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The Closure of New Orleans' Charity Hospital After Hurricane Katrina: A Case of Disaster Capitalism

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The Closure of New Orleans'
Charity Hospital after Hurricane Katrina:
A Case of Disaster Capitalism

A Thesis

Submitted to the Graduate Faculty of the
University of New Orleans
in partial fulfillment of the
requirements for the degree of

Master of Arts
in
Sociology

By

Kenneth Brad Ott (K. Brad Ott)

B.A. University of New Orleans, 2007

May 2012

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Abstract

Amidst the worst disaster to impact a major U.S. city in one hundred years, New Orleans' main trauma and safety net medical center, the Reverend Avery C. Alexander Charity Hospital, was permanently closed. Charity's administrative operator, Louisiana State University (LSU), ordered an end to its attempted reopening by its workers and U.S. military personnel in the weeks following the August 29, 2005 storm. Drawing upon rigorous review of literature and an exhaustive analysis of primary and secondary data, this case study found that Charity Hospital was closed as a result of *disaster capitalism*. LSU, backed by Louisiana state officials, took advantage of the mass internal displacement of New Orleans' populace in the aftermath of Hurricane Katrina in an attempt to abandon Charity Hospital's iconic but neglected facility and to supplant its original safety net mission serving the poor and uninsured for its neoliberal transformation to favor LSU's academic medical enterprise.

Keywords

Charity Hospital; New Orleans; public hospitals; safety net; Hurricane Katrina; Naomi Klein; disaster capitalism; medical neoliberalism; LSU Health Care Services Division; Huey Long

Introduction

Amidst the worst disaster to impact a major city in the United States in one hundred years, New Orleans' Reverend Avery C. Alexander Charity Hospital was permanently closed. The twenty story Art Deco public health landmark commonly referred to as "Charity" served as southeast Louisiana's main trauma center, the teaching hospital for several colleges and universities, and the healthcare provider of last resort for the poor and uninsured.

Within one day of Hurricane Katrina's August 29, 2005 landfall, conditions at Charity rapidly deteriorated from its operation as a modern urban safety net hospital. It quickly became a Third World facility hobbled without electricity, air conditioning and running water. As in much of New Orleans, Charity's patients, staff and their families were literally marooned for days awaiting rescue. Some died awaiting that rescue. Everyone endured great hardship and discomfort as the languid summer heat inundated the hospital as floodwaters swelled outside. Evacuation of Charity's patients, staff and their families, finally completed five days later – left behind a shuttered building representing nearly three centuries of healthcare tradition.

Charity Hospital's closure in the wake of Hurricane Katrina forced the layoff of nearly all of its 3,600 workers. Graduate training programs were destabilized, leading to the disruption of the education of students and medical residents. The finances of the area's remaining private and non-state hospitals hemorrhaged due to overnight inundation with impoverished patients that Charity would have normally seen. Many primary care practices and outpatient health centers citywide, already decimated by flood damage and the dislocation of their patient base, also lost the only hospital which would accept their referrals. Charity's closure also compromised emergency trauma services and psychiatric crisis intervention – leaving a fractured response to cope with New Orleans' staggeringly high levels of depression, mental illness, and suicide.

The doctors, staff and residents of Charity’s emergency department nevertheless attempted to reopen the hospital following the storm evacuation of its patients. They almost succeeded. Joined by several U.S. military units and international response teams, key operational services of Charity were readied for interim use within one month of Hurricane Katrina. In spite of this heroic effort, Charity Hospital’s administrative operator, the Louisiana State University Health Care Services Division (LSU-HCSD or LSU), deemed the facility unfit for medical use to reopen. Instead of expeditiously repairing and reopening New Orleans’ main trauma center in the wake of the storm, hospital administrators, backed by state officials including Governor Kathleen Blanco halted – then cancelled – a disaster recovery operation.

Ordered under the threat of arrest to end their attempted hospital resurrection, Charity workers were forced instead to practice medicine in hastily-erected MASH-style tents located five blocks away from the campus they had restored just days before. Thus began an odyssey of makeshift disaster trauma medicine – resulting in a still-fractured New Orleans healthcare system unable to fully restore its acute care capabilities back to even pre-storm levels.

This thesis considers the closure of Charity Hospital as well as the future vitality of the state hospital system it spawned. Developing over almost three centuries out of the European almshouse tradition to yield modern medicine, Charity’s now-shuttered downtown New Orleans hospital became the emblematic flagship of iconic populist Huey P. Long’s *Share Our Wealth* commitment to the poor and dispossessed. Charity and its inspired network of Louisiana public hospitals – a holdover remnant of Keynesian New Deal-era policies – have also endured through decades of institutional neglect and cannibalization of its assets for private medical interests. Yet only now has Charity Hospital been seriously challenged – by authorities taking advantage of the epic catastrophe sparked by Hurricane Katrina – to permanently supplant its historic mission.

Theoretical Foundation

Consideration of the closure of Charity Hospital following Hurricane Katrina sociologically demands a deeper explanatory investigation rooted within a theoretical foundation. Yin (2009, p. 36) suggests that, far from having to develop a “grand theory” of immense scope and proportion, “the simple goal is to have a sufficient blueprint” for a study. Yin, citing Sutton and Staw (1995, p. 378), states “this requires theoretical propositions [to convey] a story about why acts, events, structure, and thoughts occur.”

Creswell (2009, p.51) defines theory as “an interrelated set of constructs (or variables) formed into propositions, or hypotheses, that specify the relationship among variables (typically in terms of magnitude or direction).” In this study, the *proposition* is “New Orleans’ Charity Hospital was closed as a result of disaster capitalism, to supplant its original mission, for its neoliberal transformation to favor LSU’s academic medical enterprise.” The stated proposition is examined through the review and analysis of literature, data and participant observation.

The theoretical parameter for this study starts from its subject of investigation – namely the *conflict* between efforts of New Orleans’ Charity Hospital’s doctors, medical residents and the U.S. military to reopen Charity after Hurricane Katrina as the city was virtually emptied of its population; and direct actions of Louisiana State University (LSU) and the State of Louisiana to forbid the hospital’s reopening. Reallocation of Charity’s capital assets away from its historic mission to treat the medically indigent to favor LSU’s graduate medical education for a private healthcare marketplace completes the theoretical limit of this case study’s research proposition.

Abercrombie, Hill and Turner (1994, p. 80) roots *conflict theory* in free market competition for “resources or advantages desired by others.” This is expressed through the mobilization of economic “power resources” out of which social conflict arises.

Conflict theory is also the leading theoretical construct for the discipline of *medical sociology*. Characterized as the sociology of healthcare access and delivery, this thesis draws from this scholarship to explore research questions arising out of Charity Hospital's closure.

Matcha (2000) observed the confluence of medical sociology and conflict theory:

Medicine is more than a biological interpretation of symptoms. For instance, medicine involves the values of the health-care provider and the patient, as well as the resultant consequences associated with the similarities or differences of these values (p. 17).

Weitz (2001) notes medical sociology frames "problems as public issues rather than merely personal troubles." She cited C. Wright Mills' critique of the division between "troubles" and "issues" through comparison of an individual patient's experience where issues transcend the personal into the larger structural realm, whether in a hospital or in society (p. 5). Referencing conflict theory, Weitz also said that the sociology of medicine "often challenges both medical views of the world and existing power relationships within healthcare" (p. 9). Weitz writes that hospitals once "functioned as total institutions, in which patients traded individual rights for health care," (p. 291) but "the bureaucratic nature and large size of modern hospitals, coupled with the highly technological nature of hospital care, often means the patient as individual person and not just diseased body gets lost" (p. 296).

