Interview: Dr. Ray Terry

The downsizing of health care in D.C.

Dr. Terry, Ph.D., is a Public Health Analyst in the Washington, D.C. Health Department. He was interviewed by Dr. Ernest Schapiro.

EIR: Is it fair to say that there have been massive changes in the delivery of health care in the city?
Terry: We are going through major changes, with the creation of a new Health Department, the creation of a PBC [Public Benefits Corp.], and the whole movement toward managed care in the private and public sector. We really are in a major state of transition.

EIR: Would you say it's orderly?
Terry: There's such a thing as chaotic consistency. You've got the Control Board, and you've got consultants coming here, every which way, from all angles. You wonder, when is the lull period going to come? There's a fear of the unknown; people don't know what the hell's happening, who's in charge. Is it the mayor, the Control Board, the consultants? Where will all of this end?

EIR: You mentioned that previously, a lot of health care was delivered through the Health Department.
Terry: Yes, in the health clinics. That was for the low-income individuals, or the uninsured. Those clinics have now been moved over to the PBC, a quasi-governmental organization, with the focus being on D.C. General Hospital. . . . There'll be probably some type of privatization activity of health care, but that's to be defined. You say you have a PBC, but what does that mean? You have a public side and a private side.

EIR: Let's say you are an indigent person, and you come to one of these clinics to have your diabetes and high blood pressure treated—
Terry: Yes, and also the old concept of the "well baby" clinics, where you bring the baby if you don't have enough money. And D.C. General has always been the public hospital. Now, the question becomes, what is the PBC, and how will it function, in relation to the poor? Will it be into managed care, managed behavioral care? Going after the same kind of contracts that other private agencies are going after? It's a possibility.

EIR: Where are the people going who depended on these clinics? How many of these clinics have closed?
Terry: They are in a process of determining how many should be kept open. The clinics were transferred from us, the Department of Health, over to D.C. General. They're still there. How many will be on the chopping block? D.C. General has ambulatory care. The resources being scarce, they may have to look at how to distribute that clinic population. . . .

EIR: I've heard it said that private clinics and physicians are located outside the areas where poor people live.
Terry: Probably a good assessment. Most of your health care services are in the Northwest Washington area. The city is trying to get health care providers to work in those at-risk communities, the Southeast-Northeast corridor, but it is true that the bulk of your health care services are rendered in the Northwest.

EIR: Are these places still open?
Terry: Yes, so far as I know.

EIR: But the people are under the threat that the clinics will close, and they will have to go for care to the Northwest.
Terry: It could happen, it's an uncertainty. They could have an option whether to go there, or into managed care. The clinics at D.C. General may have the option to go into managed care.

EIR: I noticed that the number of babies delivered at D.C. General was down to 1,000. It had been around 2,000 several years ago. Where do women go for their deliveries?
Terry: Good question. Maybe they are being picked up by managed-care contracts. There are quite a few of them in the city. Last week, there was a report of a decrease in infant mortality rate in the city. Is that because of access to programs like the Healthy Start Program, with people becoming more educated? Something is happening, since the numbers are going down slightly. Or, are people having fewer babies? Also, they have better health status, when you get to them between the first and second trimester, not the last trimester.

EIR: That would seem to me to include nutritional support throughout pregnancy, plus also treating AIDS-infected mothers with AZT.
Terry: That would cut the infant mortality rate. That, however, can increase your morbidity rate. We don't know what disabilities the AIDS babies will have in later years.

EIR: They will be living longer, because of the new drugs.
Terry: But even if they are living longer, they may be living longer with chronic disabilities. Also, the Baby Boomer population in the district is living longer, but with chronic disabilities. Is the system putting something together to deal with this? That's another cost factor. If I have chronic illness or disability and I'm between 40 and 64, I may or may not be eligible for Medicaid—definitely not Medicare.

