D.C. Officials Conspire With Bankrupt Privateers To Destroy Health Care

by Edward Spannaus

District of Columbia government officials are again colluding with the corrupt Doctors Community Healthcare Corp. to slash health-care services for city residents. At the same time, more evidence of fraud and corruption is emerging in the ongoing bankrupty proceedings of DCHC's financial partner, National Century Financial Enterprises, in Ohio. NCFE has announced that it will shut down over the next few months. It will probably take DCHC down with it, because of DCHC's involvement in National Century's fraudulent financing schemes.

David Coles, a restructuring specialist appointed to manage NCFE after its bankruptcy filing, was quoted in the *Wall Street Journal* as saying: "I've been involved with some badly-run businesses, some of which we've been able to recuperate, others which we've had to liquidate; but I've not had experience with a falsification of information component that compares to this."

Corruption Costs Lives

In 2001, in a rotten deal between D.C. Mayor Anthony Williams, the Wall Street-controlled Financial Control Board, and DCHC—facilitated by lying promotion of the plan by the *Washington Post*—the District's public-health system was dismantled. The privatized system thus created was handed over to DCHC—a gangster-like outfit partially owned by the NCFE health-care looters.

DCHC's Nov. 20, 2002 bankrupty, which followed NCFE's filing by two days, includes Greater Southeast Community Hospital in the District, which was supposed to "replace" D.C. General Hospital, the city's only public hospital, as part of the corrupt privatization plan.

D.C. General provided top-quality medical care to all who came through its doors, regardless of ability to pay. The HMO-type system which was created when D.C. General was shut down (called the D.C. Healthcare Alliance), was supposed to enroll 60-80,000 people, but it has only signed up about 26,000—and the quality of care they are getting has drastically deteriorated.

As was predicted at the time by *EIR* and other opponents of the shutdown of D.C. General, the entire city-wide hospital system is being overwhelmed by the effects of the hospital's closure, and by cutbacks of service at Greater Southeast—and it is now about to get a lot worse, under the perverted scheme being proposed by the city and by DCHC.

At a Dec. 10, 2002 "Healthcare Summit" held by city officials, executives from the District's private hospitals described how their emergency rooms are overcrowded, ambulances are being diverted, and their institutions are serving many more uninsured patients. They also reported that they were not getting paid by the D.C. Healthcare Alliance, forcing them to bear the losses.

Reports are circulating in D.C. about more patients who have died because they had to be taken to distant hospitals for treatment. Ambulances are often stacked up outside emergency rooms, waiting one to two hours, or more, before patients receive care.

Under the privatization contract, Greater Southeast was required to provide emergency services equivalent to those that had been provided by D.C. General's Level One Trauma Center. As was predicted at the time, DCHC's Greater Southeast never even tried to establish such a Trauma Center, and now its low-level emergency room is often closed for lack of doctors and nurses. District officials never even tried to enforce this provision of the contract, and have allowed DCHC to flagrantly violate other parts of the contract—which may be related to DCHC's generous financing of Mayor Williams' re-election campaign.

(Two more deaths the week of Jan. 21 may be attributed to DCHC's failure to establish a trauma center at Greater Southeast. Two teenagers who were critically injured in a auto accident just across the District line in Prince George's County, Maryland were taken to Greater Southeast, where they died of their injuries. Health-care activists say that the two might have survived, if the Trauma Center at D.C. General had still been open.)

In November 2002, for the second time, Greater Southeast failed inspection by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and as a result JCAHO has refused to restore Greater Southeast Community Hospital's full accreditation, leaving it in "conditional" status. JCAHO said that, except for the "special circumstances" of the hospital's bankruptcy filing last month, it would have refused to give Greater Southeast any status at all, because of the poor conditions found during re-inspection.

As *EIR* has previously reported, an inspection last Spring

found numerous safety and health violations. Problems found this time include: emergency room patients having to wait because of back-ups in the ER and intensive care; medical charts not being updated properly; lack of medical supplies; no effective infection-control program; the safety plan not updated; and preventive safety maintenance not being performed.

Officials Allow Contract Violations

Now, city government officials and DCHC are conspiring to obtain court approval for still further violations of the 2001 contract.