Brown (1989) addresses the polarity of health, illness, politics, economics and culture:

Health and illness cannot be understood by simply looking at biological phenomena and medical knowledge. Rather, it is necessary to situate health and illness in the framework of larger political, economic, and cultural forces (p. v).

Considering deeper these dimensions in the context of the conflict over Charity Hospital's closure following Hurricane Katrina, this thesis extends its social conflict theoretical foundation to include the related paradigms of *neoliberalism* and *disaster capitalism*.

Harvey (2005) contextualizes *neoliberalism* within its economic basis:

Neoliberalism in the first instance (is) a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade (p. 2).

Horton (2007, p.1) etymologically links “neo” to neo-classical free market economics emerging in the late nineteenth century; “Liberal” signifies freedom from governmental intervention. Harvey (p. 19) noted that neoliberal conceptions of freedom have served only as the theoretical *legitimizing* of a merger of the public sphere into the private sphere, reducing daily life into quantified financial transactions to advance capital accumulation above all life pursuits, “in short, the financialization of everything” (p. 33).

Coining the term *medical neoliberalism*, Jill Fisher (2007, pp. 64-65) said this variant also emphasizes “a cultural sensibility toward the commodification of health and wellness.” No longer seen as a necessity, healthcare under medical neoliberalism “transforms individuals from patients to consumers.” Rather than holistically considering one’s actual health needs within the healthcare system, the emphasis is placed upon individualizing the health experience “in terms of opportunities for [consumer] choice” – the *choice* to purchase health services like commodities – leading “to a prioritization of choice over equity and access” – as well as an altered landscape for doctors and hospitals *to favor privatization*. Fisher noted this impact:

The changing structure of payment for medical services had profound effects on the culture of medicine. For example, it can be said to have undermined the authority of physicians, who under managed care must adhere to the rules of medical diagnostics and treatments set by insurance providers ... Ultimately, managed care played a key role in the commodification of health care. By assigning values and standards to clinical practice, medicine became less a social good and more a set of commodities to which individual patients have differential degrees of access (pp. 65-66).

Focusing on the “internal disagreement” liberals themselves have apart from conservatives over healthcare delivery and access, Bodenheimer (2005) argued that the neoliberal paradigm simultaneously judges healthcare as a human necessity; yet one that also affords it to be most efficiently delivered through private capital, by marshalling public resources in order to achieve the fullest and most productive economic and social results. Bodenheimer suggests that under this rationality, government health assistance programs like traditional Medicare and Louisiana’s Charity hospitals are expected to incorporate private mechanisms to manage and distribute otherwise intrinsic public benefits, because market competition is expected to produce the strongest program for the best price.

Klein (2007, pp. 14-15) said “the ideology [of neoliberalism] is a shape-shifter, forever changing its name and switching identities.” U.S. adherents “who associated liberals with high taxes and hippies,” identify themselves as “conservatives,” “classical economists” and “neoconservatives.” Fathered by Nobel Prize-winning economist and self-identified classical liberal Milton Friedman, Klein (pp. 17-19) suggests neoliberalism is a return to classic pre-Keynesian liberalism fused with “corporatism” through forced economic and political “shocks.”

Extending neoliberalism into the post-modern global capitalism realm, Naomi Klein’s 2007 book *THE SHOCK DOCTRINE: The Rise of Disaster Capitalism*, popularized the second variant of conflict theory considered within this thesis. Klein defines *disaster capitalism* as the use of a disaster or major event for the deliberate re-engineering of economic, political and community spheres to create capital investment opportunities while affected populations are internally displaced. Klein suggests that disaster capitalism transforms crisis relief and social reconstruction to reflect *neoliberal values*, defying any attempt to return to simply restoring what was before the calamity. Instead, this “reconstruction” paradigm *deconstructs* what was.

This thesis documents the calamitous healthcare and social impacts of the disaster capitalist paradigm on Charity Hospital and New Orleans in the wake of Hurricane Katrina. Occurring with greater frequency beyond the United States over the past forty years, Bello (2006) has described this kind of disaster response, “influenced by neoliberal market economics, as promoted by the World Bank and influenced by the U.S.” as the *Relief and Reconstruction Complex*. Bello argues that the once dominant role played by the United Nations and the Red Cross in post-war and natural disaster relief and reconstruction has been overtaken by a “brand of ‘humanitarianism’ (that) has put strategic considerations before people’s needs.” Bello, citing Klein (2005), recalls another attempt to “fast track” privatization of public services following the 1998 disastrous Hurricane Mitch in the Central American nation of Honduras, “while the country was still knee deep in rubble, corpses and mud.” This ‘reconstruction’ has now come to define a *First World* disaster response, with the closure of Charity Hospital amongst its first acts.

The attempt to reopen Charity Hospital by its doctors, medical residents and U.S. military personnel in the weeks following Hurricane Katrina, in defiance of LSU and the State of Louisiana signals just the most dominant theoretical conflict explored in this case study. Indeed, from discussions of how to finance construction before this ‘Big Charity’ facility was built in 1939, through previous attempts to close this iconic but worn hospital just a month before the 2005 storm, this thesis explores its theoretical proposition through a social historical narrative and data analysis of the case of Charity’s permanent closure. It is showcased in part by this history; in what RMJM Hillier (2008, p. 23) termed as having *national* architectural, cultural, technological and historical significance, with its “unique model of publicly funded care for the poor and uninsured,” as being one of the oldest and largest safety net / teaching hospitals of its kind, and being emblematic of public healthcare facing restructuring by free market competition.

Narrative Structure of this Case Study

Yin (2009, pp. 175-179) explores the various ways a case story report can be structured as predicated by its purpose. Compositional structures include linear-analytic, comparative, chronological, theory-building, “suspense” and unsequenced. Synthesizing data pertaining to its theoretical proposition, this case study is set *chronologically* in a social historical narrative format to represent time periods in Charity Hospital’s almost 300 years of history:

Chapter One – From Charity Hospital’s founding through Medicare and Medicaid

This chapter reviews the social history of Charity Hospital from its 1736 founding through creation of the 1965 federal Medicare and Medicaid programs. Founded as a French colonial almshouse, Charity was the home of one of America’s first and most enduring medical schools, and became one of the nation’s largest safety net hospitals. Chapter One’s first theoretical flashpoint details Huey P. Long’s use of Charity as the catalyst for his challenge to the Louisiana bourbon and petrol elites (in expanding public health services, his creation of the LSU Medical School, and laying the groundwork for a statewide Charity Hospital system). Another conflict that led to the delay in construction of the iconic Art Deco ‘Big Charity’ building was Long’s audacious challenge to U.S. President Franklin D. Roosevelt’s *New Deal* with Long’s *Share Our Wealth* program towards the development of a deeper Keynesian liberal social welfare state. Chapter One also explores the major post-World War II federal healthcare initiatives that brought Charity Hospital’s *raison d’être* into question because of their substantial competitive challenge for patients as well as for federal government financial and healthcare resources: the 1946 Hospital Survey and Construction Act (better known as the Hill-Burton Act), and the 1965 advent of the Medicare and Medicaid programs.

Chapter Two – From Medicare and Medicaid until Hurricane Katrina

Chapter Two reviews the status of Charity and its inspired public hospital system two decades out from Medicare and Medicaid's late 1960s programmatic realization.

