D.C. General Is History. Let's Focus on Its Replacement
Commentary
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After months of wrangling, a decision has been made: D.C. General Hospital will close. Its replacement, a private health care network of local clinics and hospitals led by Greater Southeast Hospital, promises to improve care while containing costs.

The debate leading to the decision was fueled by good arguments on both sides. As seen in other cities, either an improved public hospital or careful private contracting can provide good care. But the Feb. 10 decision of the D.C. financial control board and the funding restrictions imposed by Congress are final. The D.C. Council should abandon its confrontational approach to the issue and put its energy into identifying ways to fulfill the promises of the new system.

For starters, the council and the Public Benefit Corp. (PBC), which now runs D.C. General, need to promote an orderly transition for the workers who will be displaced. Fortunately, D.C. General employees who need new jobs will find that demand for good health care workers is high, especially for nurses. Beyond that, the council must seek assurances of continued service for D.C. General's clients and much more community care than previously provided.

First, the council should set goals and establish a system of vigorous monitoring. Clear standards will help administrators enforce the contract's provisions. Tracking performance and sharing data with the public also will give voice to the many patients who lack the means to take their business elsewhere.

Good monitoring is rare in health care, especially for services to low-income public clients. But it can be done if the District consistently applies pressure to measure up.

Second, the council should do what it can to lock in future funding. Experience shows that safety net support can wane after privatization. A private contractor may not fight for enough funding to cover the needs of indigent patients, so the council must extract concrete promises from the mayor to continue funding. Of course, political promises aren't binding, but they do resurface during hearings and elections.

The District also should follow the lead of other communities by seeking federal funds to support its health care safety net. Medicaid research and demonstration projects have provided support in Los Angeles and New York. Even Boston's system, which is partly privatized, as the District's will be, has received help. The Bush administration favors private enterprise for public purposes. Here is an opportunity for it to follow through with dollars.

Third, the council, along with the mayor and the PBC, should develop a backup plan in case the new system quickly falls short, as well as a long-term strategy to encourage alternative bidders in the future. Today the control board seems to have called the shots through competitive bidding. But once a monopoly provider is in charge, the balance of power can shift. The contractor may also come back in five years with a less valuable or more expensive proposal.

Possibilities abound:
• Can the District retain ownership of some tangible assets of the franchise?
• Can the public clinics be autonomous so that they can align with a different contractor in the future?
• Can the District use monitoring to preserve other hospitals' interest should the current venture fail?
• Can assistance be offered to providers left out of the proposed new network so that they will still be around for the next contracting cycle?

The council should demand answers to all these questions. Teeth gnashing and grieving over what went wrong do nothing to help poor people or the uninsured.

Our vulnerable residents need good health care, delivered when illness first strikes, at convenient locations, in culturally sensitive ways. For their sake, we must stop ranting and get on with the task of building a model indigent health care system for the 21st century.

**Other Publications by the Authors**

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