City Administrator John Koskinen is complaining that even the maintenance of a scaled-down emergency room at the old D.C. General Hospital campus is costing the District too much money, and he is proposing that it be cut back to an "urgent-care" center that is only open 12, instead of 24, hours a day. The urgent-care center would not be open to ambulances, and would treat nothing more serious than cuts, bruises, and fractures.

DCHC claims that Greater Southeast has lost $14 million in running the emergency room and outpatient clinics at D.C. General. The reason given for the "losses" is that nearly 30% of patients treated at D.C. General have no medical coverage or insurance of any sort. The lesson seems to be: If you can't make a profit off of medical treatment, forget the treatment and throw the patients on the scrap-heap.

DCHC's lawyers have taken the Koskinin plan, and are presenting it in their own name, as part of a motion to modify the contract, to be presented to the Federal Bankrupty Court.

(By way of background, we note that Koskinen is by profession a budget-cutter and asset-stripper, not a health-care expert. He was Deputy Director for Management of the Federal Office of Management and Budget in the mid-1990s, and then headed President Clinton's hoaxster Y2K Commission. For over 20 years before going to OMB, Koskinen was an executive of a "turnaround" management firm dealing with bankrupt and insolvent companies.)

The Koskinen plan has been met with outrage by executives of the District's private hospitals, who point out that it would divert more than 10,000 patients a year to their facilities. They note that their hospitals are already being overwhelmed by the effect of the shutdown of D.C. General and the curtailing of patient services at Greater Southeast. "The impact on other hospitals, in terms of patient care capacity and finance, is overwhelming," said Sister Carol Keenan, the chief executive of Providence Hospital. "The city is playing that down. . . . It's a crisis point for everybody who uses a D.C. hospital—not just the poor."

Observers expect Federal Bankruptcy Judge S. Martin Teel to give DCHC a lot of leeway to continue reduced-scale operations, because he does not want to be seen as shutting down the only hospital in the eastern, poorest section of the city.

Council Mandates Public Hospital

The only sensible thing to do in the face of this looming health-care disaster would be to immediately reopen D.C. General as a full-service public hospital, and for the city to take over and operate Greater Southeast as an adjunct of the revived public hospital. But Williams and Co. seem determined to stick with their lunatic scheme, no matter what the cost in suffering and lives.

The D.C. City Council, which unanimously opposed the closing of D.C. General, has recently mandated the construction of a new public hospital, but as part of a compromise on the disposition of the 67-acre D.C. General campus—a prime piece of riverfront real estate. Over the past year, Mayor Williams and his Office of Planning developed a "Master Plan for Reservation 13," which allows for the development of high-rise private residential and commercial buildings on the site. The Council then passed legislation which sets aside two acres of the 67, for "the development of a new full-service hospital, including approximately 200 beds, and emergency department with Level 1 trauma care, general pediatric care," and other services.

At the insistence of David Catania, the Council member who had fought the hardest against the DCHC/NCFE takeover, the legislation requires that the proceeds from any sale or lease of property on the site be deposited into a fund for a public hospital on the acreage set aside for that purpose. The Council also said that if instead, a full-service private hospital is constructed, the special fund must be used "solely for the purpose of providing health care to the uninsured residents of the District." The bill also requires that all property taxes and commercial sales taxes collected on the site, also be dedicated solely to the provision of health care for uninsured District residents.

The LaRouche proposal

As *EIR* has documented, Reservation 13—as the site has been known since George Washington's time—was originally designated for public health purposes by President Washington and the designer of the City of Washington, Pierre L'Enfant.

The most comprehensive proposal for the appropriate development of the site was presented last year by Lyndon H. LaRouche, whose movement led the fight in 2001 to save D.C. General, as the leading edge of a national campaign to scrap the HMO system and revive the post-war Hill-Burton system. LaRouche proposed that Congress reconstitute D.C. General as the centerpiece of a research and teaching complex dedicated to national health-care security, operating under the authority of the U.S. Surgeon-General and the U.S. Public Health Service. The provision of health-care in the nation's capital is a responsibility of the United States Congress, and in this case, this complements the requirement for an expanded, strategically-oriented national health-care research program located in Washington, D.C.