Disproportionate Share Hospital (DSH) funds, enacted by Congress to support safety net hospitals that took care of a disproportionate share of the poor and uninsured, initially promised Charity Hospital's renewal after years of institutional neglect. But the siphoning of over \$2 billion of these funds by Louisiana's Medicaid program to favor private medicine exacerbated Charity's crisis – even as a seemingly more focused state, and later, a LSU administration sought to modernize Charity's inspired but beleaguered public hospital network. Spotlighted are conflicts between the Edwards' administration and the Louisiana State Legislature, LSU and the Foster administration, and respective Louisiana Health Care Authority (LHCA) / LSU Health Care Services Division (LSU-HCSD) plans to close New Orleans' Charity Hospital *before Hurricane Katrina*.

Chapter Three – Hurricane Katrina and Charity's Hospital's forced closure

Chapter Three recounts how New Orleans' Charity Hospital's patients, staff and their families endured Hurricane Katrina's landfall, left to fend for themselves until their evacuation a week after the storm. The conflict between LSU and Louisiana Governor Blanco and Charity's doctors, workers, medical residents, U.S. military personnel and others seeking to resurrect hospital operations following Hurricane Katrina is detailed. Also explored are the medical consequences of keeping Charity Hospital closed in the months and years following the storm; as well as the dispute between the Federal Emergency Management Agency (FEMA) against the State of Louisiana's claim that Charity was more than 50% damaged and thus eligible for full FEMA replacement funds.

Discussion – Was the closure of Charity Hospital a case of disaster capitalism?

The Discussion Chapter considers in depth whether Charity Hospital's closure was a case of disaster capitalism. Its occurrence during the height of the internal displacement of New Orleans' population following Hurricane Katrina, who was disproportionately impacted by Charity's closure, and its demographic and human rights implications are detailed. With regards to disaster capitalism's definition *as an opportunity for the creation of investment opportunities*, this chapter highlights the Bring New Orleans Back Commission (BNOB) and the Louisiana Health Care Redesign Collaborative efforts to take advantage of Charity Hospital's closure. Also explored in depth are LSU's often contradictory motivations, in *defense* of Charity's inspired statewide public hospital system (against critics seeking to end LSU administration) and LSU's own calls for its *dissolution*, to supplant its historic *Charity* heritage for a *medical neoliberal* enterprise.

Findings – Confirmation of the theoretical proposition for this case study

The Findings Chapter summarizes the key theoretical foundational results in considering this case study's conflict supposition that New Orleans' Charity Hospital was closed as the result of disaster capitalism in order to supplant Charity's original safety net mission in favor of LSU's neoliberal University Medical Center academic medical enterprise.

Epilogue – Conflict between LSU and the Jindal administration over the LSU-HCSD state budget appropriations recalls how broken our healthcare system is without Charity Hospital

Louisiana Governor Bobby Jindal and his Department of Health and Hospitals (DHH's) mid-year raid of the LSU Health Care Services Division (LSU-HCSD) Fiscal Year 2011-2012 budget to cover DHH's own budget shortfall portends grim consequences for LSU's current and future public hospital system administration; and recalls how broken our healthcare system is without Charity Hospital – completing the theoretical parameter.

Methods

The research strategy for this thesis is *a case study*. Creswell (2009, p. 13), citing Stake (1995), defines a case study as a rich and exhaustive description of an issue, detailed through one or more cases within a setting or context. Yin (2009, p. 130) suggests “the first and most preferred strategy is to follow the theoretical propositions that led to your case study.”

In Yin’s case study strategies (pp. 130-131), theoretical propositions drive the development of research questions; shaping the literature review and guiding the collection of data, “(focusing) attention on certain data and (ignoring) other data.” The theoretical proposition, said Yin, “also helps to organize the entire case study and to define alternative explanations to be examined.” Yin suggested research questions rooted in theoretical propositions emphasizing ‘how’ and ‘why’ “can be extremely useful in guiding case study analysis.”

This case study is *qualitative*. Abercrombie, Hill and Turner (1994, p. 341) said:

This refers to analysis which is not based on precise measurement and quantitative claims. Sociological analysis is frequently qualitative, because research aims may involve the understanding of phenomena in ways (requiring neither quantification nor precise measurement).

Creswell (2007, pp. 129-130) grouped qualitative data into “four basic types:” observations, interviews, documents and audio-visual materials. Research for this case study involved the collection of primary and secondary data, consisting of documents and audio-visual materials.¹ Free of interpretation or evaluation, *primary* source material document original ‘real-time’ occurrences on which evaluative literature is later based. *Secondary* source material usually consists of “accounts written after the fact with the benefit of hindsight.” Depending on the context, literature and data can serve as both primary and secondary sources (University of Maryland Libraries 2011).

¹ The list of 73 literature and 519 data items utilized for this case study is available in the reference section.

Collection and processing of archival data occurred in tandem and as the result of the literature review to explore theoretical and historical propositions of the study and to develop new lines of inquiry. Coding and content analysis classified data into manageable categories that formed the basis for development of the thesis outline, discernment of findings and drafting of the narrative in relation to the research questions.

The collection of primary and secondary data for this thesis began conscientiously in January 2006. During New Orleans' first Martin Luther King, Jr. parade following Hurricane Katrina, a group of Tulane Medical School residents, who said they had helped clean out Charity Hospital, proclaimed the facility had been repaired from flood damage it received during the late August 2005 storm. To substantiate the claims, they passed out copies of a December 17, 2005 article by Adam Nossiter in *The New York Times* entitled: "Dispute Over Historic Hospital for the Poor Pits Doctors against the State." Their claims elicited my interest, as I was an outpatient of Charity Hospital at the time of the storm. I engaged in extensive library research and review of electronic databases at the University of New Orleans (UNO) Earl K. Long Library. I attended numerous public meetings of post-Katrina recovery and healthcare reform efforts, collecting publicly distributed materials. I also filed Louisiana Public Records Act requests of LSU and Louisiana state officials.

Under direction of my thesis advisor Dr. Vern Baxter, a theoretical foundation built on open-ended questions began to take shape. It was under Dr. Baxter's direction that I explored broader areas of healthcare policy; and was introduced to the paradigm of neoliberalism – especially in conjunction with Klein's exploration of disaster capitalism. This latter line of study was also greatly enhanced thanks to my tenure as a Student Research Assistant at the UNO Center for Hazards Assessment, Response and Technology (UNO-CHART) from 2006 to 2010.

