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UNEQUAL ACCESS: THE CRISIS OF HEALTH CARE INEQUALITY FOR LOW-INCOME AFRICAN-AMERICAN RESIDENTS OF THE DISTRICT OF COLUMBIA

ROBYN WHIPPLE DIAZ*

“There is a health care crisis in our city...when the life expectancy of our African-American men is 10 years less than the rest of America, and when this country’s highest rates of infant mortality, diabetes, and HIV infection are in our own backyard, it is time to fix health care in Washington.”—Mayor Anthony A. Williams¹

“Of all forms of inequality, injustice in health care is the most shocking and inhumane.”—Rev. Martin Luther King, Jr.²

INTRODUCTION

Merely three years ago, District of Columbia Mayor Anthony Williams proclaimed that health care is a “right” and he expressed continued commitment to the elimination of health disparities in the District, particularly those based on race and income.³ For years, the Mayor and the D.C. Department of Health have voiced concerns regarding the limited access to health care providers facing residents of Southeast D.C., and have publicized their goals of ensuring the stability of hospitals in that quadrant. Yet despite the myriad speeches and proposals, poor minority residents of Southeast D.C. face ever-increasing obstacles to the access of basic health care services.

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1. Neighborhood Action Alert, District of Columbia Mayor’s Office (Mar. 12, 2001), at http://www.dc.gov/mayor/news/2001/march/03_12_01_naa.shtml (last visited Jan. 31, 2004).

2. D.C. PRIMARY CARE ASS’N, DCPCA HEALTH JUSTICE UPDATE, SAFETY NET REFORM 1 (Apr. 29, 2003) (quoting Martin Luther King, Jr.).

3. Press Release, D.C. Mayor’s Office, Mayor’s Commitment to a Healthy District of Columbia, (Feb. 20, 2001), at <http://www.dc.gov/mayor/news/statement.asp?id=80&mon=200102&archive=1> (last visited Jan. 31, 2004).

The safety-net hospitals that traditionally served the most economically depressed and hypersegregated⁴ area of the District are now imperiled. D.C. General Hospital's inpatient services were terminated in 2001, leaving only the emergency room and several clinics open at the D.C. General site. In early 2003, an agreement was reached to close the emergency department which had long served as the primary provider of medical services for uninsured patients in need of health care but who lacked the financial resources to pay for it.⁵ Greater Southeast Community Hospital, the only remaining acute care hospital in the Southeast quadrant, has filed for bankruptcy protection. Its financial woes gravely impact its ability to care for the District's neediest residents, as electricity outages, staff layoffs, and emergency room closures are common occurrences.⁶ The situation at Greater Southeast is so dire that the hospital has lost its accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which may result in its ineligibility for receipt of Medicaid and Medicare reimbursement, the lifeblood of any hospital serving the poor.

Without access to these hospitals, many of D.C.'s poor African-American residents face extremely limited access to health care services, while those in the remainder of the metropolitan area choose from an abundance of providers vying to serve them. In order to receive preventive care, residents of Southeast D.C. often must travel to another neighborhood, one with which they are likely unfamiliar, or forgo care altogether.⁷ The sickest patients, those in need of emergency treatment, may be diverted to hospitals several miles away.

This paper argues that combined racial and economic segregation in hypersegregated inner city neighborhoods have created a crisis of health care access for poor, African-American residents. The focus of this paper is on the concentration of black poverty in Southeast D.C., which has created significant unmet demand for health care services and has been exacerbated by federal and local failures to effectively address the impact of geography on access to care.

Part I describes the gap in accessible care caused by concentrated African-American poverty. Accessibility of health care is measured by the affordability

4. DOUGLAS S. MASSEY & NANCY A. DENTON, *AMERICAN APARTHEID: SEGREGATION AND THE MAKING OF THE UNDERCLASS* 74 (1993). Hypersegregation is a term coined by Douglas Massey and Nancy Denton. It refers to the severely high levels of segregation faced by many poor blacks living in America's inner cities. Hypersegregation occurs when blacks are highly segregated on four of five dimensions at once. Those dimensions are: (1) unevenness; (2) racial isolation; (3) clustering of black neighborhoods; (4) concentration of blacks in a geographic area; and (5) centralization of blacks in a geographic area. *Id.*

5. D. C. PRIMARY CARE ASS'N, *supra* note 2, at 6-7.

6. See *infra* notes 110-12 and accompanying text.

7. A small number of primary care clinics are located in Southeast D.C. and are operated by organizations such as Unity Health Care and Children's National Medical Center. D.C. PRIMARY CARE ASS'N, *PRIMARY CARE SAFETY NET: HEALTH CARE SERVICES FOR THE MEDICALLY VULNERABLE IN THE DISTRICT OF COLUMBIA* 8-9 app.C (Oct. 2003)

and location of services. Part I will illustrate that the high number of poor African-American residents who are uninsured or on Medicaid, combined with a maldistribution of primary care and emergency services, leaves many of Southeast D.C.'s residents without access to health care. Part II is a critique of federal and local decisions that have exacerbated this crisis, such as federal threats to cut disproportionate share payments to safety-net hospitals and the District government's apparent inability to ensure the survival of at least one fully functioning hospital in Southeast D.C. Finally, Part III sets forth the normative arguments for the provision of accessible health care to those in concentrated African-American poverty and recommends several policies that would address the ways in which geography structures the inaccessibility of health care services. This paper concludes that geographic health care gaps in areas of concentrated black poverty can be redressed by (1) simultaneously preserving affordable access to hospitals, and (2) increasing the number of primary care physicians practicing in hypersegregated areas, such as Southeast D.C.

I. A POPULATION AT RISK

A. Economic and Racial Segregation Create Concentrated Black Poverty.

Low-income households are disproportionately urban, and economic segregation has created "poverty pockets," or areas of concentrated poverty, in many inner cities.⁸

The racial segregation that has persisted in this country has caused these poverty pockets to be inhabited primarily by African-Americans.⁹ Douglas Massey and Nancy Denton concluded that African-Americans remained heavily segregated throughout the 1970s and 1980s, and that one-third of African-Americans lived "under conditions of intense racial segregation."¹⁰

Although racial segregation in the United States decreased between 1980 and 2000, the 2000 Census clearly indicated that residential segregation for African-

8. JAMES W. FOSSETT & JANET D. PERLOFF, THE KAISER COMM'N ON THE FUTURE OF MEDICAID, THE "NEW" HEALTH REFORM AND ACCESS TO CARE: THE PROBLEM OF THE INNER CITY 8 (1995). Studies suggest that economic segregation continues to increase. *Id.* at 11-12. "In 1990, about 2800 census tracts (out of 45,000 total) had poverty rates in excess of forty percent of the tract population, compared to about 1000 in 1970." Scott A. Bollens, *Concentrated Poverty and Metropolitan Equity Strategies*, 8 STAN. L. & POL'Y REV. 11, 11 (1997).

9. FOSSETT & PERLOFF, *supra* note 8, at 8. "Low-income households, particularly blacks, have become increasingly concentrated in depressed inner-city areas." *Id.*

10. MASSEY & DENTON, *supra* note 4, at 75-77.

Americans remained higher than for all other racial or ethnic groups.¹¹ Racial segregation rates remain extremely high, particularly in large cities with significant African-American populations.¹² Approximately 60% of African-Americans live in large urban areas, compared with 46% of whites.¹³

In many cities, out-migration of people and employers to the suburbs make it difficult for poor minorities to access jobs and educational opportunities in suburban locations, leaving them trapped in hypersegregated inner city neighborhoods. "Because racial segregation concentrates poverty and systematically builds deprivation into the residential structure of black communities, Douglas Massey and Nancy Denton have deemed it 'the principal feature of American Society that is responsible for the creation of the urban underclass.'"¹⁴

1. *Racial Segregation and Poverty in the District of Columbia*

The percentage of people in the District living in poverty is highly concentrated, and increased during the 1980s and 1990s.¹⁵ In 1998, the D.C. poverty rate was approximately 22%, with one in five District residents living in poverty.¹⁶ Pockets of concentrated poverty in the District are primarily concentrated east of the Anacostia River, in Wards 6, 7, and 8. More than two-thirds of the District's poverty census tracts (where poverty was 30% or more) are located in those three wards.¹⁷

11. See JOHN ICELAND ET AL., U.S. CENSUS BUREAU, CENSUS 2000 SPECIAL REPORTS PUB. NO. CENSR-3, RACIAL AND ETHNIC RESIDENTIAL SEGREGATION IN THE UNITED STATES: 1980-2000, 59, 95 (2002), available at <http://www.census.gov/prod/2002pubs/censr-3.pdf> (last visited Jan. 31, 2004).

12. *Id.* at 59. The 2000 Census revealed that metropolitan areas with 1 million or more people had higher residential segregation than middle-sized or small metropolitan areas. *Id.* In addition, the dissimilarity index was higher in areas with large African-American populations. *Id.* at 64.

13. FOSSETT & PERLOFF, *supra* note 8, at 4 (citing William H. Frey, *The New Urban Revival in the United States*, 30 URB. STUD. 741, 754 (1993)).

14. Bollens, *supra* note 8, at 11 (quoting MASSEY & DENTON, *supra* note 4, at 9). Whether or not you agree with the term "urban underclass," many scholars have accepted the notion that racial segregation and economic segregation combine to create what might be considered dismal living conditions for many African-Americans. See Sheryll D. Cashin, *Civil Rights in the New Decade: The Geography of Opportunity*, 31 CUMB. L. REV. 467, 470 (2001) ("[O]ne third of all African Americans live in hypersegregated communities that none of us would choose for ourselves—communities where children and adults are frequently terrorized by violence, where schools typically perform far below the standards necessary for participation in the economic and educational mainstream, and often where more men are not working than are working.").

15. CAROL J. DE VITA ET AL., CTR. ON NONPROFITS AND PHILANTHROPY & THE URBAN INST., POVERTY IN D.C.—THEN AND NOW 15-16 fig.7 (2000).

16. *Id.* at 15.

