Bush Sees Katrina as Pretext for Reducing Health-Care Infrastructure

by Patricia Salisbury

At an Aug. 7 press conference, officers and physicans associated with the National Association of Community Health Centers (NACHC) presented a devastating picture of the failure to rebuild the most basic health infrastructure along the U.S. Gulf Coast, and its consequences for the health of the devastated survivors, almost a year after the Hurricane Katrina disaster. They also pointed to maneuvers on the part of the Bush Administration to use the catastrophe to accelerate the takedown of the nation's hospitals and other parts of the high-technology medical base; manuveurs which threaten to confuse and capture at least some leaders of NACHC. In fact, the Bush Administration, which abandoned the Gulf States portion of the lower 80% of the population both during and after Katrina, is shamelessly attempting to use the desperation of survivors and their advocates within the medical community to institutionalize a lower health-care capacity nationwide.

The press conference was called to release the report, "Legacy of a Disaster, Health Centers and Hurricane Katrina, One Year Later." The panel was composed of Michael Andry, CEO, EXCELth, Inc., a New Orleans health-advocacy organization; Dr. Maria Crawley, physician, Gulfport-Biloxi Mobile Medical Unit, and medical director, La Clinica de Familia, Las Cruces, N.M.; Dan Hawkins, vice president for policy, NACHC; Bernard Simmons, board chair NACHC and CEO, Southwest Health Agency for Rural People, Tylertown, Miss.; and Dr. Gary Wiltz, director, Teche Action Board, Inc., Franklin, La. A number of these panelists had and continue to have front-line experience in the Katrina-devastated areas of Louisiana and Mississippi.

The On-the-Ground Picture

Bernard Simmons opened the panel, noting that Katrina could not have chosen a more vulnerable location. Prior to the storm, Mississippi and Louisiana ranked near the bottom for health-care infrastructure, and since Katrina, the two states have moved to the absolute bottom, now ranking 49th and 50th. Prior to Katrina, he reported, the majority of counties in Louisiana and Mississippi had at least 76% of their residents considered medically under-served, given high rates of poverty and poor health conditions.

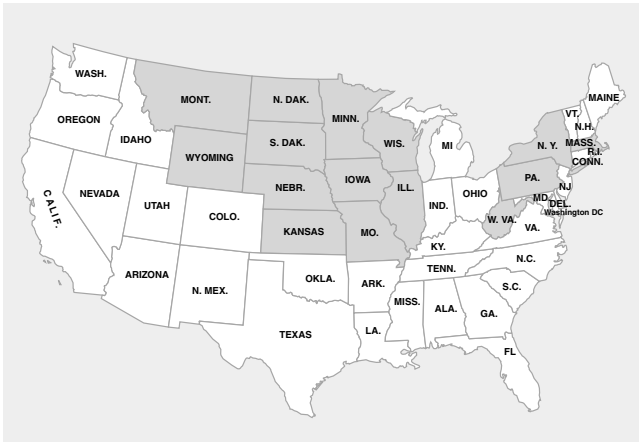
Simmons then summarized the current situation: "If you are poor, uninsured, chronically ill, and live near a Katrina footprint, finding a doctor or some place to go for health care is nearly impossible. . . ." He reported on an NACHC survey that found 11 health centers completely destroyed by the storm, and more than 80 facilities across Louisiana and Mississippi significantly damaged. Virtually no rebuilding has taken place. Simmons recounted that while he and others believed the relevant authorities when they promised, "Help is on the way," they did not expect that almost one year later, they would still be waiting for that help. Still, he said, to provide shelter in the storm remains the commitment of NACHC.