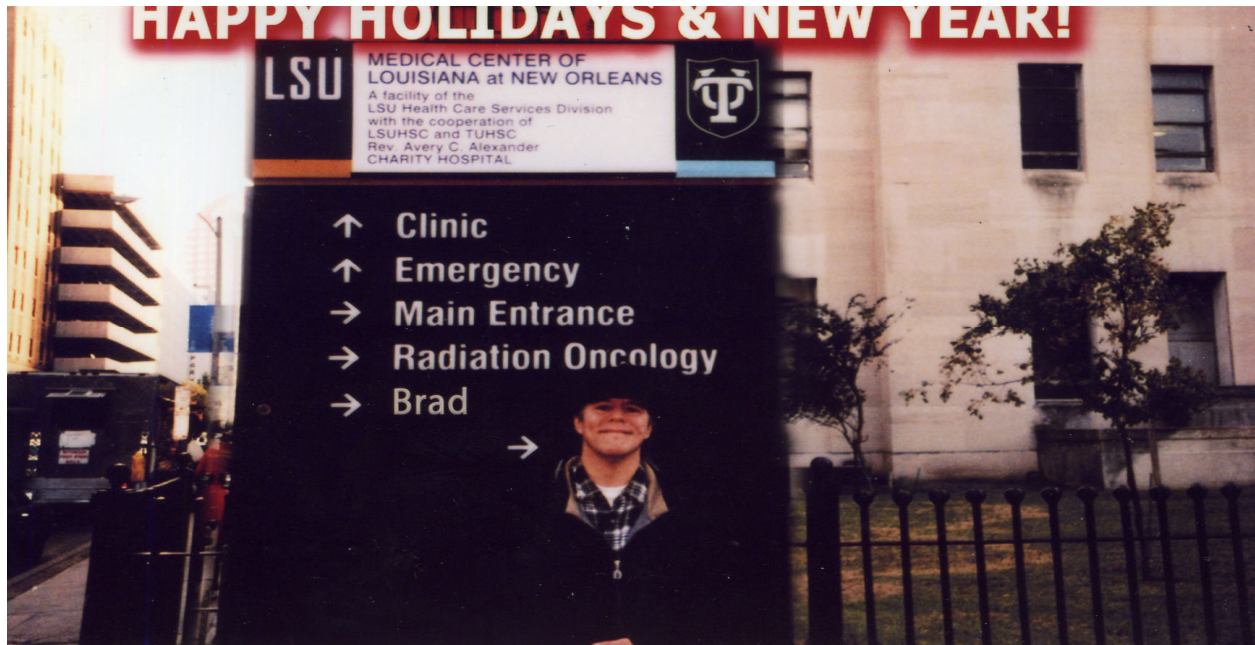
Study Validity and Reliability

Concerning study validity and reliability, Yin (2009) notes “because a research design is supposed to represent a logical set of statements, you also can judge the quality of any given design according to certain logical tests.” Yin identifies case study “tactics” for validity and reliability testing as they apply to descriptive case studies (pp. 40-45):

- *Construct validity*: Identification of correct operational measures for the concepts studied
 - Use multiple sources of evidence / in data collection
 - Establish chain of evidence / in data collection
 - Have key informants review draft case study report / in composition
- *External validity*: defining domain of generalization of study findings
 - Use theory in single-case studies / in research design
- *Reliability*: demonstrate study operations can be repeated for same results
 - Use case study protocol / in data collection
 - Develop case study data base / in data collection (p. 41)

This thesis uses multiple sources of evidence and establishes a chain of evidence drawn from historical literature and data – reflected primarily through a conflict theoretical lens to maintain construct validity. Ongoing discussion over specific subject areas regarding Charity Hospital’s closure and parallel ‘how’ and ‘why’ reasons serve as key informant review indicators. Generalization of study findings tests external validity. Reliability of study findings is assured with the advance statement of data collection protocol and attaching a detailed bibliography of all cited literature and data.

Standpoint of the Researcher



K. Brad Ott's 2003-2004 Winter Holiday Greeting. December 2003 self-portrait produced by Blaine Dunlap.

My personal standpoint of this thesis began as a patient. Just shy of two years before Hurricane Katrina, I suffered a deep vein thrombosis – a leg clot following an extended period of sitting during vacation travel. Within a week of my return from the trip, I experienced partial paralysis on the right side of my body. Upon admittance to the Emergency Department of Charity Hospital, I was injected with blood thinners to break the clot. I had already suffered a stroke – but the paralysis was substantially reversed thanks to Charity's emergency intervention.

Out of concern for a potential stroke recurrence, Charity's medical staff kept me in the hospital six days – in time to determine that I also had an undiagnosed congenital heart defect – which would require heart surgery. I received this corrective surgery at LSU Interim Hospital in 2008. Awaiting this, I became a regular Medical Center of Louisiana at New Orleans (MCLNO) outpatient – receiving regular blood clotting monitoring and medicine calibration under coordination of the Robert Hamilton Coumadin Clinic and other LSU medical units.²

² The Medical Center of Louisiana at New Orleans (MCLNO) comprises Charity and University hospital campuses.

Due to suffering a stroke, heart and brain injury, I was evaluated by Louisiana Rehabilitation Services (LRS). My job retraining program was to return to the University of New Orleans to complete my undergraduate degree in sociology and seek an advanced degree for enhanced employment potential. I completed my undergraduate studies in 2007.

Within a few months of my stroke, I joined Advocates for Louisiana Public Healthcare (ALPH), a community advocacy group supporting Charity Hospital operations. Serving as its legislative director in 2004 and 2005, I was also the appointed representative for health care consumer interests on the Region 1 Health Care Consortium (R1HCC – comprised of Jefferson, Orleans, St. Bernard and Plaquemines parishes) and served as co-chair of its “Care for the Uninsured Committee.” This latter advisory council was one of nine inaugurated during the Louisiana Governor’s Health Reform program under Governor Kathleen Babineaux Blanco.

Operating under the Participatory Action Research paradigm (PAR),³ I am combining both my standing as a former Charity Hospital patient and an advocate for its reopening with my role as a researcher. Participant observations expressed herein are solely my own. Through rigorous review of the literature backed by recognized theoretical standpoints and the expansive consideration of multiple sources of data, these research procedures intend to afford replication and validation of my findings, as well as address any perceptions of researcher bias. In addition to disclosing my standing as a researcher, the ethical dimensions of this case study which I adhere to are to honestly represent all findings, interpret clearly applicable literature and theory and properly attribute all material sources utilized. Concerns that would otherwise arise with the subject of healthcare and its provision which might involve research directly upon human subjects are greatly minimized with reliance upon public documents and audio visual materials.

³ See West, Alcina, Peterson and Laska (2008). Also known as *Advocacy/Participatory*: Creswell (2007, pp. 21-22) and *Action Research*: Brydon-Miller, Greenwood and Maguire (2003) and Hilsen (2006).

In this harbor weary sea-worn ships drop anchor and new launched vessels start their outward trips. Within these walls, life begins and ends.

Seal of Charity Hospital, embossed on its entrance floor ⁴

But perhaps Huey's most tangible legacy comes with the essential things he made: the government programs that eventually transformed Louisiana from one of the most ruthlessly irresponsible caretakers of its people in the nation to one of the most beneficent ... [like] the Charity Hospital system, with its anchor and architecturally handsome New Orleans base, providing the necessity of health care...

Garry Boulard, *Huey Long Invades New Orleans* (1998, p. 211)

Perhaps not surprisingly, the public hospital has suffered much loss of support since passage of the Medicare and Medicaid programs in the mid 1960s...

Andrew J. Brown, *Community Health* (1981, p. 100)

Chapter One

Charity Hospital's founding through Medicare and Medicaid

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⁴ Viewed via participant observation; See also Tulane University School of Medicine (1990, p.3)

Charity Hospital's First 200 Years: Yielding Modern Medicine

The etymology of *charity*, with twelfth century origins, denotes “benevolence for the poor” (Online Etymology Dictionary 2011). *Hospitals*, as social institutions, are also said to be rooted with “the concept of charity care” (Missouri Foundation for Health 2005). Founded as a colonial infirmary, Charity Hospital is also amongst the oldest teaching hospitals in America.