EIR: I was reading how, in terms of TB mortality, the problem is being able to provide directly observed treatment, ensuring that patients are getting their prescriptions and taking them properly; that this has been the key to the decline of TB mortality in New York. But in D.C., they don't seem to have the vehicles and the manpower to go out and take care of this. We have here a real breakdown.
Terry: You can say that, it's true. The other question you look at, when there is a decreasing population, is, does that mean you need less money for health care purposes? No. The ones who stay are the Baby Boomers; they have homes here. They are living longer, they will need more care per person. The younger ones are moving out. So that decrease in population may be very misleading, in reference to the assertion that there should therefore be a decrease in the number of services offered. We may have to redefine the type of services, based on the fact that you are getting another generation that is living longer.

EIR: So, here you are getting a reduction in the health care dollar per person, while in fact you are getting a population which has a greater need of health care per person.
Terry: You got it. The illnesses they have, and the fact that they may live longer and therefore use the services more—i.e., both the elderly, and the Baby Boomers who are moving into being elderly.

EIR: Who is responsible for evaluating these problems and proposing solutions? Is there any central body in D.C. responsible for devising solutions?
Terry: One would assume it would be your new Health Department. The question is, are they ready to do this?

EIR: Would you have enough people there—
Terry: To even do it.

EIR: And the adequate technologies—
Terry: To collect the information you need.

EIR: Would you have the cooperation of the health care practitioners and bodies to provide the—
Terry: Information, and if you look at another type of person, in addition to the people who are known legal residents, what about the others that are coming in?

EIR: You mean the illegal residents, or even legal immigrants—
Terry: Who may be, theoretically, just living with their sons and daughters, and may have no desire to become citizens, but who are growing older in the old country, and their children have brought them over—what kind of health services do they get? We'll have to look at this.

EIR: I think under the welfare reform bill, these people can no longer get any health care, isn't that right?
Terry: So, what are we going to do if they are staying here? Say, if they have a chronic disability, and they are 59 years old. How long does it take to become a citizen?

EIR: Seven years.
Terry: So, they're in their sixties. Our own population is getting older. We've got the new immigrants coming in, who are going to have to have some health care, even though they may not be citizens; we have to do something, because we need to stop the spread of disease. And they're not eligible to get full services, whatever that means, until such time as they become American citizens, which may be a seven-year process. Once they get there, they are entitled to whatever everyone else is entitled to. Others may argue that they haven't paid into the system, because they may or may not be working. So what do we do?

Then, we've got the prison population, which is living longer. They will be coming out, perhaps with disabilities that we are going to have to deal with.

EIR: I understand that if you are 24 months in a homeless shelter here, the chances are 50% that you will have a positive tuberculin test.
Terry: Isn't that amazing? You are only talking about 63 square miles. And it's a very transient square mile. People are in and out. Suppose you are only staying for two months, and you get sick, where are you going to go for health care? To one of the institutions that are here. We're a very transient kind of community, with people in and out, probably more than any other state, if you want to look at this as a state. This is both foreigners and people travelling back and forth across-country. They can stay for a couple of months.

EIR: As of now, can you go to D.C. General in that situation?
Terry: Technically, you can go to any emergency room. If it's a major problem, they'll stabilize you and then probably transfer you.

EIR: But with the changes coming in, that will no longer be an option, I imagine?
Terry: That's a good question, that is the big question mark. Where do you go?

EIR: That might also be the question for people who live here who are indigent.
Terry: Where do you go? Or which entitlement program do you fall under?

EIR: Is there any systematic report on what happens to people who have no place to go, what happens to them because necessary care is being postponed?
Terry: There is no systematic report on that, that has to be looked into. It takes awhile. We've got cross-jurisdictional

stuff, where I may go into Prince George's County and wind up in an emergency room over there. But that's the kind of resources that need to be here, to look at what is happening, what is the trend, where people seek the services, what will be the impact of all these changes on where people will go to get services. If everybody is going to be covered under the PBC or a managed care plan, will that be an attractive kind of mechanism to have people come in? They may be homeless and establish themselves as homeless in the District. They may say: Hey, over here we can get three meals and health care. Not that you want to be cruel against the homeless, but that can really put [a strain] on your system, if the package is too attractive. Those are the questions that are up in the air.