17. *Id.* Ward 8 suffers from the highest poverty rate in D.C., with 38% of all residents and more than 50% of children living in poverty. D.C. PRIMARY CARE ASS'N., PRIMARY CARE SAFETY NET: HEALTH CARE SERVICES FOR THE MEDICALLY VULNERABLE IN THE DISTRICT OF COLUMBIA 9-10 (2002).

Massey and Denton's findings regarding concentrated black poverty come to life in D.C. Approximately 60% of D.C.'s 572,000 residents are African-American; and African-Americans, particularly those who are low-income, are heavily concentrated in the Southeast quadrant of the District.¹⁸ Low-income African-Americans are four times more likely than low-income whites to live in the inner city, and twenty-five times more likely to live in high poverty neighborhoods, resulting in heavily concentrated black poverty.¹⁹ The extent of concentrated black poverty in D.C. is revealed by 2000 Census numbers, illustrating that one-quarter of D.C.'s African-American population lives in poverty, comprising more than three-quarters of all D.C. residents living in poverty.²⁰

The dissimilarity index is often used to measure residential segregation by "compar[ing] the spatial distributions of different groups among units in a metropolitan area."²¹ The United States Census describes the dissimilarity index as a means of measuring "the percentage of a group's population that would have to change residence for each neighborhood to have the same percentage of that group as the metropolitan areas overall."²² Use of the dissimilarity index indicates that segregation of African-Americans from whites in the D.C. metropolitan area is high—63 on a scale of 0 to 100.²³

2. Health Risks Arising from Economic and Racial Segregation

Poverty-related Health Problems

As a result of the concentrated minority poverty found in inner cities, poverty-related health problems are also disproportionately high in the inner city. The geographic concentration of poverty in areas with higher-than-average exposure to occupational and environmental hazards puts poor inner city residents at higher risk for conditions such as asthma and cancer.²⁴ The poor and uninsured

18. D.C. PRIMARY CARE ASS'N., *supra* note 17, at 6; BARBARA ORMOND ET AL., THE URBAN INST., HEALTH CARE FOR LOW-INCOME PEOPLE IN THE DISTRICT OF COLUMBIA 2 (1999). More than 90% of the population of Wards 7 and 8 are African-American. D. C. PRIMARY CARE ASS'N., *supra* note 17, at 7.

19. MARGERY AUSTIN TURNER & CHRISTOPHER HAYES, THE URBAN INST., POOR PEOPLE AND POOR NEIGHBORHOODS IN THE WASHINGTON METROPOLITAN AREA 2 (1997), available at <http://www.urban.org/urlprint.cfm?ID=6565> (last visited Jan. 31, 2004).

20. D.C. PRIMARY CARE ASS'N., *supra* note 17, at 9. In comparison, only 8% of D.C.'s white population lives in poverty. *Id.*

21. ICELAND ET AL., *supra* note 11, at 119 app. B,

22. ICELAND ET AL., *supra* note 11, at 119 app. B.

23. MARGERY AUSTIN TURNER ET AL., THE FANNIE MAE FOUND. & THE URBAN INST., HOUSING IN THE NATION'S CAPITAL 3 (2002).

24. See DENNIS P. ANDRULIS & BETSY CARRIER, MANAGED CARE AND THE INNER CITY: THE UNCERTAIN PROMISE FOR PROVIDERS, PLANS AND COMMUNITIES 1-3, 11-14 (1999); FOSSETT &

are also less likely than the affluent to have a regular source of health care, either because such care is unaffordable or because it is simply not available in their neighborhoods.²⁵ Lack of access to care may lead to further decline in the health status of the poor.

Race-related Health Problems

Certain health conditions are experienced at disproportionately high rates in the African-American community. African-Americans live, on average, six years less than whites and have higher rates of infectious disease and certain cancers than the general population.²⁶ In addition, African-Americans living in the inner city have significantly higher-than-average asthma and cirrhosis-related death rates.²⁷

Concentrated black poverty in D.C. means that national health statistics for African-Americans are not only reflected within the District, but in many cases the District's statistics are worse. D.C.'s Commission on Public Health found that African-Americans in the District "were more than four times as likely as whites to die prematurely (before 65), of heart disease, asthma, pneumonia, and some cancers."²⁸ The life expectancy of African-American men in the District is ten years less than the average life expectancy in the rest of the nation.²⁹ The 2000 D.C. infant mortality rate for African-American mothers was nearly 10 times higher than the rate for white mothers, while nationally the infant mortality rate for African-American mothers was 2.5 times that for white mothers.³⁰ Not surprisingly, the Southeast quadrant, suffering from both concentrated poverty and racial segregation, has the city's highest risk of infant mortality, heart disease, and cancer.³¹

PERLOFF, *supra* note 8, at 22 ("The disparity in health status between poor, high-risk, inner-city populations and more prosperous, lower risk, suburban ones is likely compounded by reduced access to adequate diet and housing, greater exposure to drugs and STDs, and higher stress and uncertainty associated with inner-city residence.").

25. ANDRULIS & CARRIER, *supra* note 24, at 15-16.

26. ANDRULIS & CARRIER, *supra* note 24, at 12-13.

27. ANDRULIS & CARRIER, *supra* note 24, at 13.

28. Elisabeth Rosenthal, *Health Problems of Inner City Poor Reaching Crisis Point*, N.Y. TIMES, Dec. 24, 1990, at A1.

29. Neighborhood Action Alert, *supra* note 1; BUILDING A CITY THAT WORKS FOR EVERYONE, NEIGHBORHOOD BY NEIGHBORHOOD, BUILDING A COMMUNITY-BASED HEALTH CARE SYSTEM, at 7-2, available at http://www.dc.gov/mayor/policy_agenda/pdf/14_chapter_7.pdf (last visited Jan. 31, 2004); David Brown & Avram Goldstein, *Death Knocks Sooner for D.C.'s Black Men*, WASH. POST, Dec. 4, 1997, at A1.

30. D.C. PRIMARY CARE ASS'N., *supra* note 17, at 14; MATERNAL & CHILD HEALTH BUREAU, DHHS, CHILD HEALTH USA 2002 23 (2002), available at <ftp://ftp.hrsa.gov/mchb/chusa02.pdf> (last visited Jan. 31, 2004).

31. ORMOND, ET AL., *supra* note 18, at 2. Note that the District as a whole has the highest infant mortality rate in the country. See CHILDREN'S DEFENSE FUND, THE STATE OF CHILDREN IN AMERICA'S

B. Impediments to Health Care Access in Poor, Minority Communities.

1. Lack of Access to Primary Care Services

Access to primary care services is generally considered vital for good health.³² Most urban areas have a generous supply of physicians, including primary care physicians. The location of teaching hospitals in urban centers with large populations and a significant number of hospitals make cities an attractive place for physicians to practice.³³

Unfortunately, the abundance of physicians in many urban areas typically does not translate into an adequate supply of physicians within inner cities, particularly those with poor, minority populations. The urban poor frequently have difficulty obtaining primary care services. “A study of 10 urban areas between 1963 and 1980 found a 45% decline in the availability of office-based primary care in poverty-stricken areas.”³⁴ Shortages of primary care physicians (PCPs) in inner cities have been attributed to a number of disincentives for primary care physicians to locate in economically depressed urban areas, including the presence of (1) fewer people with “disposable income” and greater reliance on Medicaid; (2) high levels of drug abuse, violence, and poverty; and (3) a “[s]icker population, language differences, higher rates of noncompliance and missed appointments.”³⁵

Low Medicaid physician payments and high administrative costs associated with Medicaid also may discourage physicians from practicing in poor, medically underserved communities.³⁶ In order to prosper with a substantial number of

UNION: A 2002 ACTION GUIDE TO LEAVE NO CHILD BEHIND 47 (2002). Ward 7 has the highest homicide rate in the city, as well as the city’s highest death rates due to cancer and diabetes. *Id.* Ward 8 has the highest number of teen births, infant deaths, and low birth weight babies in the city. D.C. PRIMARY CARE ASS’N., *supra* note 17, at app. A, 69, 72 (2002).

32. Noah Lewin-Epstein, *Determinants of Regular Source of Health Care in Black, Mexican, Puerto Rican, and Non-Hispanic White Populations*, 29 MED. CARE 543, 544 (1991) (“[A] regular source of care is believed to facilitate timely and continuous treatment and contribute to better health.”); see also Leiyo Shi, *The Relationship Between Primary Care and Life Chances*, 3 J. HEALTH CARE POOR & UNDERSERVED 321, 321-25 (1992) (finding that access to a PCP is more significantly correlated to good health than availability of hospitals or specialty care physicians).

33. FOSSETT & PERLOFF, *supra* note 8, at 24.

34. American College of Physicians, *Inner-City Health Care*, 126 ANNALS OF INTERNAL MED., 485, 487 (1997).

35. ANDRULIS & CARRIER, *supra* note 24, at 20.

36. FOSSETT & PERLOFF, *supra* note 8, at 27. Physicians and advocates contend that increased physician reimbursement under Medicaid might make working in poor areas more lucrative. FOSSETT & PERLOFF, *supra* note 8, at 50. Many advocates for the poor have argued that the District government should change its method of calculating Medicaid provider payments in order to increase Medicaid fees for physician services. Chris Silva, *Medicaid Rate Increases Unlikely til '03*, WASH. BUS. J., April 6, 2001, available at <http://washington.bizjournals.com/washington/stories/2001/04/09/story6.html?t=printable> (last visited Jan. 31, 2004); Medicaid fees for physician services in the District lag behind most other metropolitan areas, making it undesirable for health care providers to accept

Medicaid patients, a doctor needs to subsidize the costs of participating in Medicaid with privately insured patients, who are charged higher-than-normal prices for care.³⁷ The segregation of poor populations, particularly poor African-American populations, however, makes it unlikely that doctors frequently succeed in attracting such a mix of clients.³⁸

Limited access to PCPs for the poor means that African-Americans living in concentrated poverty receive regular care less frequently than others, and may instead rely on hospital-based care.³⁹ Care received by low-income African Americans in urban areas is often “hospital-dependent, crisis-oriented, episodic and fragmented.”⁴⁰ Studies have shown that low-income African-Americans may have a preference for hospital-based care. This “preference” may be attributed to any of the following factors: (a) residential segregation and location of hospitals in low-income African-American neighborhoods; (b) lack of private physicians with offices in low-income African-American neighborhoods; (c) perceived cultural competency of hospitals; or (d) financial barriers to seeing private physicians, such as insurance requirements and co-payments.⁴¹

Reliance on hospital-based care means that many poor African-Americans delay seeking treatment for medical problems and fail to receive the preventive care often necessary to detect health problems.⁴² In addition, unnecessary use of hospital-based care results in higher health care expenditures for public safety net programs.⁴³ This problem has been recognized by the D.C. government, which has repeatedly cited the need for affordable primary care services in poor, minority neighborhoods.⁴⁴

Medicaid patients. MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA, ISSUE BRIEF: MEDICAID REIMBURSEMENT (Aug. 2001), available at http://www.msdc.org/body_medicaid_brief.htm (last visited Jan. 31, 2004). However, some studies indicate that physicians would not change their practices for small income increases. Rather, the substantial income increases that would be needed to entice physicians to these areas may be unrealistic, particularly in light of budget shortfalls and a national trend toward reducing Medicaid funding. FOSSETT & PERLOFF, *supra* note 8, at 50-52.