Mechanic (1978) noted the practice of medicine is a relatively recent development:

Medicine has really developed primarily in the past 100 years. Before that time medical practice consisted for the most part of trial-and-error attempts by self-appointed practitioners to deal with the ills of people. Although hospitals can be traced back as far as the pre-Christian era, it was not until late in the nineteenth century (that) hospitals cared for any large number of patients (p. 316).

Stoeckle (1995), citing Vogel (1980) said hospitals “were founded in the 1600s to attend to the ‘sick poor’ with ‘medical relief,’ not simply to house ‘the poor’ as ‘poor relief’ ... removed from the community and hospitalized because of infectious disease...” (p. 4).

Starr (1982) observed hospitals were places most people avoided:

Almost no one who had a choice sought hospital care. Hospitals were regarded with dread, and rightly so. They were dangerous places; when sick, people were safer at home. The few who became patients went into hospitals because of special circumstances ... (as) seamen in a strange port, travelers, homeless paupers, or the solitary aged – those who, traveling or destitute, were unlucky enough to fall sick without family, friends, or servants to care for them (p. 72).

Salvaggio (1992, p.11) recalled New Orleans' Charity Hospital's 1736 founding. The first infirmary of the French colonial port, the Royal Hospital, was restricted to military personnel and colonial administrators. Capuchin religious fathers were left to care for the rest of the populace: “Horried by the plight of indigent patients being turned away from the Royal Hospital,” French sailor and master ship builder Jean Louis forged a provision in his 1735 will to establish the Hospital of St. John, or L'Hopital des Pauvres de la Charité (Hospital for the Poor).

Salvaggio (1992) said a second hospital was built in 1743 (p. 12). Later, under Spanish colonial rule, hurricane destruction in 1778 and 1779 led to construction of a third *Saint Charles / San Carlos Hospital* in 1785 through the generosity of prominent Spanish businessman Don Andrés Almonester y Roxas (pp. 20-22). Destroyed by a fire in 1809, a fourth Charity Hospital would be built by the Louisiana state government in 1815 (pp. 26-37).

Underscoring Charity Hospital's almshouse status, Salvaggio said African slaves and Ursulines nuns were Charity's permanent medical staff in its earliest years (pp. 13-14). Conditions were overcrowded, necessitating the placement of two patients per bed (p. 16). Most of Charity's doctors performed without payment as volunteer physicians (pp. 27-28).

Within a year of the inauguration of the fifth Charity Hospital in 1833, Salvaggio (1992, pp. 67-68) observed that new milestones would be set. Charity's governing board "took an important step in an effort to eliminate political problems and placed hospital management entirely in the hands of the Daughters of Charity" – the famed French order of Catholic religious women who gave distinguished nursing care during the 1832 yellow fever-cholera epidemic. Salvaggio also said The Medical College of Louisiana, forerunner of the present-day Tulane University School of Medicine – was established at Charity as the first one in the city and state.

Salvaggio (p. 68) noted that initially, the French-trained physicians of Charity Hospital scoffed at the medical college's establishment – "who undoubtedly considered American medical schools inferior to those of Europe." Starr (1982, pp. 40, 146) underscored this skepticism, saying many of the first American medical schools actually operated just as apprenticeships, without the benefit of hospital experience or training. Salvaggio (pp. 86-87) said that the Medical College of Louisiana's proprietary nature did not inspire confidence in its medical education – until 1884, when Paul Tulane gave \$1.25 million to form Tulane University.

Matcha (2000) said “a 1906 survey (of 162 medical schools) by the American Medical Association (AMA) brought about not only fundamental change in medical education, but also provided the basis for the professionalization of medicine.” In an act of peer review, Matcha noted the AMA “turned to the Carnegie Foundation for the Advancement of Teaching” which enlisted Abraham Flexner to perform a similar study in 1910. He found “only 31 of the medical schools should remain open” (p. 230). Salvaggio (1992) said Flexner declared Tulane made the cut: “It is unthinkable that Tulane could have received such a good rating had it not been for the wide variety of patients and the hands-on teaching provided by Charity Hospital” (p. 98).

New Orleans’ Charity Hospital’s evolution into a major teaching center portended the late nineteenth century transformation of American medicine. Starr (1982, p. 169) noted the record rise in the number of American hospitals to over 4,000 by 1910 from under 200 in just forty years. Roberts and Durant (2010, p. 13) recorded that this dramatic rise “was influenced by a number of social and demographic changes, including immigration and rapid urbanization, which resulted in densely populated cities with increased demand for healthcare.”

Starr (1982, p. 145) now described hospitals “developing from places of dreaded impurity and exiled human wreckage into awesome citadels of science and bureaucratic order.”

Charity Hospital pioneered much of this development in its first 200 years. Salvaggio spotlights an editorial lauding Charity by the Cameron Parish *Courier*, May 26, 1923:

New Orleans wears proudly the honor of being the home of Charity Hospital. It is an institution that confers distinction upon the city. New Orleans, because of the magnificent work done by Charity Hospital, is rated among the first in medical science.

But Charity Hospital serves the whole state of Louisiana. Its mantle of mercy shields the sick and the injured of the city street, country road, pine hills, and cypress swamp. From wheresoever he comes, so it be within the borders of this state, his wound will be bound up, his ailment ministered to (pp. 102-103).

Huey Long launches LSU Medical School, ‘Big Charity’ and a statewide hospital armada

Murray (2006, p. 468) said “sickness” insurance based on half of a worker’s pay was available in the U.S. by the late nineteenth century. Starr (1982, pp. 206, 240-241) noted that while fraternal societies provided insurance to just over a quarter of American families, most remained uninsured. Starr elaborated that while the federal government enacted “a system of compulsory hospital insurance for merchant seamen as far back as 1798 (following European precedents),” this was the exception. Starr said “although general hospitals in Europe became primarily governmental and tax supported, in America they remained mainly private.”

Louisiana, descendent from French and Spanish colonial rule, became a noteworthy U.S. exception. McDonald (1984) noted that “Louisiana was the first state in this country to maintain and operate a general hospital from state funds...” (p. 3).

Campaigning for governor in 1927 for a second time after suffering a narrow loss in 1924, Huey P. Long, an attorney who had successfully challenged Standard Oil’s unmitigated profits while a Public Service Commission regulator, proclaimed a new course for Louisiana – one in which Charity Hospital would ultimately play a pivotal role. Long’s vision of social and economic change was encapsulated in a campaign speech he gave under the tree which inspired the poet Henry Wadsworth Longfellow in St. Martinville, Louisiana – the Evangeline Oak:

And it is here under this oak where Evangeline waited for her lover, Gabriel, who never came. This oak is an immortal spot, made so by Longfellow’s poem, but Evangeline is not the only one who has waited here in disappointment. Where are the schools that you have waited for your children to have, that have never come? Where are the roads and the highways that you send your money to build, that are no nearer now than ever before? Where are the institutions to care for the sick and disabled? Evangeline wept bitter tears in her disappointment, but it lasted through only one lifetime. Your tears in this country, around this oak, have lasted for generations. Give me the chance to dry the eyes of those who still weep here! (Long 1933, p. 99).

Long was resoundingly elected governor in 1928. Enacting sweeping social and economic reforms, he consolidated power to push through his ambitious agenda. Surviving unrelenting impeachment attempts by his political and corporate enemies, Long practiced the craft of previous governors by freely dispensing state jobs and contracts to his supporters. Yet loyalists were drawn however – not from the ossified Bourbon plantation elite that ruled the state virtually uninterrupted since its colonial French founding – but from the common hard-scrabble men and women of north Louisiana Long had come of age with; first as a traveling salesman, then as a tenacious trial lawyer representing the dispossessed (Williams 1969, pp. 9-106).