Panelist Michael Andry described the destruction of the network of six primary-care centers he ran in New Orleans, and the improvised response to it. Finding that only one center in the New Orleans area was salvagable, he and his staff relocated to Baton Rogue to attempt to assist the 350,000 evacuees, whom they found battered both physically and mentally. The survivors shared a sense of being rescued, but then shipped off and forgotten, after days of wandering through the flooded streets of New Orleans. After arriving in Baton Rouge, at the first of the FEMA villages, called "Renaissance," the New Orleans team seemed to be the only one providing medical assistance. With almost no resources, they set up triage units under the trees and began to treat patients. What resources and aid they received came primarily from mobile units from other NACHC Centers around the country; within two weeks, a fully loaded and staffed mobile unit from Sioux City, Iowa arrived.

Andry reported that the challenge of restoring the network of health-care centers he ran in New Orleans still lies ahead. The problem, he said, is particularly acute for facilities that did not operate from Federal buildings, since there will be no FEMA funds forthcoming to rebuild, and no ready source of private capital has been found. Andry also pointed out that commercial interests are making demands for the remaining commercial space, making it almost impossible to find a place to relocate a Center even if funding were forthcoming. Yet, he concluded, it is urgent that the Centers' infrastructure be restored, since they operate as the ultimate safety net for the uninsured. Andry said that during Katrina and immediately thereafter, the eyes of the world were on New Orleans; he hopes they are still watching.

FIGURE 1.1

1969: 15 States Had Federal Legislated Minimum Hospital Beds Per 1,000

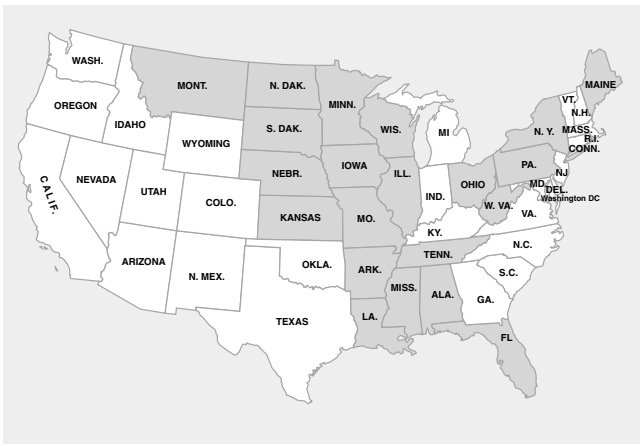


Source: U.S. Statistical Abstracts.

The Federal Hill-Burton Law of 1946, "The Hospital Survey and Construction Act," mandated a minimum standard of hospital beds per 1,000 people. The system has been dismantled.

FIGURE 1.2

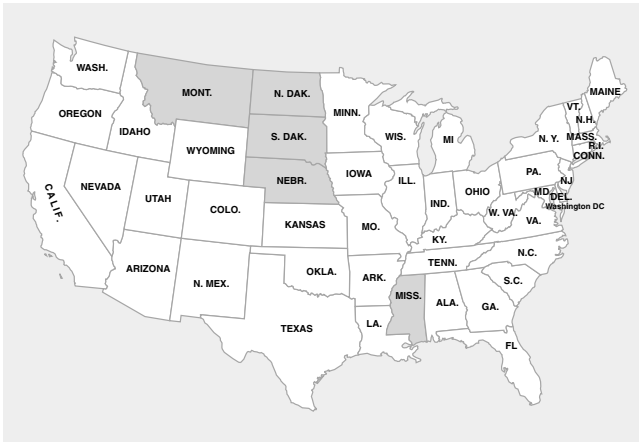
1980: 21 States Had Federal Legislated Minimum Hospital Beds Per 1,000



Source: U.S. Statistical Abstracts.

FIGURE 1.3

2000: 5 States Had Federal Legislated Minimum Hospital Beds Per 1,000



Source: U.S. Statistical Abstracts.