37. FOSSETT & PERLOFF, *supra* note 8, at 27.

38. FOSSETT & PERLOFF, *supra* note 8, at 27.

39. Studies have demonstrated that many low-income African-Americans obtain hospital-based care at significantly higher rates than whites. See Marsha Lillie-Blanton et al., *Site of Medical Care: Do Racial and Ethnic Differences Persist?* 1 YALE J. OF HEALTH POL'Y, L. & ETHICS 15, 28 (2001) (finding that African-Americans are “twice as likely as whites to rely on a hospital-based provider as a source of regular care.”).

40. American College of Physicians, *supra* note 34, at 487 (citing Gerald E. Thomson, Health Care in Underserved Urban America: Implications for National Health Reform (1993) (unpublished paper, presented at conference sponsored by Columbia University, New York)).

41. Lillie-Blanton et al., *supra* note 39, at 29.

42. Lewin-Epstein, *supra* note 32, at 544-45.

43. Lewin-Epstein, *supra* note 32, at 544.

44. See Neighborhood Action Alert, *supra* note 1; Letter from D.C. Mayor Anthony A. Williams, to District Residents (Mar. 28, 2001), available at http://www.dc.gov/mayor/health_care/letter.shtm (last visited Jan. 31, 2004).

An example of the extent of primary care accessibility problems in the District is the distribution of pediatricians in the city. The American Academy of Pediatrics says that an area is underserved if there are more than 2,500 children per pediatrician.⁴⁵ The affluent Northwest quadrant and the suburb of Bethesda, Maryland combined have a pediatrician-to-child ratio of 1 to 400, while the Southeast quadrant has a ratio of 1 to 3,700.⁴⁶ Wards 6, 7, and 8, comprising the most economically depressed areas of the city, have a combined total of 29 pediatricians, with a ratio of 6.4 pediatricians for every 10,000 children.⁴⁷ These numbers are shocking, particularly given the fact that equal percentages (roughly 25%) of the city's population live in the Northwest and Southeast quadrants.⁴⁸

The inequalities do not end with access to pediatricians. More affluent areas of the District have more than three times the number of PCPs than the poorer neighborhoods.⁴⁹ The District has more than double the number of generalists (another term for a PCP) per 100,000 population than the nation as a whole, but there are more than twice as many people in the District underserved by PCPs than in the rest of the nation (approximately 25% in the District as compared with 9.5% for the United States).⁵⁰ Despite the high number of providers per capita, 71 of D.C.'s 192 census tracts are designated as health professional shortage areas (HPSAs).⁵¹

2. *Financial Barriers to Care*

A major obstacle in obtaining access to health care is economic. Provision of services to those without adequate medical insurance is unattractive to health care providers, and may cause hospitals and individual physicians to terminate or severely limit services to the uninsured. Low Medicaid reimbursement for physician services and for emergency and outpatient care also makes Medicaid recipients less desirable than patients with other types of insurance.⁵² Communities with substantial numbers of residents incapable of paying for

45. FOSSETT & PERLOFF, *supra* note 8, at 24.

46. ANDRULIS & CARRIER, *supra* note 24, at 19.

47. Thomas W. Chapman, *Inadequate Primary Care*, WASH. POST, Jan. 10, 2003, at A20, available at 2003 WL 2367246.

48. BARBARA A. ORMOND & RANDALL R. BOVBJERG, *THE URBAN INST., THE CHANGING HOSPITAL SECTOR IN WASHINGTON, D.C.: IMPLICATIONS FOR THE POOR* 11 (1998).

49. ORMOND, ET AL., *supra* note 18, at 6.

50. STATE HEALTH PLANNING & DEV. AGENCY, D.C. DEP'T OF HEALTH, *PRELIMINARY DRAFT: PRIMARY CARE CHAPTER, DISTRICT OF COLUMBIA STATE HEALTH SYSTEMS PLAN 10-11 tbl.1* (2003).

51. ORMOND & BOVBJERG, *supra* note 48, at 10. HPSAs and medically underserved areas (MUAs) are "geographic area[s], population group[s], or medical facilit[ies] that ha[ve] been designated by the Secretary of the Department of Health and Human Services as having a shortage of health professionals." NAT'L HEALTH SERV. CORPS, DHHS, *HEALTH PROFESSIONAL SHORTAGE AREAS FACT SHEET*, available at <http://www.urban.org/uploadedPDF/dchosp.pdf> (last visited Jan. 31, 2004).

52. See FOSSETT & PERLOFF, *supra* note 8, at 27.

medical services often have difficulty convincing health care providers to remain within the neighborhood.⁵³ This trend is especially problematic in poor black communities, possibly because of the large number of African-Americans who are uninsured.⁵⁴ This is best illustrated in Southeast D.C. where high numbers of poor African-Americans, who are uninsured or on Medicaid, face a severe shortage of accessible health care providers.

The Uninsured and the Problem of Uncompensated Care

More than forty-one million people in the United States were uninsured in 2001.⁵⁵ The large number of uninsured individuals requiring medical care forces many health care organizations to provide uncompensated care, meaning care that is not paid for by insurance (public or private) or personally by the patient. It is estimated that in 2001, such organizations provided \$34.5 billion in uncompensated care to uninsured individuals.⁵⁶ In 1999, hospitals alone (excluding physicians and community health centers) provided \$20.8 billion in uncompensated care, an amount equivalent to more than 6% of their total expenditures.⁵⁷ Uncompensated care cuts into hospitals' bottom lines, reducing operating margins and straining their financial stability.

The challenge of financing health care for the poor is exacerbated by the concentration of minority poverty in the District. Approximately 30% of District residents below 200% of the federal poverty level are uninsured,⁵⁸ and a full 20% of the general D.C. population is uninsured.⁵⁹ A disproportionate share of the District's uninsured are concentrated in Southeast D.C., with 38% residing in Wards 6, 7 and 8.⁶⁰ Thus, any health care provider located in Southeast D.C. will be faced with a higher uncompensated care burden than providers geographically located in more affluent neighborhoods.

53. Gwendolyn Roberts Majette, *Access to Health Care: What a Difference Shades of Color Make*, 12 ANNALS HEALTH L. 121, 126 (2003).

54. *Id.* at 123 (stating that the national uninsured rate for African-Americans is 22.8%, compared with 12.7% for whites).

55. Jack Hadley & John Holahan, *How Much Medical Care Do the Uninsured Use, and Who Pays For It?*, HEALTH AFF. WEB EXCLUSIVE W3-66 (Feb. 12, 2003), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.66v1.pdf> (last visited Jan. 31, 2004).

56. *Id.* at W3-69.

57. *Id.* at W3-70.

58. ORMOND ET AL., *supra* note 18, at 1.

59. ORMOND & BOVBJERG, *supra* note 48, at 1.

60. NICOLE LURIE & MICHAEL STOTO, RAND, HEALTH INSURANCE STATUS IN THE DISTRICT OF COLUMBIA 9 tbl.5 (2002), available at <http://www.dcpca.org/media/rand%20report.pdf> (last visited Jan. 31, 2004).

Reliance on Medicaid

Medicaid insures one in seven Americans under age 65.⁶¹ Under federal guidelines, each state establishes its own benefits packages, provider payment rates, and eligibility standards.⁶² Until the late 1990s, the District's federal matching rate for Medicaid was 50%; it was increased to 70% under the District of Columbia Revitalization provisions of the 1997 Balanced Budget Act.⁶³

The District's per capita Medicaid expenditures in 1996 were the highest of all the states.⁶⁴ The District's high level of Medicaid expenditures can be partly attributed to the city's high poverty levels and to the significant health problems faced by poor District residents. For example, the District has the highest rate of AIDS cases reported per 100,000 population of all states and the second highest rate of new cancer cases per 100,000 population.⁶⁵ When a state has a high number of enrollees with conditions that are expensive to treat, high expenses are unavoidable.

Approximately one-fifth of D.C.'s population is comprised of Medicaid beneficiaries.⁶⁶ "D.C. ranks second highest among the states in the number of Medicaid beneficiaries as a percentage of state population."⁶⁷ The percentage of Medicaid recipients residing in Southeast D.C. is particularly high, with 48% of all adult Medicaid recipients and 53.2% of all child Medicaid recipients residing in Wards 6, 7 and 8.⁶⁸ Thus, health care providers located in or near Southeast D.C. serve a disproportionately high number of Medicaid patients and are financially dependent on Medicaid. They are also particularly vulnerable to cuts in Medicaid funding.

61. NAT'L ASS'N OF CHILDREN'S HOSPITALS & RELATED INSTS., DISTRICT OF COLUMBIA MEDICAID FACTS, available at http://www.aap.org/advocacy/washing/elections.mfs_us.pdf (last visited Jan. 31, 2004).