Seeing that Charity Hospital was a rich center of patronage, Long:

...moved to take over the board of administrators of one of the largest institutions operated by the state – Charity Hospital in New Orleans, which was maintained for indigent patients and which was the most extensive hospital of its kind in the South. It was governed by a nine-man board, of which the governor was an ex-officio member (Williams, p. 292).

Long chose Tulane University-trained doctor and Rhodes Scholar Arthur Vidrine to replace Charity's previous superintendent Dr. William Leake – who was the son of a Standard Oil attorney Long had fought in a number of cases when he served on the state Public Service Commission. With Vidrine at the helm, Long proceeded to study whether Charity could clinically support another medical school (Williams, p. 293). Salvaggio (1992, p. 110) noted that few Louisianans could afford to attend the private Tulane -- then the only one in the state.

Williams (pp. 512-513) cited Tulane overcrowding that “it had to refuse many qualified applicants.” Long said “creation of a second institution would enable these and other young men to secure a medical education and would provide Louisiana with more doctors.” Both Salvaggio and Williams observed however that the creation of LSU’s Medical School next to Charity Hospital would likely be seen – not as a healthy addition – but as a direct assault upon Tulane.

Long's relationship with Tulane had been complicated. In one of his most catalytic life events, Long compressed a three-year Tulane University Law program into one, passing the bar to become "a full-fledged lawyer at the age of twenty-one" (Williams 1969, p. 79). Salvaggio (1992, p. 106) said Governor Long in 1929 also reserved "500 beds in Charity Hospital specifically for Tulane" – cementing the school's medical training program within Charity and resolving a major bureaucratic impasse that had bedeviled Tulane for decades.

Yet Long (1933) certainly also knew that Tulane's chair was a ringleader against him:

Impeachment would have been over anywhere except in Louisiana, and over in Louisiana with anybody except the kind of opposition which I had aroused. ... The controlling political factor of *The Times-Picayune* newspaper was a railroad, telegraph and power company lawyer by the name of Esmond Phelps. He was also the head of the Board of Supervisors of Tulane University, on which sat others affiliated with such interests. The institution was largely supported by the Rockefeller Foundation (Long, pp. 180-181).

Salvaggio (pp. 108-110) detailed the "colossal mess" of Vidrine being denied a coveted Tulane professorial appointment, reportedly at the hands of Dr. Alton Ochsner, then head of Tulane surgery. Ochsner later would lose his Charity medical privileges because of a confidential communication with another colleague Vidrine may have intercepted – which warned that Tulane's dependency on a politicized Charity and its house staff would doom Tulane's program.

Long's desire to create a LSU Medical School wasn't out of any antipathy against Tulane or its leadership. Long responded to *The Times-Picayune*:

Huey snapped back: "Raise all the hell you want to, print what you want to. But we're going to have that medical school and every qualified poor boy can go" (Williams, p. 514).

Long's confrontation with Tulane's defenders paid off handsomely. LSU's medical building was constructed next to Charity in record time for its October 1931 opening. Medical school enrollments, despite the economic depression of the 1930s, *swelled at both schools*.

Louisiana in the early 1930s became a national leader in healthcare. Care of the mentally ill improved dramatically through the most modern therapeutic interventions of the day. Arbitrary restraints of psychiatric patients and prison inmates had ceased. Psychiatric patients and prison inmates alike received for the first time “a system of regular medical care” (Williams 1969, pp. 546-547). Rural healthcare in particular saw unprecedented improvement:

Through the Board of Health Long tripled funding for public healthcare. The state’s free health clinics grew from 10 in 1926 to 31 in 1933, providing free immunizations to 67 percent of the rural population. By expanding the state’s network of roads and bridges, Long made it possible for citizens – especially the rural poor – to seek professional healthcare and hospitalization (Long Legacy Project, 2010).

Williams noted that Long’s “critics could not deny his claim that the hospitals had been enlarged and bettered” even as they lambasted his authority over them. New Orleans’ daily newspaper, *The Times-Picayune*, charged that Long’s health reforms were a guise for patronage:

[*The Times-Picayune* charged] Long associates who were not poor received free Charity Hospital treatment ... The charge was substantially accurate. But it did not cite the fact that the practice was not new: persons with political influence had always been able to get into the hospital. What was new, and hence very apparent, was now that more of them got in – because there were more beds (Williams 1969, p. 547).

Starr (1982, p. 173) noted medical patronage was also prevalent in *private* hospitals throughout the United States – favoring *upper-class* rather than *working class* groups with free medical care and that “staff appointments went to physicians from established families...”

Referencing the aging 100-year old fifth Charity building, Salvaggio (1992, pp. 125-126) said Huey Long made substantial improvements in the downtown New Orleans facility. Yet by 1936 daily hospital admissions at Charity were higher than counterparts in Chicago, New York and Los Angeles – *because of Long’s promise of free care for all poor Louisianans.*

Salvaggio (1992, p. 126) said a federal grant was sought in 1933 to pay 30 percent of costs of a new Charity building. The balance was proposed be paid over 30 years “from revenues generated by a few private, paying wards...” Admitting private physicians of Southern Baptist Hospital and Touro Infirmary however charged that the plan “would put them out of business...”

Leighninger (2007, pp. 139-141) said in June 1934, Huey Long “announced that he had a new plan to finance a new sixth Charity Hospital: The pay beds would be withdrawn, and in their place the state’s corporation tax would be raised.” Long’s plan seemed to initially gain federal confidence. A volatile political situation in New Orleans at the time however, between pro-Long and anti-Long forces, coupled with Long administrative moves to “keep federal projects out of the hands of his enemies” – ultimately halted the process of constructing the sixth Charity Hospital until after Huey Long’s death.

Wall, Cummins, Schafer, Haas and Kurtz (2002) said while Long “worked hard to elect Franklin D. Roosevelt to the White House, the harmonious relationship between the two men soon collapsed, largely for the same reason that Long had fallen out with Governor Parker in the early 1920s: Huey wanted FDR’s job.” (p. 283) Wall, et al on Long’s “Share Our Wealth”:

In 1934 while a U.S. Senator, (Long) proposed a national plan of income redistribution called “Share Our Wealth” as a superior alternative to the existing “New Deal” of President Franklin D. Roosevelt. To many of the unemployed or marginally employed during those Depression years, “Share Our Wealth” sounded attractive indeed, with its assurances of guaranteed family incomes, free college educations, homestead exemptions, veterans’ bonuses, shorter work weeks and similar benefits – supposedly all to be funded by taxes levied on the incomes of the very wealthy... (p. 268).

Klein (2007, p. 251) said President Roosevelt strengthened his own New Deal program to stem calls for even more radical economic proposals – such as Huey Long’s call for stricter regulation of finance capital and sweeping social welfare – “to steal Long’s thunder.”

Klein (2007, p. 251) proposed that Long represented the popularization of much more direct calls for a centralized economic restructuring of the American economy in the face of a deepening Great Depression – and that in response to this popular threat, America’s industrial and financial titans saw that Roosevelt’s “New Deal” was the preferable route.