EIR: I read an interview in the *City Paper* with Dr. Abramson, who runs the Zacchaeus Clinic. She said that because of the cuts at D.C. General, she doesn't necessarily refer people there anymore, because they can't get things done there. A patient who needed a gastroscopy couldn't get it done over there—that's the kind of thing you're beginning to run into—
Terry: That's right. What are we going to do about it? That's something that is going to have to be addressed.

EIR: There is a big problem with accountability in this: Who is minding the store? Who sees to it that with these changes, for everything you remove, you put something in its place that is as good or better? Who is there to make sure that actually happens?
Terry: Or, at least to make sure that the people have adequate access to something as good or better. Now, one could argue that it's the Health Department or that it's the "office of the mayor's something something," but who is the responsible entity to make sure that the question of access, as well as the question of quality, is dealt with? Because it's one thing to have access to a program, but will the program have the quality that the person deserves, with or without the ability to pay?

EIR: This is a bit dizzying. It sounds as though you have a chaotic process, putting it mildly. What does this situation do to the individual physician? How does this affect the individual working in this environment?
Terry: I think it's affecting health care workers, whether they're inside the hospital or not. You have to remember that we've come to "downsizing." Hospitals are downsizing, government is downsizing. Individuals who heretofore were providing health care services will find themselves without health care coverage, because *they* are no longer employed. So it's having a rippling effect, both on the employee, as well as the residents of the District. The question is, how do you turn that around? You've had a lot of people who have taken early outs [early retirement], so that they could remain within a system where they could still have some form of health benefits as they retire. These are the doctors and nurses who are themselves no longer being employed.

Privatized prisons: a travesty of justice

by Dennis Speed

Over 1,500 Washington, D.C. residents are currently incarcerated in Youngstown, Ohio, at a torture-chamber operated by the Corrections Corporation of America (CCA). There, prisoners are not only unable to maintain contacts with close relatives, as well as legal counsel, but they are also abused, mistreated, and denied medical care and reading materials. They are treated like dogs.

Under the guise of "tough justice," the D.C. City Council has, as of an Aug. 29 vote to contract with CCA, become complicit in a gross violation of the rights, not only of these prisoners, but of their families. Two years ago, the 39th Police District of Philadelphia made headlines, when it was discovered that its officers had engaged in the frame-up of hundreds of African-American citizens, including a grandmother who was forced to spend several years in jail for a crime she did not commit. The "prison industry," worth $30-40 billion, with only 4% of the system privatized so far, is now selling stock on Wall Street. In July, CCA formed a holding company, CCA Realty Trust, which sold every share it offered on the New York Stock Exchange, for $400 million. Its chief executive officer, Mike Quinlan, once ran the D.C. Federal Bureau of Prisons. He was also the head of the U.S. Bureau of Prisons, during the Bush administration, heading it while Lyndon LaRouche was incarcerated.

The issue of criminal abuses of prisoners in privatized facilities is a dire one for the District of Columbia. With the impending closing of the Lorton Correctional Facility, by 2001, the intent is that all D.C. felons will be dispersed to prisons around the country, and that many—at least 50% of those currently in Lorton—must be placed in privatized jails by 2003, according to sources.

Not just a D.C. problem

With the frenzied drive to make America's number-one construction industry—the building of prisons—yield as great a profit as possible, it will become a lucrative business to supply as many "employees" as are necessary for the slave-labor army of America's poor and illiterate. In a 1996 report entitled "Unhealthy Choice: How New York State Is Sacrificing Education for Incarceration," New York State Sen. Alton R. Waldron revealed that the 16 districts with the worst-performing schools in New York City, are identical to those from which 46% of juvenile criminals hail. Is it possible, that disciplinary problems, and "juvenile delinquents," will be