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Friday, April 27, which thoroughly discredited the proposed contract. Moreover, hospital employees were continuing to meet and mobilize within the hospital against the privatization scheme.

(Moreover, there are persistent reports that Greater Southeast Community Hospital, owned by DCHC and the prime contractor, was on the verge of bankruptcy and needed an immediate bailout, which the contract and takeover of D.C. General would provide.)

So, the Control Board declared an "emergency"—which provided the pretext for the Board to utilize the special powers reserved to the Council for emergency situations. Under emergency conditions, the Council is empowered to enact emergency measures. Such measures are only in effect for 90 days, but that would be enough for the Control Board to carry out its dirty work: to ram the contract through over the opposition of the elected Council, and to begin the takeover and dismantling of D.C. General. This allowed them to also shut down the employee organizing and meetings which were taking place, and to summarily fire the CEO and other top officials who were actively and publicly opposing the privatization scam.

And so, declare an "emergency" is what the Control Board did. One of the resolutions adopted by the Control Board states as its purpose: "To declare the existence of an emergency with respect to the need to privatize comprehensive community-based health care for uninsured residents of the District and to abolish the Public Benefit Corporation." (The PBC was created by the Council in 1996, and it operates D.C. General Hospital and six community health centers.)

The justification for the declaration of an emergency, was that the Control Board had recommended that the Council repeal the PBC law, and that it adopt laws for the privatization of health care. Because the Council failed to adopt the Control Board's recommendations, which therefore supposedly triggered Congressional restrictions which would cut off funds for D.C. General, the Board declared that these circumstances "constitute emergency circumstances making it necessary that the Health Care Privatization Emergency Amendment Act of 2001 be adopted immediately."

The Council's offense was to do their duty as elected officials, by representing the best interests of their constituents and the District as a whole. Democratically elected officials, carrying out their duties, were declared to be the cause of the "emergency."

Last December and January, *EIR*'s Founding Editor Lyndon LaRouche warned that, with the George W. Bush Administration taking office during onrushing financial and economic collapse, the nation would soon likely head into a period of "crisis management" and "rule by decree." What has just happened in Washington, D.C., is just a foretaste of what is to come, unless the Congress and the courts return to their constitutional commitment to establish justice and to promote the general welfare.

Michael Barch

We Are Committed To Staying This Battle

On April 30, the D.C. Control Board ousted Michael Barch as chief executive officer of the Public Benefit Corp., along with other officers of the PBC, which had been established to operate D.C. General Hospital. Barch had been an outspoken opponent of the Control Board's illegal efforts to shut down the hospital. Here are his remarks to the weekly town meeting called by the Coalition to Save D.C. General Hospital on April 4, held at the Union Temple Baptist Church in Washington, D.C.

Barch was introduced by the meeting's moderator, Dr. Abdul Alim Muhammad.

What we are hearing today, about the Mayor's plan, or [the Mayor's health-care adviser] Ivan Walks' plan—and we don't know what the plan is, because the truth of the matter is, it isn't a plan: It is an evolving contract, arrived at through negotiations; has very little substance to it, going in, and I suspect it'll have a lot of complications to it coming out.

But, let me tell you about PBC II, a little bit, and about D.C. General. And I must admit, when I came to D.C. General, I came with a lot of Northwest Washington prejudice [referring to the wealthier quadrant of the city]. And those prejudices were formed, largely, from the *Washington Post,* from Av Goldstein's articles. And, I thought I was coming into a hospital, where I had massive chaos, with labor unions, I had a medical staff that was sub-optimal, and had a wonderful history, but was in a nose-dive.

The truth of the matter was, it was anything but that. We had labor unions that needed to have a sense of leadership, and needed to have a sense of faith in that leadership, in order to enter into sensible talks. Labor is not a problem at D.C. General; quite the opposite: It's one of its strengths. The medical staff, as we learned *very* quickly, after my presence, is actually outstanding. And the joint commission saw it that way. And, it's not just the medical staff—it's the entire staff.

To think of what these people have lived through over the last four or five years, and *intensified* over the last five or six months—just to stick it out, and hang in there, it's a commitment to this community, unlike any other hospital I've ever been in.

Taking Down a Comprehensive Health System

But, the PBC is so much more than just a hospital (and then, I'll get to comparing the plans, a little bit): It is really a

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The Coalition to Save D.C. General Hospital did not give up when the Control Board moved to shut the hospital and fire its officers. Here, demonstrators on May 9 prepare for popular "reinstatement" of CEO Michael Barch and two other directors sacked by the Control Board.

health system. And, it's a health system that consists of a large number of school health programs, taking care of all of our kids in the schools out there; it's the public health clinics, delivering primary care; it's the specialty clinics, with all the specialty physicians there. I first learned about those specialty physicians way back when I was working for health care for the homeless, and we had no place, after we took care of their primary care problems, to refer the patients. And, so, when we needed specialty care, we referred to D.C. General. And, that's *every* free clinic, every not-for-profit clinic all over this city, depends on D.C. General specialty care.