Dethloff (1976, pp. 31-32) explored Long’s challenge to Roosevelt, quoting from his 1935 *Share Our Wealth* circular that free market failures demanded government intervention:

We looked upon the year 1929 as the year when too much was produced for the people to consume. We were told, and we believed, that the farmers raised too much cotton and wool for the people to wear, and too much food for the people to eat. Therefore, much of it went to waste. ... But, when we picked up the bulletin of the Department of Agriculture for that year 1929, we found that, according to the diet which they said everyone should eat in order to be healthy, multiplying it by 120 million, the number of people had the things which the government said they should eat in order to live well, we did not have enough even in 1929 to feed the people. ... But why ... did it appear we had too much? Because the people could not buy the things they wanted to eat, and needed to eat. That showed the need for and the duty of the Government then and there, to have forced a sharing of our wealth, and a redistribution, and Roosevelt was elected on the pledge to do that very thing.

Leighninger (2007, pp. 52-53), focusing on Louisiana’s Public Works Administration projects, first noted that the *fiscal* architecture of the New Deal had to be hashed out – as President Roosevelt’s initial economic stimulus began to falter amidst worries about deficit spending. Leighninger mused whether Roosevelt really did consider deeply the merits of Huey Long’s cogent argument to equalize wealth with *consumption* as its basis through direct government intervention. Long’s economic theory ran parallel to the ideas of John Maynard Keynes, the influential British economist. Keynes called for investment to stimulate “community consumption.” This, said Klein (2007, p. 20), represented the “mixed, regulated economy” mitigating capitalism’s excesses through wage hikes, social welfare and public works programs.

The controversy between Long and Roosevelt which blocked construction of the new Charity Hospital was eclipsed in dramatic fashion. On the evening of September 8, 1935, Huey Long was assassinated in the Louisiana State Capitol. His New Deal legacy was momentous:

In the space of seven years he gave (Louisiana) a highway system second to none in the nation, an outstanding state university, vastly improved public schools, and the beginnings of a comprehensive system of state aid to the sick and the elderly, far in advance of the national Medicare program (Wall, et al, 2002, p. 284).

Leighninger (2007) said Louisiana's reconciliation with the Roosevelt administration after Long's death, along with his corporation franchise tax – restarted the Big Charity project:

Laws Long had passed to keep federal agencies at bay were repealed. The way was cleared for a third Charity Hospital proposal. This time only a grant was requested, which freed the (Public Works Administration) from concerns about hospital bond issues. Matters were further helped by the new regulations increasing the size of the grant from 30 to 45 percent. For the state's share of the project, the Charity administrators could rely on funds from (Long's) corporation franchise tax that had been dedicated to it and which, a newspaper noted as early as March 1935, had been "piling up in the banks and ... not doing anybody any good" (p. 141).

Five months of patient relocation and demolition of Charity's nineteenth century fifth hospital building cleared the way for construction on the sixth 'Big Charity' in July 1937. It was completed in July 1939. Charity became the second largest hospital complex in the U.S. with 2,680 beds in its main building and 850 additional beds in "four memorial buildings." Also built were a power house, ambulance, laundry and warehouse buildings, and a new school of nursing.

Detailing building subsidence of about 18 inches following Charity's construction, Leighninger recalled "investigators found various corners cut by contractors," necessitating reimbursement (p. 147). But Salvaggio (1992) observed:

Charity again became one of the world's great hospitals – a model of health care for indigents years before modern federal health-care programs were put into effect (p. 137).

Table 1: New Orleans' Charity Hospital and its inspired public hospital system

Hospital, Original name	Year opened	Location
Charity Hospital	1736	New Orleans
Shreveport Charity Hospital ⁵	1876	Shreveport
Huey P. Long Memorial	1938	Pineville
Lafayette Charity Hospital ⁶	1938	Lafayette
Florida Parishes Charity Hospital ⁷	1938	Independence
Northeast Louisiana Charity Hospital ⁸	1941	Monroe
Washington-St. Tammany Charity ⁹	1943	Bogalusa
Lake Charles Charity Hospital ¹⁰	1958	Lake Charles
Earl K. Long Memorial ¹¹	1968	Baton Rouge
South Louisiana Medical Center ¹²	1978	Houma
University Hospital ¹³	1992	New Orleans

Source: Roberts and Durant. 2010. *A History of the Charity Hospitals of Louisiana*. Table by K. Brad Ott

Popularly attributed by many to Huey Long, it was his younger brother Earl K. Long who “built more charity hospitals than any other governor.” Kurtz and Peoples (1990, p. 267) noted then Lieutenant Governor Earl Long in 1936 enacted the old-age pension “(expanding) it into the nation’s largest program for senior citizens” to pay out considerably more monthly benefits than Social Security at the time. A free “welfare prescriptions” program, “free ambulance service and dental care (via) mobile medical clinics, were particularly helpful for those in ... rural areas.” Louisiana became a national model for social welfare innovation.

⁵ Second location built in 1889. (p. 67) Replaced in 1953 as Confederate Memorial Hospital. Became LSU Shreveport in 1976 with medical school. Now known as LSU Health Sciences Center-Shreveport (p. 74).

⁶ Replaced and renamed University Medical Center in 1980 (p. 113).

⁷ Renamed Lallie Kemp Charity Hospital in 1954 (pp. 122-124).

⁸ Replaced and renamed E. A. Conway Medical Center in 1987 (p. 134).

⁹ Expanded in 1951, (p. 148) it merged to become Bogalusa Medical Center in 2002 (p. 153).

¹⁰ Renamed W. O. Moss Medical Center (p. 159).

¹¹ Renamed Earl K. Long Medical Center (p. 169).

¹² Renamed Leonard J. Chabert Medical Center (p. 191).

¹³ Formerly Hotel Dieu Hospital; with Charity: The Medical Center of Louisiana at New Orleans (MCLNO) (p. 48).

Charity Hospital and its inspired safety net system faced competitive pressure because of the 1946 Hospital Survey and Construction (Hill-Burton) Act

Anderson, Boumbulian and Pickens (2004, p. 1163) cite Dowling's (1982) *City*

Hospitals to outline four stages of urban public hospitals. Charity led most in all the stages:

- *Stage one* was the 'poor house' or almshouse. "During this period hospitals were components of almshouses and medical care was considered subordinate to the almshouses' social and welfare functions."
- *Stage two* was "the practitioner period" ... "when medical and nursing care became the focus of the urban public hospital. Physicians took time away from their private practices to see patients in an inpatient hospital setting."
- *Stage three* was known as "the academic period," when "urban public hospitals installed full-time medical staffs controlled by medical schools largely in response to the Flexner Report. ..."
- *Stage four* was the "large investment of federal funds to build academic infrastructure for research, education and patient care."

Salvaggio (1992, p. 97) said while New Orleans hospitals such as Hotel Dieu, Touro Infirmary and Southern Baptist Hospital grew, "as late as 1950, Charity probably contained two-thirds of all occupied hospital beds in New Orleans." Indeed, 'Big Charity' and its armada of Louisiana safety-net public hospitals expanded to lay the groundwork toward an integrated healthcare system decades before most American hospitals or states. Especially for low-income people, Charity's multiple facilities revolutionized access to the latest advances of modern medicine unbounded by geography or one's ability to pay.¹⁴

Advancing a comprehensive *European social health insurance model*, Louisiana's nascent Charity Hospital system served its public well.¹⁵ Yet its ability to keep doing so now faced new challenges from federal programs that favored patient access to *proprietary medicine with private insurance*. In time, this would have a profoundly detrimental impact on Charity.