62. *Id.*

63. ORMOND ET AL., *supra* note 18, at 7. D.C. had 127,500 people enrolled in Medicaid in 2000, an increase of 13,000 people from 1998. D.C. PRIMARY CARE ASS'N., *supra* note 17, at 3.

64. ORMOND ET AL., *supra* note 18, at 9. Note that comparisons of per capita spending are affected by number of persons enrolled, poverty rates, and costs. See ORMOND ET AL., *supra* note 18, at 14.

65. ORMOND ET AL., *supra* note 18, at 15.

66. ORMOND & BOVBJERG, *supra* note 48, at 1.

67. ORMOND & BOVBJERG, *supra* note 48, at 9.

68. D.C. PRIMARY CARE ASS'N., *supra* note 17, App. A, at 68-74.

II. THE DISTRICT'S SAFETY NET FAILURE

A. D.C. General Hospital—What Went Wrong?

For almost 200 years, D.C. General Hospital was the place where the District's poorest, sickest residents were treated. It was by far the most active trauma center in the District, with 2,000 major trauma cases annually, and one of the ten busiest in the nation.⁶⁹ It was also a place where ordinary people, usually poor minorities, came to be treated for less serious conditions: “[I]n come people for treatment of their ulcers and diabetes and stomachaches and dizzy spells because they know of nowhere else to go; in come people looking for free medicine, free food, free shelter from cold weather. . . .”⁷⁰

Yet, in 2001, the hospital's inpatient unit was closed, and the emergency room was closed in 2003 and replaced with an urgent care clinic.⁷¹ The closure of D.C. General, combined with the serious financial and operational problems facing Greater Southeast Community Hospital, which is the District's current primary source of care for the indigent, threatens to leave residents of Southeast D.C. without access to an acute care hospital. In this section, the principal federal and local policy decisions that have contributed to the demise of Southeast D.C.'s hospitals will be critiqued. In addition, privatization of inner-city public health care systems will be discussed in order to assess the effect of the privatization of D.C.'s indigent health care program on the current state of the system.

1. History of Poor Management and Reliance on Limited D.C. Resources

The D.C. government operated D.C. General Hospital until 1997, when its operation was assumed by the quasi-public Public Benefit Corporation (PBC). This freed the hospital from the city's contracting and procurement regulations and allowed it to compete in the market, which the city hoped would make the hospital more financially stable.⁷²

After the PBC assumed control, the city allotted D.C. General millions in annual subsidies, but the hospital had a long history of cash flow shortfalls and

69. Steve Vogel, *'If I Was Shot, This is Where I'd Want to Go,'* WASH. POST, Jan. 4, 1998, at W10, available at 1998 WL 3460116.

70. *Id.* at 3.

71. Craig Timberg, *For Trauma Care, Miles to Go in D.C.; Teen's Death Raises Questions on ERs*, WASH. POST, Nov. 16, 2003, at A1, available at 2003 WL 67886609.

72. ORMOND AND BOVBJERG, *supra* note 48, at 29. See also Randall R. Bovbjerg et al., *Health Care for the Poor and Uninsured After a Public Hospital's Closure or Conversion*, ASSESSING THE NEW FEDERALISM OCCASIONAL PAPER NO. 39, Sept. 2000, at 2, available at http://www.urban.org/UploadedPDF/309647_occa39.pdf (last visited Jan. 31, 2004) (“[p]ublic hospitals...often have trouble responding to...challenges as nimbly as private competitors, as management flexibility and access to capital are harder to achieve under public ownership.”).

reliance on city funds once it exceeded its annual budget.⁷³ For example, the hospital was predicted to use up its subsidy for fiscal year 2001, \$45.3 million, approximately six months into the fiscal year.⁷⁴ D.C. General was also in need of major renovations and had “suffered from years of inadequate maintenance and capital investment.”⁷⁵ This combination of financial woes led to frequent suggestions from individual members of the D.C. government and the United States Congress that the hospital be closed in order to reduce costs.⁷⁶

2. Dependence on Medicaid Funds

As noted above, the District has a large number of Medicaid beneficiaries. The dependence of the population on Medicaid results in a situation in which some D.C. hospitals cannot afford to remain open without Medicaid funding. In 1995, approximately 23% of inpatient days for all hospitals in the District were attributed to Medicaid patients, compared with a national average of less than 15%.⁷⁷

Although reliance on Medicaid funding may be a problem faced by many hospitals in urban areas, the extent of reliance by inner-city hospitals treating poor patients, such as D.C. General, is unparalleled.⁷⁸ Medicaid beneficiaries, because of residential segregation and their low-income status, are concentrated in certain neighborhoods and are likely to seek care at hospitals near their homes. Due to the large number of poor residents living in close proximity to D.C. General, and because of its reputation as a public hospital dedicated to serving the poor, D.C. General received much of its compensation for services provided from the Medicaid system. Over 42% of inpatient days at D.C. General were attributable to Medicaid.⁷⁹ This high number, however, may not adequately represent the full

73. CONG. RESEARCH SERV., THE LIBRARY OF CONG., CRS REPORT FOR CONGRESS APPROPRIATIONS FOR FY 2002: DISTRICT OF COLUMBIA 4 (2002) [hereinafter CRS REPORT FOR CONGRESS]

74. *For the Record: D.C. General to Specify Cuts*, MODERN HEALTHCARE, Dec. 11, 2000, at 18 [hereinafter *For the Record*].

75. ORMOND AND BOVBJERG, *supra* note 48, at 26.

76. See CRS REPORT FOR CONGRESS, *supra* note 73, at 4-5 (detailing the debate over whether to restructure or close D.C. General because of its financial crisis). Note that these problems are not uncommon for public hospitals. Public hospitals often receive most of their revenue from a locality with a fixed tax base. In addition, public hospitals have “generally high staff-patient ratios, and often aging capital plants.” Bovbjerg et al., *supra* note 72, at 2.

77. ORMOND AND BOVBJERG, *supra* note 48, at 12.

78. See LAURIE KAYE ABRAHAM, MAMA MIGHT BE BETTER OFF DEAD: THE FAILURE OF HEALTH CARE IN URBAN AMERICA 5 (1993) (“Hospitals have come to rely on a perverse system of cost shifting: that is, covering the costs of uninsured, Medicaid, and Medicare patients by charging the privately insured higher and higher rates, which in turn increases the premiums employers and workers pay and contributes to the middle-class health care squeeze. It is a game of dominoes, but one that . . . hospitals that treat mostly poor patients cannot play” because most of their patients do not have commercial insurance).

79. ORMOND AND BOVBJERG, *supra* note 48, at 12.

extent to which D.C. General relied on Medicaid for its financial survival. Due to the high levels of uncompensated care provided by D.C. General, a smaller percentage of its patients were paying patients than those of other hospitals in the city. Thus, Medicaid patients comprised a substantial portion of D.C. General's paying patients.

3. *Uncompensated Care Burden*

Inner-city hospitals are more likely than hospitals in affluent areas to provide uncompensated care, and public hospitals often provide the most uncompensated care.⁸⁰ This may be due to a lack of primary care services available to poor inner-city residents, who then report to emergency rooms as their initial point of contact. This has held true in the District, where despite the existence of many other hospitals and academic medical centers (AMCs), approximately 36% of uncompensated care was provided by the public hospital, D.C. General.⁸¹ Before the closing of its inpatient unit, D.C. General and its associated clinics provided more than 50% of the primary care services for D.C. residents.⁸² Data from the American Hospital Association and the District of Columbia Hospital Association show that D.C. General had more emergency room visits in both 1991 and 1996 (the two years studied) than any other D.C. hospital.⁸³

In 1996, D.C. General had more than \$74 million in uncompensated care costs, a number more than double that of Howard University Hospital, which provided the second highest amount of uncompensated care.⁸⁴ Other AMCs in the District had vastly smaller burdens of uncompensated care, with George Washington University Hospital at almost \$12 million and Georgetown University Hospital at less than \$9 million.⁸⁵ This is in contrast to many other cities, where despite their distance from areas of poor black concentration, AMCs tend to provide significant levels of uncompensated care.⁸⁶ Yet in D.C., with its abundance of AMCs, academic mission does not appear to be a driving force in the

80. "Public hospitals, in cities that have them, almost always provide the largest proportion of care to low-income populations." DENNIS P. ANDRULIS, AM. COLL. OF PHYSICIANS, *THE URBAN HEALTH PENALTY: NEW DIMENSIONS AND DIRECTIONS IN INNER-CITY HEALTH CARE*, available at <http://www.acponline.org/hpp/pospaper/andrulis.htm> (last visited Jan. 31, 2004).

81. ORMOND AND BOVBJERG, *supra* note 48, at 14 tbl.5.

82. ORMOND ET AL., *supra* note 18, at 6.

83. ORMOND AND BOVBJERG, *supra* note 48, at 13 tbl.4. Public hospitals are often leaders in trauma care, partly because trauma care "can be underprovided in the private sector for fear of attracting less well-insured patients." Bovbjerg et al., *supra* note 72, at 1. Some speculate that D.C. General handled more than half of the District's trauma cases. See Vogel, *supra* note 69.

84. ORMOND AND BOVBJERG, *supra* note 48, at 14 tbl.5.

85. ORMOND AND BOVBJERG, *supra* note 48, at 14 tbl.5.

86. ORMOND AND BOVBJERG, *supra* note 48, at 17.

delivery of uncompensated care.⁸⁷ Thus, D.C.'s poor black residents have fewer options for accessing health care services, and the geographic health care gap is intensified.

Medicare and Medicaid Disproportionate Share Hospitals (DSH)

Both Medicare and Medicaid make additional payments to hospitals treating a large percentage of poor patients in order to help those hospitals offset some of the costs associated with uncompensated care. For example, in 2001, hospitals in the United States received approximately \$5 billion in Medicare disproportionate share hospital (DSH) payments and \$6.7 billion in Medicaid DSH payments.⁸⁸ D.C. hospitals received \$45.7 million in DSH funding (Medicare and Medicaid combined) in 2000, an amount that did not adequately compensate D.C. hospitals for uncompensated care to patients in emergency rooms and outpatient settings.⁸⁹ Without sufficient DSH payments, the few hospitals that provide significant amounts of uncompensated care face financial crises, further endangering the ability of D.C.'s black poor to access health care services.