Cutting the Red Tape

Next, Dr. Maria Crawley gave a compelling report on her week in the Biloxi area of southern Mississippi in March and April of 2006. Dr. Crawley said that it took her months simply to cut the red tape she encountered when she, along with hundreds of other frustrated medical personnel who volunteered to go to the devastated area, were told that their medical insurance would not cover their activities. While most found no way around this, Crawley was fortunate in that her Center in Las Cruces turned out to have "gap" coverage, which allowed her and her nurse to finally go to Mississippi in the last week of March. The doctor recounted her shock when, as the plane landed, she exclaimed over the lovely colors of the roofs below, only to find that they were the blue hurricane tarps still in place eight months after the disaster. The second shock was the difficulty in simply finding her patients, since street signs and even landmark buildings were simply nonexistent.

While Dr. Crawley is a pediatrican, and arrived expecting to treat children, she found 40-80% of the patients presenting for treatment were adults. Believing that a specialist was needed, Crawley considered returning to New Mexico, but stayed because she realized that if she left, there would be no treatment available. As she put it, she turned herself into a "pseudo-internal medicine specialist" overnight.

Among the most striking medical conditions that Dr. Crawley found among both children and adults were the high levels of anxiety, depression, and sleep deprivation. Without exception, every person she treated was using some form of medication to get any sleep at night. And while she encountered many cases of what medical professionals in the area had begun referring to as "Katrina krud," persistent respiratory problems, the most pressing medical conditions were not directly caused by the hurricane, but were chronic illnesses worsening under conditions of neglect and devastation. All of these problems, both mental and physical, Crawley emphasized, need to be addressed by both the state and Federal governments.

Crawley was followed by Dr. Gary Wiltz, a New Orleans native who interned at the city's well-known Charity Hospital, whose doors have remained shut since the hurricane. Dr. Wiltz stressed the importance of the health centers in New

Orleans and throughout Louisiana, saying that they operate from a sense of mission, and that each one should have the slogan from the Statue of Liberty welcoming the "huddled masses" over its door. He stressed the importance of rebuilding and expanding the Centers.

Hospitals Remain Closed

The picture painted by the panelists makes it clear that virtually no rebuilding of the Gulf health-care infrastructure has occurred—a finding supported by statistics assembled in the NACHC report from a Government Accountability Office (GAO) survey and other sources. In Louisiana, among the nine acute-care hospital systems in service pre-Katrina, five remain closed, and those that were open were operating at only 20% of their pre-storm bed capacity as of February 2006, according to the GAO report. Charity Hospital—once one of the largest safety-net hospitals in the area, serving mostly the uninsured and Medicare patients, has shut its doors. Charity's closure, including that of its Level 1 trauma center—the only one in the region—has shifted demand to the few remaining emergency departments. At the time of the GAO investigation, no decision had been made, as to whether to rebuild or replace Charity. The GAO also found that more than three-fourths of New Orleans safety-net clinics were closed. Of the 19 that remained open, most were operating at less than half-capacity. Specialty and diagnostic care were "extremely limited," and primary and emergency care were available at significantly reduced levels. Shocking, given the testimony on the state of mental health of Katrina survivors: There is not a single designated inpatient psychiatric bed in New Orleans Parish.

Compounding these difficulties is a workforce shortage. The New Orleans Parish Medical Society reports that of the estimated 3,200 Society physicians who were practicing in the Orleans, Jefferson, and St. Bernard Parishes prior to Katrina, only between 1,400 and 1,600 remain. A study by the University of North Carolina at Chapel Hill estimated that the decline in active patient-care physicians in six Louisiana parishes and four Mississippi counties may number as high as 6,000. The scarcity of nursing-home and home-health-care services for discharged patients, such as the elderly and chronically ill, has also lengthened hospital stays and exacerbated the lack of hospital beds, creating a logjam and increased costs of care.

Worsening Health Conditions

In addition to the anticipated skin problems and gastrointestinal illnesses associated with flooding and its aftermath, the combination of destroyed infrastructure, medical personnel shortages, and the continuing clean-up problems, is resulting in a still-growing level of medical need with no means to meet it. Burning storm debris, increased diesel exhaust, heavy metals, toxic chemicals, mold, and fumes from glue and plywood in new trailers, have caused a spike in lung and nasal irritation, exacerbating already high pre-Katrina levels of asthma and respiratory problems. Health-care experts continue to warn people with serious respiratory conditions to stay away from the ravaged areas.

