. It was all my doing. I got him to agree to let them overspend the budget. What I had to do was negotiate more money, so I could keep Tony Williams out of jail. I said, 'Let them take the money out of the reserve fund.' I was able to get $90 million, so that they wouldn't be in violation anymore, but I told Williams that next time, he was going to have to deal with it, because it was a matter of home rule. I don't know the issues. There has to be a plan. The Control Board has deferred to the Mayor and the Council, and they have to *come up with a plan on how they are going to close this damn place down*. But it would have been closed, and Tony Williams' ass would be in jail if it wasn't for me."

Threat Against General Welfare

What Delegate Holmes Norton's statements underscore, is that Mayor Williams and the City Council officials have been acting under threat from the fascist Control Board, and that responsibility for the threatened closure of D.C. General, with its attendant genocidal consequences, lies squarely in the Congress.

In the now-famous town meeting, held at Union Temple Baptist Church by Mayor Williams on Feb. 28, in which the Mayor attempted to sell his plan to shut the hospital, LaRouche representative Lynne Speed, who did not know the above story, confronted the Mayor with the following policy-option. "You, the City Council, and the Control Board, were chastised by Representative Istook of the Appropriations Committee last July for continued financing of D.C. General Hospital. That Committee acted to force on you a policy that would directly result in the deaths of citizens of the District. That is well known. Such



Rep. Ernest Istook (R-Okla.) appears to use the tactic of threatening with jail, officials and opponents who may obstruct his slashing of Washington, D.C.'s budget. He reportedly threatened Mayor Anthony Williams over D.C. General Hospital, and demanded the names of opponents of his school closings.

a policy, willfully adopted, is no different than the policies of the Nazi government from 1933-45. If you are interested in the well-being of the people, as you say you are, then will you lead them to the Congress to demand that this hospital not be shut down, and that the principle of the general welfare be upheld, instead of that of Nazi shareholder values?" Williams replied, "I appreciate the passion of your statement, but we must be careful as to how we use the term 'Nazi.' "

Given the revelation by Delegate Holmes Norton of their intended "done deal" to shut D.C. General, no matter what its predominantly African-American population thinks, it is now clear why he answered that question, in that way. It is also clear that citizens concerned to stop the shutdown of D.C. General Hospital, now about to be privatized into the care of a corporation beset by charges of racketeering nationally, have to direct their opposition to the center of decision-making, the Congressional Committee on Appropriations. This term, the committee is headed by Rep. Bill Young, Republican of Florida; the D.C. Subcommittee is chaired by Rep. Joe Knollenberg, Republican of Michigan.