To fund the DSH program, the federal government has established an allotment that it will contribute annually to each state.⁹⁰ States must contribute revenues to the program in order to receive the federal funds.⁹¹ States contributing a larger amount have a greater ability to access more federal money up to a statutorily defined limit.⁹² However, federal DSH funds have been threatened with many cuts since the passage of the 1997 Balanced Budget Act, including scheduled fiscal year 2003 cuts of \$1.3 billion, or 13 percent.⁹³ In the 107th Congress, companion bills were introduced in the House and Senate (HR 854/S 572) that would have prevented substantial cuts in federal DSH funds scheduled to take

87. *Id.* ("The implication of this distribution of care is that, in Washington, geographic location rather than academic mission is driving the provision of charity hospital care.")

88. Hadley & Holahan, *supra* note 55, at W3-73-74.

89. MUHAMMAD ALI PATE ET AL., WORLD BANK, IMPROVING HEALTH CARE ACCESS FOR THE POOR: A CASE STUDY OF THE WASHINGTON D.C. PUBLIC HEALTH CARE SYSTEMS REFORMS 8-9 (2003). The formula used to distribute DHS funds has been criticized for only partially compensating hospitals for uninsured admissions, and for a complete failure to account for charity care provided in emergency rooms and outpatient clinics. *See id.*

90. 42 U.S.C. § 1396r-4(f) (2000); *See also* CLARE KELLY, NAT'L ASS'N CHILDRENS HOSPS. & RELATED INSTS., INTRODUCTION TO MEDICAID: MISSION IMPOSSIBLE?, CHILD. HOSP. TODAY, Spring 2002, available at http://www.childrenshospitals.net/content/ContentGroups/Publications/Childrens_Hospitals_Today/Articles/200211/Introduction_to_Medicaid_Mission_Impossible_.htm (last visited Jan. 31, 2004).

91. 42 U.S.C. § 1396r-4(a) (2000). *See also* KELLY, *supra* note 90, at 3.

92. KELLY, *supra* note 90, at 3.

93. KELLY, *supra* note 90, at 3.

effect in 2003.⁹⁴ Unfortunately, these bills stalled in committee, leaving the DSH payments, so desperately needed by inner-city hospitals, vulnerable to further cuts.

4. Privatization of Urban Indigent Health Care Systems

Closing D.C. General and Privatizing D.C.'s Indigent Health Care System

By late 2000, the Mayor and the D.C. financial control board were convinced that the obstacles of poor management at D.C. General and the hospital's increasing reliance on funds from the city budget were burdens too significant to overcome.⁹⁵ On April 30, 2001, the D.C. control board abolished the Public Benefit Corporation, and the contract for the District's safety net system was offered to a private health care system.⁹⁶ As part of this process, D.C. General's inpatient unit was closed by the District government and replaced with the D.C. Healthcare Alliance, consisting of Greater Southeast Community Hospital as the primary site, and several other facilities that would receive funding for care to eligible patients.⁹⁷ D.C. General's emergency room remained open, with Greater Southeast planning to absorb the additional emergency visits caused by the change in D.C. General's status.⁹⁸ However, Greater Southeast never had the capacity to absorb the additional burdens imposed on its emergency room,⁹⁹ and failed to develop a trauma center to replace D.C. General's heavily used trauma center.¹⁰⁰ This caused a significant increase in emergency room visits at other hospitals throughout the city, in addition to a considerable number of emergency room closures and diversions due to overcapacity.¹⁰¹ Providence Hospital, Howard University Hospital, and Washington Hospital Center have all seen "double digit percentage increases in uninsured patients in the emergency room" since the

94. Medicaid Safety Net Hospital Continued Preservation Act of 2001, H.R. 854, 107th Cong. (2001); Medicaid Safety Net Hospital Preservation Act of 2001, S. 572, 107th Cong. (2001).

95. By 2001, the D.C. government was providing D.C. General more than \$45 million in subsidies. *See For the Record*, *supra* note 74.

96. *See* CRS REPORT FOR CONGRESS, *supra* note 73, at 5.

97. CRS REPORT FOR CONGRESS, *supra* note 73, at 5.

98. *See* Daniel P. McClean, *As Health Care Safety Net Unravels, D.C. Hospitals Need Help—Stat!*, WASH. POST, Sept. 14, 2003, at B8, available at 2003 WL 62215209.

99. In fact, Greater Southeast experienced fewer emergency department visits in May - June 2003 than during the same time period in 2002, even though hospitals throughout the rest of the city saw their numbers increase. *See A Health Emergency*, WASH. POST, Sept. 16, 2003, at A18, available at 2003 WL 62215753.

100. McClean, *supra* note 98. *See also* Timberg, *supra* note 71.

101. "[T]hose who rely on emergency rooms are facing longer waits, and hospitals complain of sharply increased demands. Ambulance drivers are finding that the city's other emergency rooms are so backlogged that they increasingly are turning away all but the most urgent cases." Timberg, *supra* note 71.

closure of D.C. General's inpatient services.¹⁰² From the period of January through August 2002, Washington Hospital Center's emergency room was closed or diverted for more than 1200 hours, and Howard University Hospital's emergency room was closed or diverted for more than 1000 hours.¹⁰³

Despite these emergency care problems, D.C. officials have closed D.C. General's emergency room and transformed it into an urgent care center for minor emergencies.¹⁰⁴ Under this plan, ambulances have ceased delivering patients to D.C. General.¹⁰⁵ District officials have also proposed the elimination of five outpatient specialty clinics at the D.C. General site, leaving patients of those clinics with no choice but to obtain care outside of their neighborhood or to go without care.¹⁰⁶

At the same time, the sole remaining acute care hospital serving Southeast D.C. is facing serious threats to its continued existence. In 2001, Greater Southeast Community Hospital¹⁰⁷ became the primary facility in D.C.'s privatized indigent health care system, known as the D.C. Healthcare Alliance. Greater Southeast is owned by Doctors Community HealthCare Corporation of Arizona, a private hospital system that signed a contract with the District government to operate the D.C. Healthcare Alliance.¹⁰⁸ However, Doctors Community HealthCare Corporation faced significant financial instability in 2002, forcing the city to place management and oversight of the D.C. Healthcare Alliance back in the hands of the D.C. Health Department in early 2003.¹⁰⁹

Following the financial troubles of its parent company, Greater Southeast is fighting for its financial survival and was granted bankruptcy protection, allowing

102. *The Status of the Closure of the D.C. Health and Hosp. Pub. Benefits Corp. and Transition of Servs. Formerly Provided at D.C. Gen. Hosp. to Greater Southeast Cmty. Hosp., Hearing Before the Comm. on Human Servs. of the Council of the District of Columbia* 14th Sess. 2 (D.C. 2001) (testimony of Robert A. Malson, President, D.C. Hosp. Ass'n) [hereinafter *The Status of the Closure*], available at <http://www.dcwatch.com/issues/pbc010622f.htm> (last visited Jan. 31, 2004).

103. ROBERT A. MALSON, D.C. HOSP. ASS'N, HEALTHCARE SUMMIT 2002: STATUS OF HOSPITALS 9, available at <http://www.dcha.org/Advocacy/SUMMIT%202002.ppt> (last visited Jan. 31, 2004).

104. *New Urgent Care Center Open at D.C. General Health Campus*, HEALTH MATTERS (D.C. Dep't of Health Employee Newsletter Vol. 1, Issue 2, Wash., D.C.), May 2003, at 3.

105. See Timberg, *supra* note 71.

106. Avram Goldstein, *Proposal Targets ER at D.C. General*, WASH. POST, Jan. 17, 2003, at B4, available at 2003 WL 2369056 ("Clinics marked for closing specialize in allergies, audiology, pulmonology . . . nephrology, . . . renal dialysis, and rheumatology").

107. Greater Southeast was founded with a mission to serve the poor residents of Southeast D.C. and its client base has traditionally been largely African-American and Medicare or Medicaid-eligible. ORMOND AND BOVBJERG, *supra* note 48, at 11, 20.

108. See Avram Goldstein, *Millions Spent as SE Hospital Declined*, WASH. POST, Feb. 26, 2003, at B1, available at 2003 WL 13334824.

109. *Id.* Doctors' lender, National Century Financial Enterprises of Ohio, declared bankruptcy amid an FBI investigation into alleged financial wrongdoings, causing Doctors' to lose access to the cash flow needed to run its five hospitals. *Id.*

hospital management to dramatically cut costs.¹¹⁰ These cuts are being accomplished through staff layoffs and emergency room closures and diversions that gravely impact the hospital's ability to care for the District's neediest residents.¹¹¹ The situation at Greater Southeast has become so dire that the Joint Commission on Accreditation of Healthcare Organizations has denied the hospital re-accreditation, citing a slew of operational and safety problems.¹¹² Greater Southeast is unlikely to survive financially after losing its accreditation, because most private health plans and the District's own indigent plan generally refuse to reimburse for services at unaccredited hospitals.¹¹³ In addition, unaccredited hospitals are subjected to intense scrutiny from the federal Medicare and Medicaid programs.¹¹⁴ The Health Department is currently working with Greater Southeast Community Hospital to continue Alliance funding and ensure the hospital's survival.¹¹⁵ However, if the hospital is forced to close, there will be no full-service, acute care hospital left in Southeast D.C.¹¹⁶ Faced with this grim prospect,

110. Avram Goldstein, *Hospitals Seek to Block Plan for Southeast*, WASH. POST, Feb. 14, 2003, at B1, available at 2003 WL 13332089.