As noted above, medical personnel were surprised to find that chronic, as opposed to storm-caused illnesses, were the biggest health concern to be addressed in evacuation centers in Arkansas, Louisiana, Mississippi, and Texas, accounting for 33% of the 14,531 clinical visits in the initial days following Katrina.

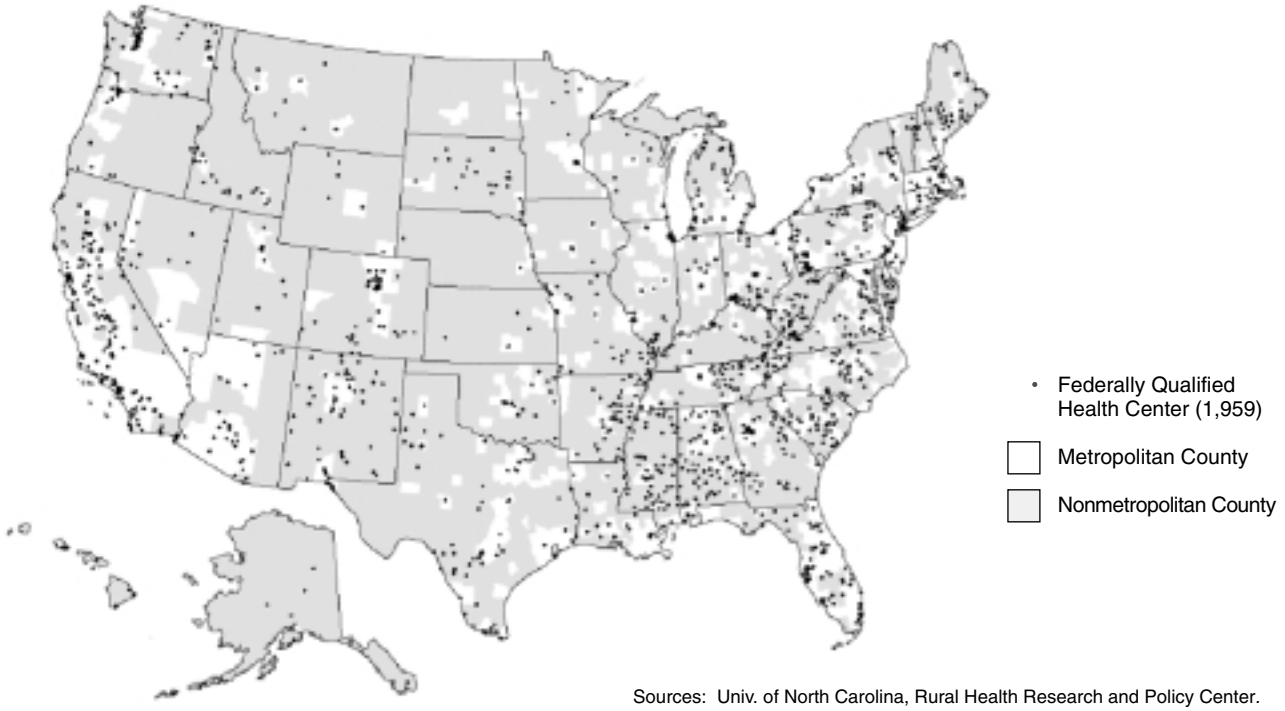
Mental-health problems are worsening as adults and children continue to live in temporary lodging and struggle to rebuild their lives with little or no help. The Greater New Orleans Medical Foundation estimates that approximately 60% of the population of New Orleans suffers from depression and/or post-traumatic stress disorder. Officials at Louisiana State University's Health Science Center reported that nearly a third of the children being screened at clinics are showing signs of emotional trauma, such as nightmares and flashbacks. At least 100,000 children who lived through Katrina are likely to suffer post-traumatic stress disorder, according to a study by PriceWaterhouseCoopers released in 2006. New Orleans officials estimate that the suicide rate has tripled in that city since before the storm.

