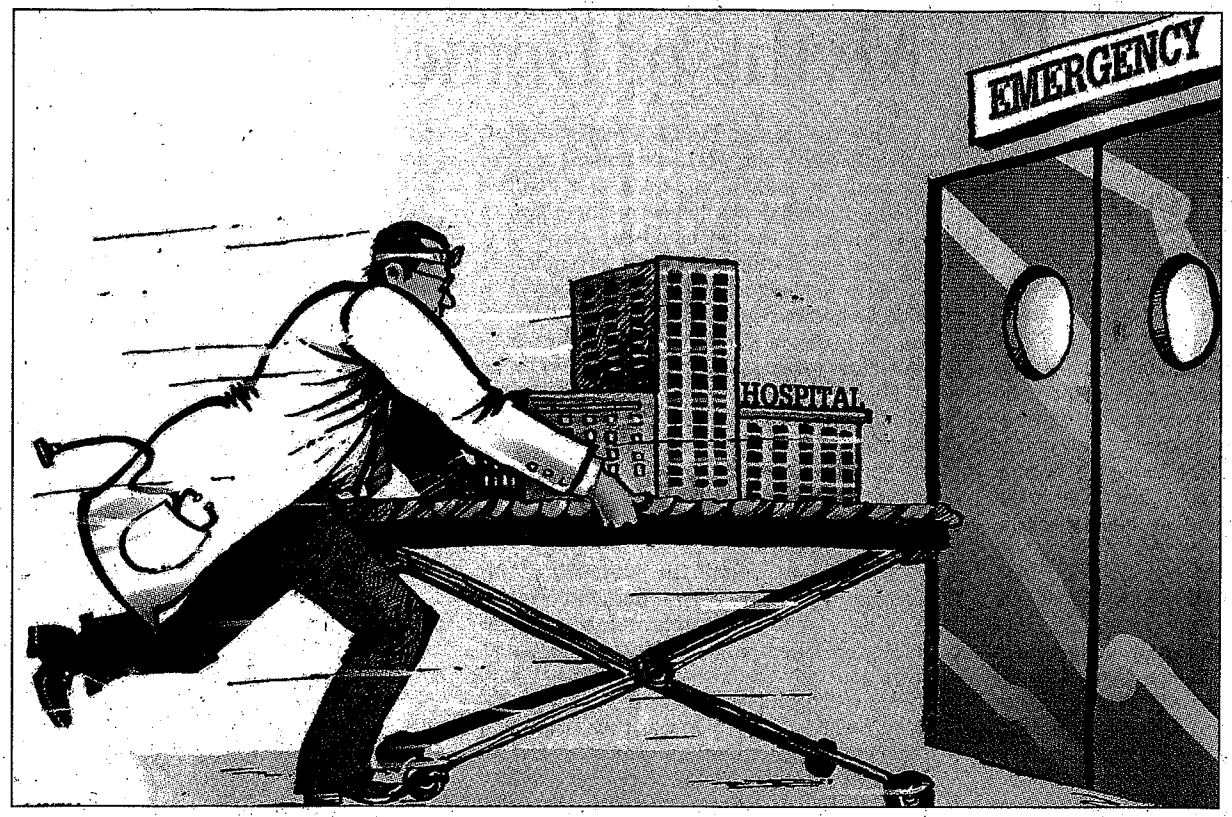

D.C. General Must Be Resuscitated

BY PEDRO MOLINA

WASHINGTON POST
3 DEC. 2000

When the 43rd president of the United States is inaugurated on Jan. 20, he will stand with his back to D.C. General Hospital, 1.9 miles behind him. But he will not be able to ignore the District's deepening hospital crisis.

D.C. General's survival affects everyone who lives or works in the District, yet the hospital's future is being decided recklessly. One of four options for the hospital's future is likely to be chosen soon:

- An outright closing.
- Conversion to a truncated free-standing emergency room.
- Privatization and affiliation with other hospitals.
- Continued revitalization supported by emergency financial aid.

CLOSING: D.C. General provides almost 40 percent of the city's free care, which means that its closure would undermine the health of 80,000 residents who lack health insurance.

Closing the hospital also would undermine the finances of other city hospitals that are willing to care for D.C. General's displaced patients. Other D.C. hospitals can't afford to dispense much more free care because their profit margins average only 29 percent of Maryland's and 14 percent of Virginia's.

Further, other hospitals are badly placed to serve D.C. General's patients. Five hospitals with 1,100 beds have closed or relocated from the eastern half of the District since 1950. If Greater Southeast were destabilized by D.C. General's closing, little care would be left east of the Capitol. Last year D.C. General was the District's second-biggest trauma center, with 51,000 emergency room visits. Closing it would further crowd emergency rooms, harming all citizens.

CONVERSION: Mayor Anthony Williams has proposed converting D.C. General into a "community access hospital," which would offer minor emergency room services and short-term stabilization. Inpatient care would be provided at other hospitals. All services would somehow be coordinated.

Repeated assertions that this concept is well-tested, however, are false. Seemingly similar arrangements involve tightly integrated networks, typically in middle-income areas.

A community access hospital's start-up costs also are high. Time and expertise are not available to design the needed record-keeping, payment and coordination arrangements for thousands of patients. Financial, administrative and medical disasters likely would result.

PRIVATIZATION AND AFFILIATION: What hospital has the medical and financial resources—or the time—to revitalize D.C. General? And which partner will trust the D.C. government to continue to finance care for patients lacking insurance after privatization? Both the community access hospital and privatization-affiliation proposals could effectively grease the skids for closing D.C. General—without guaranteeing delivery and financing of substitute care.

REFORM: Because no alternative to renewing the hospital is acceptable—and because the hospital is needed—this is the sensible choice. Patients need medical security. Saving D.C. General will require long, hard work, and affiliation with another hospital might be one element of reform, but it can't be the mainstay.

Reform will require that all parties—doctors, unions, administration, the Public Benefit Corp., D.C. government and others—pledge to do everything necessary to cut costs, raise revenues, improve quality and prepare to renew the physical plant. The hospital's new management has begun many of these tasks. It needs time, support and public money to go the distance.

Congress should act to provide emergency cash relief to stabilize D.C. General. If this is not done immediately, the administration should provide emergency relief through a Medicaid waiver, as it did for Los Angeles County Hospital in 1995 and again in 2000. If neither is forthcoming, the Public Benefit Corp. should place the hospital in receivership so that it can reorganize under a court's protection and continue to pursue its vital mission.

—Alan Sager

is a professor of health services at Boston University's School of Public Health.