111. See *id.*

112. Avram Goldstein, *Greater Southeast's Accreditation in Jeopardy*, WASH. POST, Mar. 20, 2003, at B2, available at 2003 WL 15467345 (hospital's accreditation was denied on March 19, 2002); Avram Goldstein, *Greater Southeast Hospital's Accreditation at Risk*, WASH. POST, Feb. 27, 2003, at B8, available at 2003 WL 13335264 ("Inspectors cited Greater Southeast for inadequate training, leadership, planning, quality control, documentation, cleanliness and building maintenance. Also cited were serious errors in giving blood transfusions."); Chris Silva, *Greater Southeast Lays Out Program to Get Well Again*, WASH. BUS. J. (Sept. 1, 2003).

113. Chris Silva, *Greater Southeast Resuscitation Depends Upon Appeal*, WASH. BUS. J. (July 28, 2003); Chris Silva, *Greater Southeast Situation Triggers Aetna Withdrawal*, WASH. BUS. J. (Sept. 8, 2003).

114. Goldstein, *Greater Southeast Hospital's Accreditation at Risk*, *supra* note 112.

115. Although Greater Southeast Community Hospital temporarily lost its license from the D.C. Department of Health, it was recently issued a restricted license. The hospital is being monitored by the Department of Health. Press Release, D.C. Department of Health, D.C. DOH Issues Restricted License to Greater Southeast Community Hospital (Nov. 5, 2003), available at http://dchealth.dc.gov/news_room/release.asp?id=182&mon=200311 (last visited Jan. 31, 2004); Avram Goldstein, *Greater Southeast Regains License; City Officials Limit Inpatient Population*, WASH. POST, Nov. 5, 2003, at B1, available at 2003 WL 6228551.

116. See D.C. PRIMARY CARE ASS'N, *supra* note 2, at 7. The one other hospital in Southeast D.C., Hadley Memorial, is primarily a long-term care unit. It does not have an emergency room. Some politicians have proposed innovative partnerships to create new health care institutions accessible to residents of Southeast D.C. For instance, David Catania, an at-large member of the D.C. Council, has repeatedly proposed the creation of an Urban Health Care Campus in partnership with the National Institutes of Health, to be located on the grounds of D.C. General. Such creative ideas offer promise, but much more information regarding funding and operation are needed before this idea can be seriously considered as a long-term solution. See David A. Catania, *Editorial: Code Blue for D.C. Health Care*, WASH. POST, Nov. 24, 2002, at B8, available at 2002 WL 103571723.

Mayor Williams has recently proposed partnering with Howard University Hospital to build a new hospital on the D.C. General site.¹¹⁷

Does privatization have to fail?

Many citizens and advocates have criticized the D.C. government's decision to privatize its indigent health care delivery system, arguing that a private organization cannot effectively operate a health care system for the poor, because private hospitals tend to discriminate on the basis of ability to pay.¹¹⁸ Opponents of privatization have also argued that private hospitals lack the public mission of caring for the poor and the sociocultural understanding needed to best serve poor, minority populations.¹¹⁹ Proponents counter that public systems are ineffective at providing care in a cost-effective manner, and that public hospitals are overly bureaucratic, which wastes valuable time and money for government and patients.¹²⁰

Despite gloomy predictions, case studies have indicated that privatization efforts are not doomed to failure; however, these efforts must be carefully planned so as not to abandon the community being served. Privatization efforts in Milwaukee, Boston, and Tampa during the 1990s have all been considered largely successful thus far, because the public hospitals, rather than being closed, were sold to private health care organizations, thus assuring that the facilities would remain intact in their locations.¹²¹ In addition, those three privatization efforts all involved extensive efforts to encourage patients to use primary care clinics instead of hospital-based services. In contrast, the privatization of the Philadelphia General Hospital in 1977 drew criticism from around the country when the hospital was simply closed and the buildings demolished, with no successor planned.¹²² Although the city of Philadelphia did later increase funding for primary care clinics and encourage patients to use them more frequently, earlier failures still loom over that particular privatization effort.¹²³

These examples support the contention that geography is central to the adequate provision of indigent health care. Where societal and structural factors have, as in D.C. and in Philadelphia, created a health care gap in poor neighborhoods, simply abandoning those neighborhoods and their existing health care providers is an ineffective means of improving health status. Allowing

117. Craig Timberg & Avram Goldstein, *Hospital Proposal Seen as Reversal*, WASH. POST, Nov. 2, 2003, at C1, available at 2003 WL 62227888. Note that major details, such as control over, and funding for the new hospital, have not been finalized as of the date of publication.

118. Bovbjerg et al., *supra* note 72, at 2.

119. Bovbjerg et al., *supra* note 72, at 2-3.

120. Bovbjerg et al., *supra* note 72, at 3.

121. See Bovbjerg et al., *supra* note 72, at 5-6.

122. Bovbjerg et al., *supra* note 72, at 9-11.

123. See Bovbjerg et al., *supra* note 72, at 19.

Greater Southeast Community Hospital to simply close down, leaving Southeast D.C. without a hospital much in the way that inner-city Philadelphians were left out in the cold, would prove a very risky gamble for Mayor Williams and the D.C. government.

III. RECOMMENDATIONS

A. The Normative Argument

It is generally accepted that there is no constitutional right to social welfare services, such as the provision of health care, in the United States. Moreover, the last time the idea of universal health coverage or health care as part of the social contract was raised on a national level, there was a significant backlash, both against the administration in power and against universal health proposals in general. However, the concept of health care as a right is an ongoing part of our national dialogue. Mayor Williams has referred to the right to health care and his commitment to “ensuring that every man, woman and child has access to quality health care regardless of their ability to pay.”¹²⁴ In addition, the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research has stopped short of asserting that there is a moral “right” to health care, but has stated that society has a moral obligation to ensure equity in access to the provision of health care.¹²⁵ American society continues to accept that the elderly have a right to health care; under the Medicare program the elderly have benefited from universal coverage for almost forty years.

Progressive policy experts and free market economists regularly face off in the health policy arena, arguing over how much variation in health care access our society is willing to accept based on socioeconomic status. Although there is a clear ambivalence in America about the plight of the poor and a bias against the uninsured, few Americans would be comfortable with explicitly allowing the provision of health care to be compromised simply because of poverty.¹²⁶ It is clear to many Americans that it is not acceptable to allow the gap between the “haves” and “have-nots” to grow even wider by eliminating all rights of the poor and uninsured in the name of commercialism. This is illustrated through continued federal intervention in the medical marketplace, with laws such as the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act

124. D.C. WATCH, *MAYOR’S COMMITMENT TO A HEALTHY DISTRICT OF COLUMBIA* (2001), available at <http://www.dcwatch.com/mayor/010220.htm> (last visited Jan. 31, 2004).

125. PRESIDENT’S COMM’N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *SECURING ACCESS TO HEALTH CARE: A REPORT ON THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES* 32 (1983).

126. See Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1451, 1484 (1994) (“We feel morally comfortable if sick people have health care—and uncomfortable if they do not....”).

(EMTALA), which forbids hospitals with emergency rooms from “dumping” poor patients in need of emergency care.¹²⁷

1. *Social contract theory*

Some prominent theorists have examined the role of distributive justice in health care, arguing that poor and vulnerable members of society must be given access to such basic goods as part of the social contract.¹²⁸ Michael Walzer argues that a modern democratic state should provide some services, such as health care, in return for the rights we give up as members of society.¹²⁹ We give up property through the payment of taxes, and in return we expect the government to provide certain public goods. “We never question whether it is the appropriate role of the government to provide . . . interstate highways . . . fire departments . . . or public schools . . . [o]ur behavior indicates that this is still an expectation; that this is a function of the social contract.”¹³⁰

A health care safety net should be provided through the social contract because government can most effectively and fairly provide health care to those who cannot purchase it themselves. This is particularly true in the case of poor, black inner city residents, who have been marginalized and isolated from the rest of society. Their concentration in inner city areas has compromised their access to health care and created a health care gap structured by geography. According to the social contract theory, citizens expect government to transcend the boundaries of geography and preserve access to health care, because individual citizens are unable to do so as effectively as government.¹³¹

2. *Moral fairness and equity*

Theorists have long argued that it is incumbent upon government institutions to provide universal access to health care to all members of society as a result of a moral duty. Under that line of reasoning, illness is an act of God, and it is simply unfair to overburden the poor without spreading the financial risk associated with illness. This argument is particularly resonant in the case of the geographically structured health care gap, because affirmative public policy choices resulted in the ghettoization of high poverty blacks, which in turn created a health care crisis. It

127. Examination and Treatment for Emergency Medical Conditions and Women in Labor Act, 42 U.S.C. § 1395dd (2000).

128. See generally MICHAEL WALZER, SPHERES OF JUSTICE 31 (1983); Pope John Paul XXIII, *Pacem in Terris*, para. 8 (April 11, 1963).

129. WALZER, *supra* note 123 at 31 (“The primary good we distribute to one another is membership in some human community. It determines. . . to whom we allocate goods and services.”)

130. Christine Cassel, *The Right to Health Care, The Social Contract, and Health Reform in the United States*, 39 ST. LOUIS U. L.J. 53, 56 (1994).

131. See *id.*

would be immoral for American society, which has been complicit in the concentration of black poverty, to refuse to absorb any of the health care costs resulting from ghettoization. Affluent white communities, such as those in Northwest D.C., have benefited for years from the concentration of black poverty found in areas such as Southeast D.C. Much of affluent white society continues to live in poverty-free enclaves, while refusing to shoulder any of the financial burden created by concentrated black poverty, such as extraordinarily high morbidity and mortality rates for ghettoized blacks.¹³²

It is incumbent upon the federal government, in particular, to begin to right some of the wrongs it created by isolating poor blacks and entrenching the black ghetto. Jerry Frug has argued that the federal government's financial support for suburbanization, combined with a federal housing policy that segregated poor blacks, helped spawn concentrated black poverty.¹³³ Because the federal government helped create the inner city ghettos occupied by poor blacks, it is morally obligated to address the health care accessibility gap by redistributing resources between the geographically favored and disfavored.¹³⁴

3. *Enlightened self interest*

Another argument is that the provision of health services to the poor promotes social efficiency and positive externalities. Access to regular medical care can affect the long term health of a population because preventative care may reduce the prevalence of serious health conditions.¹³⁵ The health care accessibility gap creates extraordinarily burdensome costs for society directly, through more uncompensated emergency room visits and indirectly through the need for expensive future treatments.¹³⁶ Poor blacks that don't have access to primary care services do not benefit from preventive care and early detection of diseases, and therefore may suffer from chronic illnesses at very high rates. Chronic illnesses are expensive to treat, and patients with chronic illnesses tend to require costly emergency room-based care on a frequent basis.¹³⁷ Emergency room visits by the poor are often uncompensated, causing financial crises for hospitals serving large numbers of poor patients.¹³⁸ Uncompensated emergency room visits are even

132. See *supra* Part I.A.2.

133. Jerry Frug, *The Geography of Community*, 48 STAN. L. REV. 1047, 1068-70 (1995-1996) (describing the manner in which defense spending, federal highway development, and the Federal Housing Acts of 1937, 1949, and 1954 helped create the black ghetto).