No Funds for Brick-and-Mortar Rebuilding

Attendees and media at the press conference were naturally startled by the failure to rebuild and the references by the panelists to the lack of funding hampering their efforts. In answer to these questions, NACHC Vice President Dan Hawkins reported that only a tiny portion of the funds appropriated by Congress and community block grants have found their way to affected community health centers. Hawkins explained that Federal funds earmarked for the region's community health centers pay for the sites' day-to-day operations, but that the centers get no upfront funding for "brick-and-mortar" rebuilding—those expenses can only be reimbursed. And for now, the reimbursement process is stuck in a morass of red tape, he said. He called for Federal aid to go directly to the rebuilding effort, and that while FEMA has the money, it has "no system for dispensing it."

While the Bush Administration may have no system for urgent rebuilding, it is chock-full of plans for using the Katrina debacle to further its intention to deliver less and less health care to the nation. Hawkins reported that the leadership of the NACHC has joined with Health and Human Service Secretary Mike Leavitt to urge that any rebuilding of the health-care infrastructure in Louisiana and Mississippi will rely on Community Health Centers as its foundation, in explicit opposition to what is termed "costly institutional care"; meaning full-service, high-technology hospitals. Leavitt recently made the Administration's intentions crystal clear when he stated that the circumstance of Katrina has "contrived to create an unprecedented opportunity" to remodel health

FIGURE 4
Location of 1,959 Federally Qualified Health Centers, 2001



Sources: Univ. of North Carolina, Rural Health Research and Policy Center.

care around a lower-cost community-based model. The shameless Leavitt had described a new health-care system in which "community health centers dot the landscape, and every citizen has a medical home where the goal is to keep people healthy, not just treat them after they get sick. With Federal funding as a bait, many institutions that should know better are getting into the act and giving up the fight to restore full-service hospitals. In July of 2006, Louisiana state officals announced the creation of the Louisiana Health Care Redesign Collaborative, which will propose changes to the Medicaid and Medicare programs aimed at reshaping the system to rely on primary and preventive care, and curtail what is termed inappropriate and costly care, such as visits to emergency rooms.

Hill-Burton Provided Community Health Care

The United States once had an efficient high-technology, community-based medical system, that of the public and private hospitals built under the 1946 Hill-Burton legislation; a system destroyed by the HMO shareholder-value insanity. From the end of World War II, until the 1970s, the Hill-Burton policy prevailed: the principle that ratios of health-care delivery hospitals, nursing homes, diagnostics, medical staff, and so on, should be provided on a per-capita basis, as required according to where people lived, and based on their demographics. Following World War II, it was seen as a Federal responsibility to provide all citizens with access to health-care delivery infrastructure, which meant a commitment to seeing that there was a public hospital or several—depending on density of population—located in each of the 3,069 counties of the nation. This is in stark contrast to the current Federal attitude, where the Administration denies responsibility, even for a nationwide catastrophe such as a bird flu pandemic.

Before passage of Hill-Burton, some 1,700 counties had no public hospital at all. Hospital construction proceeded and the ratio of beds and other resources to population increased steadily—until the introduction of the 1973 HMO Act which declared the profit motive primary in medical care.

In addressing this problem, economist and stateman Lyndon LaRouche called for a reversal of the policy of "primitive accumulation" against health care instituted in the 1970s, and the need to situate the threatened national health care "as a special feature of a broader issue, the general breakdown, through mismanagement and neglect, of national basic infrastructure as a whole." (See Lyndon H. LaRouche, Jr., "Situating Health Care Policy: What Is Infrastructure?" *EIR* April 8, 2005.) The experience of Hurricane Katrina poses the question of the reversal of this takedown of health care and all other categories of infrastructure, and a return to Hill-Burton policy. This should include an appropriate role for the Community Health Center network, which has demonstrated its flexibility and dedication under conditions of crisis.