And, the hospital. The hospital is a wonderful place, where you have a dedicated staff taking care of problems in a very culturally sensitive way. They've been dealing with the population for 200 years. They know it. It's not learning it: They know it. They know it instinctively. They know the problems of the family; they know the problems on transportation, and communication. They deal with the language problems. It is something to behold, to watch the dedication of that staff to the patient care.

Now, they're talking about disassembling all of this, and it is a system. It is one where, now, we're installing the information systems that allow the communications and the immediate referral into the specialty clinics and stuff, from our primary care clinics into the specialty, and right straight into the hospital, if you need to. What they're talking about, is putting into place, what they say is a higher quality operation. Well, I'm telling you: It isn't. What we see that they're talking about is, contracting out to a mess of different services—to physicians in the community, to a hospital here, to a group of clinics to manage our clinics and some other clinics; and knit together a mess of contracts, which then the Health Department will keep track of. Anyone that's ever run a system knows, once you try to do it in that fashion, it's going to be so fragmented and so hard to keep track, that the patients are going to get lost in the cracks—that it doesn't take an expert in health care to tell you that.

So, it's not the quality. Greater Southeast [Community Hospital], by the way, by outside values, got an 84% [accreditation rating] and we got a 94, in the joint commission survey, so it puts it in perspective in terms of quality.

It's not about cost. Let me tell you about the cost, because you're going to hear a lot about cost in this argument. And, the truth of the matter is, this whole thing supposedly started over cost. It started over the overruns that D.C. General experienced year after year after year. Now why do you think they experienced overruns in the budget? Because they were underbudgeted. They have been given $45 million, basically, in subsidy every year, to take care of every uninsured, every person regardless of ability to pay, that would walk through their doors, whether it be the hospital, the ER, the clinics, wherever in the system that they landed.

And, we knew that, year after year after year, that $45 million wouldn't get it. That we spent, virtually every year, about $75 million. And, guess what? Given $45, we overspent by $30 million every year. And, you've read in the paper that

we've overspent the last three years by $109 million? That was a guesstimate by Av Goldstein, back about six months ago, which has stuck. The actual overage was about $92.7 million.

And, we can run the system that they're now going to contract out—in a *totally comprehensive* fashion, that is: taking care of all the correctional care, all the prisoners in the jail; take care of MPD arrests, take care of youth services; take care of all the patients who walk in; take care of every agency we've always taken care of in the District; supply the people that need drugs with drugs; and do everything we have done and continue to work at *improving* doing it, for $75 million. And, what you're going to hear coming out of the evolving contract, is something well in excess of $100 million to do it.

Now, they're going to probably get fairly tricky about how that's presented. I'm sure it'll come out in a bifurcated or split-up fashion, where there'll be one main contract for $66, and then they'll take all the correctional care and put it in another one for about another $40; and then, they'll give a supplemental for the trauma care. (And, by the way, they're going to build a whole new trauma system, which every expert says can't be done in three months, which everyone says would minimally take a year, *if they could do it at all!*)

And our trauma service is as good as any! Probably better than most in the country. And it is definitely outstanding at dealing with penetrating wounds—as demonstrated when we had the shooting up on Capitol Hill a couple of years ago, and one of the victims, one of the guards shot, unfortunately, went to G.W. [George Washington Hospital] and another to the [Washington] Hospital Center, and the shooter—with nine bullets in him—came to D.C. General; and guess who's alive today? And this is the trauma service that they're going to replace! Good luck!

Provider-Patient Relationship Is Primary

It's not about the quality; it's not about the cost; it's not about access. Because the truth of the matter is—and I am 100% supportive of universal coverage. I think health care is a right, and we should all have a right to it, and have a right to go where we want to go. But the truth of the matter, the insurance card does not guarantee access. No matter, if we have universal coverage, I would still keep the systems that we're putting in place at D.C. General, flowing in the direction that we're heading it, and head it by *providers*—doctors and nurses—on the point to give the care, and keep the relationship between the patient and the provider, not between an insurance company and the provider.

I think we all have listened to the media long enough to learn about HMOs. How HMOs make money, is, they take in a premium, and they pay out less on that premium than they take in. And, the way they do it, is by limiting access to emergency rooms, to specialty care, and to hospitals. And, yet, we're hearing talk about, "Our real concern here is to improve access, so that we can increase the health status of the District of Columbia." It ain't gonna work that way. The best way to do it, is the way that we're talking about doing it, and that's through a provider-driven system, that constantly builds bridges to the patients, and works, starting with the kids in the school health programs, to educate them as to the importance, and works decades to change behavior. It's *nothing* we're going to do overnight. And, we're *certainly* not going to do it through an insurance card; we're going to do it through personal relationships of providers to patients.

Anyway, that's a little insight into the two health questions we're looking at: the Mayor's and the Public Benefit Corp. II, or the Urban Health Campus on Capitol Hill—whatever you want to call it. We at D.C. General and at the PBC—and I'm not speaking for my board, I've got to make sure I say that, every time I speak; but I am speaking for the staff, and for the committed professionals in that organization, we are *committed* to staying this battle, to seeing it out, and to not losing sight of the community and the patients we serve, and our responsibilities.

And I agree with Dr. Muhammad: Truth and the right *will* prevail here.

Thank you.

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