134. See generally MASSEY & DENTON, *supra* note 4.

135. See J. LEE HARGRAVES, CTR. FOR STUDYING HEALTH SYS. CHANGE, ISSUE BRIEF: RACE, ETHNICITY AND PREVENTATIVE SERVICES: NO GAINS FOR HISPANICS (Jan. 2001).

136. See MARIE C. REED & HA T. TU, CTR. FOR STUDYING HEALTH SYS. CHANGE, ISSUE BRIEF: TRIPLE JEOPARDY: LOW INCOME, CHRONICALLY ILL AND UNINSURED IN AMERICA (Feb. 2002).

137. See STATE HEALTH PLANNING & DEV. AGENCY, *supra* note 50, at 14.

138. D.C. HOSP. ASS'N, FISCAL INDICATORS FISCAL YEAR 2002 3 (2003).

worrisome for hospitals with privately insured patients, because those costs are diverted in additional fees to insurance companies, which result in higher insurance premiums for all members of society.¹³⁹ Increased emergency room visits due to high levels of chronic illness also cause emergency rooms to quickly reach capacity, resulting in ambulance diversions and overcrowding, even at hospitals in affluent areas.¹⁴⁰ Such overcrowding will strain the resources of even the most profitable hospitals, possibly affecting overall quality of care. Thus, if society refuses to act now to remedy the geographic health care gap, all members of society, including the affluent, will eventually face higher health care costs and a less efficient health care system.

B. Recommendations for the Federal Government

1. Increase number of National Health Service Corps providers assigned to the District of Columbia.

Individuals living in medically underserved areas “have little or no access to primary health care services because the demand for services exceeds the available resources, the services are located a great distance away, or are otherwise inaccessible.”¹⁴¹ The National Health Service Corps attempts to ease this burden by encouraging physicians to practice in federally designated HSPAs in exchange for scholarships and loan assistance.¹⁴² From 1972 to 1987, the National Health Service Corps program attracted 13,600 doctors, dentists, nurses, and other health professionals into medically underserved areas.¹⁴³ However, when the Reagan Administration eliminated program funding in 1988, many poor communities lost the physicians placed through the National Health Service Corps.¹⁴⁴

Although the program was reborn in the 1990s, it has historically been underfunded, despite its potential to bring physicians into the neighborhoods where

139. Allan N. Johnson & David Aquilina, *The Cost Shifting Issue*, 1 HEALTH AFFAIRS 101 (1982).

140. See D.C. HOSP. ASS'N, *supra* note 138; see also REED & TU, *supra* note 136.

141. NAT'L HEALTH SERV. CORPS, 30 YEARS OF SERVICE TO THE UNDERSERVED, available at <ftp://ftp.hrsa.gov/nhsc/factsheets/General-Info-NHSC.pdf> (last visited Jan. 31, 2004).

142. See Kristine Marietti Byrnes, *Is There a Primary Care Doctor in the House? The Legislation Needed to Address a National Shortage*, 25 RUTGERS L.J. 799, 809-11 (1994). The Scholarship program allows medical students to obligate themselves to practice in an underserved area following graduation. The Repayment program allows medical school graduates and students in their final years of medical school to work in medically underserved areas in exchange for loan repayment applied to outstanding loan balances. Physicians who default on their obligations are liable to the United States government for treble damages. See *id.*

143. GEORGE J. ANNAS ET AL., AMERICAN HEALTH LAW 44 (1990).

144. *Id.* at 721. See also GEN. ACCOUNTING OFFICE, REP. NO. HEHS-96-28, NATIONAL HEALTH SERVICE CORPS: OPPORTUNITIES TO STRETCH SCARCE DOLLARS AND IMPROVE PROVIDER PLACEMENT (1995) (documenting benefits of NHSC loan repayment program).

primary care services are most desperately needed. In early March 2003, however, the Bush Administration proposed a \$42 million increase for the National Health Service Corps, which would help support a total of almost 4,300 doctors, dentists and other health care professionals.¹⁴⁵ The additional funding would nearly double the number of physicians that the program supported in 2001.¹⁴⁶ This funding increase would be a great first step toward making the program part of a long-term solution to the recurring PCP shortage in Southeast D.C. It will only have an impact on the lives of those in Southeast D.C., however, if more of the participating physicians are located in the District, and in the Southeastern quadrant in particular. According to the D.C. Primary Care Office, there were only twenty-six National Health Service Corps providers in D.C. in 1999.¹⁴⁷ The D.C. Primary Care Office has set a modest goal of increasing that number to thirty-six providers by 2010.¹⁴⁸ Undoubtedly, the D.C. government has tried to set an attainable goal; however, this number seems woefully inadequate. Nearly 25% of the D.C. population is underserved by primary care physicians, and there are 572,059 D.C. residents according to the 2000 U.S. Census.¹⁴⁹ That means that approximately 143,000 D.C. residents are currently medically underserved. It seems unlikely that adding ten physicians will do much to change those dynamics.

Rather, the federal government should commit to supplying the District with a mere 2% of the nearly 2,000 physicians who will be added through the President's proposed budget increases, resulting in an increase of approximately forty physicians. Given the District's abysmal health statistics, a strong case can be made that poor D.C. residents are in particularly dire need of additional primary care physicians. The federal government should not pass up this opportunity to make a positive impact on the health and lives of D.C. residents, who have a moral right to health care. In addition, it has been demonstrated time and time again that the health status of a population increases when regular preventive care is received, resulting in decreased expenditures on high-cost services, such as emergency department visits, and overall decreases in Medicaid and Medicare expenditures due to fewer chronic conditions in need of treatment.¹⁵⁰ It would be wise, both

145. Press Release, DHHS, President Proposing Action "On Many Fronts" to Assist Uninsured (Mar. 10, 2003), available at www.hhs.gov/news/press/2003pres/20030310.html (last visited Jan. 31, 2004).

146. *Id.*

147. The District of Columbia, Healthy People 2010 Plan: A Strategy for Better Health 13, 44 (Sept. 2000), available at http://dchealth.dc.gov/information/healthy_people2010/pdf/DC-HP2010-Plan.pdf (last visited Jan. 31, 2004).

148. *Id.*

149. See STATE HEALTH PLANNING & DEV. AGENCY, *supra* note 50, at 10; D.C. PRIMARY CARE ASS'N, *supra* note 17, at 6.

150. See STATE HEALTH PLANNING & DEV. AGENCY, *supra* note 50, at 14 ("It is reasonable to hypothesize that greater use of primary and preventive care, as well as other lifestyle changes will reduce the burden of chronic disease among African Americans. The result of these changes may lead

ethically and fiscally, for the government to make this investment in the health status of poor, underserved residents of Southeast D.C.

2. *Ensure minimum Medicaid and Medicare DSH allotments for all states and prevent reductions in Medicaid and Medicare DSH.*

Despite a recent period of prosperity, structural and legal constraints such as large amounts of tax-exempt federal land and an inability to tax wages earned by nonresidents, have combined with post-September 11th tourism losses to put the District at risk for severe budget shortfalls. In fact, in a report commissioned by the Federal City Council, McKinsey & Company, Inc. predicted that the District could experience a \$500 million deficit by 2005.¹⁵¹

At a time when the District faces the prospect of a serious budget crisis, significant cuts in federal DSH allotments could make it even more difficult to financially support the Medicaid program. In addition, hospitals serving the poor need the protection provided by DSH payments to prevent additional financial strains, or even closures. Without reasonable DSH payments, hospitals that have traditionally provided a disproportionate share of uncompensated care may be unable to continue serving the poor in large numbers, thus further threatening the access of the poor to health care services.

The D.C. Department of Health fiscal year 2003 budget included \$39.4 million for DSH payments.¹⁵² The federal 70% match of \$27.58 million combined with the District's budgeted amount results in \$66.98 million to be distributed to hospitals in the District, a substantial increase over the \$45.7 million in DSH funding that D.C.hospitals received in 2000.¹⁵³ However, significant nationwide reductions in DSH funding took effect in 2003, endangering the 70% match that the District had been receiving.¹⁵⁴ Interested national lobbying organizations, such as the National Association of Public Hospitals and Health Systems and the National Association of Urban Hospitals intensively lobbied Congress, trying to

to reduced emergency room utilization and improved morbidity and mortality. The same argument holds true for other ethnic underserved groups with poor health status.”).

151. See FED. CITY COUNCIL, MCKINSEY & CO., ASSESSING THE DISTRICT OF COLUMBIA'S FINANCIAL POSITION 2 (2002).

152. Testimony of Robert A. Malson, President, District of Columbia Hospital Association, Concerning the District of Columbia Department of Health's Fiscal Year 2003 Budget 3, April 17, 2002.

153. See MUHAMMAD ALI PATE ET AL., *supra* note 89, at 8-9 (providing the amounts received by D.C. hospitals in 2000); ORMOND ET AL., *supra* note 18, at 7 (explaining that the current match rate is 70% in D.C.).

154. NAT'L ASS'N OF URBAN HOSP., POSITION STATEMENT ON: MEDICAID DISPROPORTIONATE SHARE (April 2003), available at www.nauh.org/Docs/positions/pp_medicaid_dsh.pdf (last visited Jan. 31, 2004).

get legislation passed to prevent cuts to Medicaid and Medicare DSH money.¹⁵⁵ One result is the Medicare Prescription Drug Improvement and Modernization Act of 2003, which established a temporary increase in Medicaid DSH payments.¹⁵⁶ For most states, the increases will be effective for Fiscal Year 2004.¹⁵⁷ Although this legislation represents a positive first step, the United States Congress should pass legislation preventing future reductions in DSH payment levels.

C. Recommendations for Local Government

Ideally, patients should have access to health care near their homes. Patients need care in their neighborhoods, and the transportation obstacles facing poor minority residents make it difficult for them to travel in order to obtain care. Given that Greater Southeast Community Hospital is the only acute care hospital east of the Anacostia River, and that it remains the centerpiece of the D.C. Healthcare Alliance, the District government is attempting to secure the hospital's future.

In an effort to save Greater Southeast, the hospital and the Health Department consented to a decree aimed at improving safety and record-keeping at the hospital.¹⁵⁸ The decree required that hospital administrators update the Health Department on a daily basis and allow a representative of the Department to be stationed at the hospital temporarily to more closely monitor improvement efforts.¹⁵⁹ Following a 60-day period, Greater Southeast was issued a restricted license. However, the long-term survival of the hospital remains uncertain.¹⁶⁰

While city officials await the results of Greater Southeast's improvement efforts and wrangle over whether (and how) to open a new hospital, they must also make contingency plans. In the event that Greater Southeast Community Hospital is forced to close, the surge of patients into other clinics and hospitals throughout the city will only increase. The Health Department must plan for such an event by

155. Testimony of Robert A. Malson, President, District of Columbia Hospital Association, Concerning the District of Columbia Department of Health's Fiscal Year 2003 Budget, April 17, 2002; See NAT'L ASS'N OF PUBLIC HOSP. AND HEALTH SYS., ISSUES ADVOCACY: MEDICAID DISPROPORTIONATE SHARE HOSPITAL PROGRAM (March 2003), at http://www.naph.org/Template.cfm?Section=Medicaid_DSH (last visited Jan. 31, 2004).

156. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1001.

157. For states with extremely low DSH allotments, increases will continue through Fiscal Year 2008. *Id.*

158. Monte Reel, *Southeast Hospital Agrees To Term; D.C. Gives 60 Days For Improvements*, WASH. POST, Aug. 14, 2003, at B1, available at 2003 WL 56512577.

159. *Id.*

160. Avram Goldstein, *Greater Southeast's Peril Jeopardizes Area Health System; Patients, Other Hospitals Fear Closure*, WASH. POST, Nov. 9, 2003, at C3, available at 2003 WL 67884826.

adequately reimbursing those facilities for care to Alliance members and by requiring that all city hospitals share the uncompensated care burden.

1. Provide funding for emergency care to non-Alliance hospitals experiencing substantial increases in emergency room visits.

The problems experienced by D.C. General and Greater Southeast have had significant effects on D.C.'s non-alliance hospitals, particularly on emergency rooms experiencing large numbers of visits from Alliance members.¹⁶¹ Since the closure of D.C. General's emergency room, emergency room closures and diversions at many of the District's hospitals have become commonplace.¹⁶²

Until this crisis has been managed and the slew of emergency room closures and diversions normalizes to a level seen by other comparable cities, the District should reimburse any hospital located within its borders for emergency care provided to Alliance members.¹⁶³ It is unreasonable, in the chaos that has ensued since D.C. General's closure, to expect Alliance members (or ambulance drivers) facing a medical crisis to avoid the emergency rooms of certain hospitals simply because those hospitals are not Alliance members. It is equally unreasonable to expect hospitals to voluntarily provide care to Alliance members without receiving normal payment from the District's indigent health care program.

2. Increase and enforce minimum uncompensated care requirements for all District hospitals.

The District government should increase uncompensated care requirements for private hospitals, so that hospitals in more affluent neighborhoods share a larger portion of the burden of uncompensated care. The current level of uncompensated care that hospitals are legally obligated to provide annually is equivalent to 3% of adjusted patient revenues.¹⁶⁴ In poor neighborhoods such as those in the Southeast quadrant, this requirement is insufficient to meet demand. Yet for hospitals in more affluent areas of the District, "demand for free care is much lower" and the uncompensated care requirement is "rarely enforced."¹⁶⁵ For example, if Greater Southeast Hospital were to close, the uncompensated care

161. See *supra* notes 98-103 and accompanying text.

162. See *supra* notes 98-101 for statistics.

163. On March 3, 2003, the D.C. Hospital Association reportedly convinced the D.C. Department of Health to agree that any Alliance patient brought to any D.C. hospital by emergency transport will be covered, without regard to whether the hospital is a member of the Alliance. See Avram Goldstein, *Hospitals, City Agree on Future of D.C. General; Plan Would Turn Emergency Room into Urgent Care Center, Protect Other Providers*, WASH. POST, Mar. 4, 2003, at B1, available at 2003 WL 15463626. However, no information relating to that agreement, such as an "effective" date or whether the agreement will be retroactive, has been made public.

164. ORMOND ET AL., *supra* note 18, at 38.

165. ORMOND ET AL., *supra* note 18, at 39.

burden would largely shift to hospitals in the center portion of the city, such as Howard University Hospital or Children's Hospital, which already carry a significant uncompensated care burden, rather than to hospitals west of Rock Creek Park, such as Georgetown, or George Washington.¹⁶⁶ The skewed uncompensated care distribution places a tremendous burden on any hospital geographically located in a poor neighborhood. The D.C. government's failure to act puts certain hospitals at a competitive disadvantage and fails to promote efficient care.

The idea of forcing hospitals to provide a minimum amount of uncompensated care is not new or peculiar to the District. Many states maintain such requirements. However, some states, rather than simply imposing a minimum requirement, have instituted creative means of evenly allocating the responsibility for providing uncompensated care across hospitals, such as "charity care pools, hospital rate-setting, or expansion of publicly sponsored or subsidized insurance programs."¹⁶⁷ Although the District government will likely face significant resistance from interested parties such as the District of Columbia Hospital Association, a lobbying group for D.C.'s hospitals, it can and should require its' geographic units to work together to narrow the divide between rich and poor communities. This has been done in another context in the Twin Cities, where the Fiscal Disparities Plan allows poor communities to receive more funds than they contribute to the tax base by redistributing pooled property tax funds among all local governments.¹⁶⁸ Tax-base sharing improves the regional distribution of resources much in the same way a health care charity pool might.

Some states have been successfully using charity care pools for decades. For example, Massachusetts established an uncompensated care pool in 1985, requiring insurance companies and later, managed care organizations, to pay a surcharge on hospital costs.¹⁶⁹ Hospitals are then required to pay into the pool any revenue received from those surcharges that exceed their costs. Although changes have

166. ORMOND AND BOVBJERG, *supra* note 48, at 31. "Hospitals west of the park were frank in their appraisal of the uncompensated care situation. No active measures are needed to avoid uninsured patients because the hospitals' location makes high levels of uncompensated care unlikely. When queried about what effect closure of a hospital east of the park] might have on their hospital, each of these hospitals suggested that the burden would then fall on some other hospital east of the park. Hospitals east of the park tended to agree with this assessment." ORMOND AND BOVBJERG, *supra* note 48, at 31..

167. ORMOND AND BOVBJERG, *supra* note 48, at 47.

168. See The Rusk Report, *Twin Cities Tax-Base Sharing*, YORK DAILY RECORD, Nov. 20, 1997, available at <http://www.ydr.com/projects/rusk/1ruskz.shtml> (last visited Jan. 31, 2004); LEAGUE OF MINN. CITIES, FISCAL DISPARITIES 101 (2003), available at <http://www.lmnc.org/proptax/fiscal101.htm> (last visited Jan. 31, 2004).

169. MASS. GEN. LAWS ANN. ch. 118G, § 18 (West 2003); UNCOMPENSATED CARE POOL: SURCHARGE PAYER INFORMATION, available at http://www.state.ma.us/dhcfp/pages/dhcfp_70.htm (last visited Jan. 31, 2004).

been made to the program over the years, it remains in place today. Connecticut also has a similar program.¹⁷⁰

CONCLUSION

The District government, despite pursuing generous indigent care policies and innovative solutions to health-related fiscal problems, is experiencing a health care crisis. In a city that has some of the worst health status statistics in the nation, the geographically isolated residents of Southeast D.C. suffer disproportionately from severe health conditions and limited access to health care services. Economic and racial segregation have combined to leave the residents of Southeast D.C. in a pocket of concentrated black poverty, where they are effectively denied access to health care because of their color, their ability to pay, and even their location. The difficulties of serving this poor African-American community have convinced many physicians to practice in other areas, ANY other area, of the city. Federal and local policy decisions have contributed to this geographic health care gap, forcing this medically underserved population to face the possibility of losing its only full-service hospital. This flood can be pushed back, and the health care status of this community gradually improved, but only if both federal and local policymakers commit to the legal and financial solutions necessary to ensure residents of Southeast D.C. access to both primary and emergency care services.

The geographically structured health care crisis in D.C. may be more acute than in other cities with concentrated black poverty because of unique events in the D.C. market, such as the concurrent failure of the public hospital and the refusal of AMCs to provide significant amounts of charity care. Yet the severe concentration of black poverty in many American inner cities creates a risk that geography will result in market failure in the provision of health services, leaving poor black communities without access to health care. The challenge for those cities is to overcome geographic constraints to health care access now, by ensuring the long-term survival of inner city hospitals catering to the poor and simultaneously taking action to correct the mal-distribution of primary care services.

170. See JOHN KASPRAK, OFFICE OF LEGIS. RESEARCH, REP. NO. 2003-R-0056, HOSPITAL UNCOMPENSATED CARE (Jan. 16, 2003), *available at* <http://www.cga.state.ct.us/2003/olrdata/ph/rpt/2003-R-0056.htm> (last visited Jan. 31, 2004).