¹⁴ e.g., Charity had the first blood bank in the South (Salvaggio 1992, pp. 150, 190); pioneered in anesthesiology (p. 139); infectious disease research (pp. 158-159); and sickle cell anemia research (pp. 178-179).

¹⁵ e.g., "The state's charity hospitals are as close as America gets to a European-style public health system" (Swann 2005); "In the United States, the political conditions and preexisting institutions were altogether different ... where classical liberalism had most thoroughly shaped the relations between state and society" (Starr 1982, pp. 240-241).

President Harry S. Truman in 1946 proposed a national program to expand veterans' and community hospital capacity, support for medical research and graduate medical education, and comprehensive health insurance coverage for all Americans (Starr 1982, pp. 281-286). After encountering fierce resistance to the national health insurance part of the proposal, Truman succeeded only in passing into law a national program of veterans' and community hospital construction known as The Hospital Survey and Construction Act. Better known as the Hill-Burton Act, after its U.S. Senate sponsors Lister Hill and Harold H. Burton, this massive post-war construction program was conceived out of a 1942 American Hospital Association (AHA)-sponsored national commission. Between 1947 and 1971, Hill-Burton put up one-third of the cost of hospitals, nursing homes and outpatient facilities; with two-thirds of costs locally-raised to receive federal match funding (pp. 348-351). Starr said Hill-Burton's programmatic requirements for obtaining the loans necessarily favored projects that could prove financial viability – meaning that the new hospitals funded often served *wealthier* communities.

This mass expansion of community hospitals nationwide following World War II would pose a new competitive challenge to Louisiana's Charity system and other similarly-situated public hospitals. Two facets of the Hill-Burton Act that outwardly sought to address inequities within the legislation would in time have profound impacts upon Charity and its inspired safety net system. Starr observed the first involved *the provision of charity care*:

Hospitals receiving assistance had to make available "a reasonable volume of hospital services to persons unable to pay." But for the next twenty years, no regulations were issued specifying what a reasonable volume might be, and the provision went unenforced (p. 350).

The lack of enforcement of charity care provisions under Hill-Burton saddled the Charity Hospital system to bear a disproportionate burden of providing indigent healthcare in Louisiana – freeing newly-constructed private hospitals to attract patients with insurance.

Starr (1982) noted that the second facet *involved addressing racial discrimination in public accommodations*. Community hospitals would be barred from receiving Hill-Burton funds if they discriminated on the basis of race – yet the law contained a crucial loophole:

The law itself prohibited discrimination by any assisted hospital, but said its conditions were met if separate but equal facilities were available in an area. The Supreme Court did not rule these provisions of Hill-Burton unconstitutional until 1963 (p. 350).

Roberts and Durant (2010, pp. 172, 196, 221-225) recorded that while three Charity units or hospitals received Hill-Burton planning and design funds – racial segregation was unabated until passage by the U.S. Congress of the 1964 Civil Rights Act. Effectively, this meant that in most cases Charity Hospital system facilities were the only hospitals available for African Americans in Louisiana until the close of 1965, when the threatened loss of federal funds within one year of the Civil Rights Act's enactment forced integration of all medical facilities.

Matcha (2000, p. 317) observed that Hill-Burton's hospital expansion "(exacerbated) structural problems associated with the health-care system by creating an over-supply of facilities that are underutilized." In Louisiana, seven Charity facilities were already in operation with Hill-Burton's 1946 enactment. Charity now found itself in a new *competitive* environment competing against *newly-constructed private facilities serving a healthier population of individuals having health insurance*. Lax enforcement of Hill-Burton's charity care and racial discrimination provisions only magnified Charity's under-financed operations – which would face additional competitive pressure with the 1965 enactment of the federal *Medicare* program:

For elderly people, Medicare alleviated the very great evil of uncertainty about medical treatment; it gave them security they had never known before. For many, the greatest worry had been whether they could afford physicians and hospitalization. Before Medicare, when workers retired – typically, in those days, at 65 – many of them were on their own with regard to medical coverage... (Pence 2004, p. 453).

Medicare and Medicaid undermined “special categories” like Charity Hospital

Brown (1981) illustrated the impact Medicare (and its counterpart for the poor, *Medicaid*) had on patients whose previous source of healthcare was in hospitals like Charity:

Perhaps not surprisingly, the public hospital has suffered much loss of support since passage of the Medicare and Medicaid programs in the mid-1960s. Many of the poor and elderly who were previously dependent on this facility for curative care are now able to use private practitioners and hospitals. The image of the public hospital as the “poor people’s” hospital spurred movement of Medicare- and Medicaid-eligible patients to the private sector... (p. 100).

Salvaggio (1992, p. 193-196) suggested that *Charity’s raison d’être was now in question unless it enacted major structural changes*. Salvaggio cited a 1965 *Times-Picayune* editorial warning that state legislative appropriations for Charity could even be in jeopardy.

Rebutting the widespread view that Medicare reflected expansion of the *socialized welfare state*, Oberlander (1997, p. 597) said “Medicare was modeled after the indemnity insurance plans that predominated in 1965.” Matcha (2000) also addressed that federal spending under Medicare and Medicaid would actually *enhance* private medicine practice:

The passage of Medicare and Medicaid represented an economic boon for the medical community. Although reimbursement levels were not consistent with the private sector, these programs offered a new and growing pool of medically needy persons... (p. 349).

Freund and McGuire (1995, pp.305-306) said that the politics of Medicare’s passage compromised the possibility of an actuarially-sound public health insurance program – resulting instead in an unprecedentedly expensive public-private hybrid with few cost-controls, lacking restraints on hospital utilization and reimbursement of medical procedures reflecting *retail* costs:

The financing of Medicare had been problematic from the outset. To overcome the objections to the program by doctors, insurance companies, hospitals ... Medicare legislation created less of a public healthcare program and more of an infusion of public money into private channels (Freund and McGuire, p. 305).

Initially, the American Medical Association (AMA) vigorously opposed Medicare's creation. Freund and McGuire (1995) said however that the AMA came to support the program:

To secure the cooperation of physicians, the initial Medicare legislation allowed reimbursement of doctor's "usual and customary fees," so long as those fees were "reasonable." Such vague language, especially in the context of a seldom competitive fee-setting process, led to rapid inflation. Fees increased disproportionate to other rates of inflation; the number of elderly treated increased, and the number of medical services ordered by doctors for their Medicare patients rose markedly... (p. 306)

Starr (1982, pp. 379-388) said fissures between medical advances of the period, expanded access to care and unsustainable costs – were brought on not only by Medicare and Medicaid, but also, by unresolved contradictions of a *largely private health system*. Under these conditions, the public welfare state can only expand if it first provides a guaranteed windfall for private capital interests – leading to the vast growth of a *corporate healthcare complex*.

Medicare and Medicaid outlays now fueled widespread fear of unrestrained inflation in the U.S. economy growing throughout the 1970s:

The adoption of Medicare and Medicaid in 1965 made the federal government the dominant force in U.S. health care finance. Almost immediately thereafter, Medicare outlays skyrocketed. After the expected initial ramping up during program implementation in 1967-68, the program unexpectedly continued to grow in inflation-adjusted terms, accelerating to real rates of increase in the 10-20 percent range for the balance of the 1970s. This growth came at an awkward time, during a period in which the U.S. was experiencing simultaneous increases in both inflation and unemployment (Moran 2005, p. 1417).

This growth in Medicare costs was not sustainable. The inflation they were fueling was negatively impacting the U.S. economy. Starr (pp. 379-388) posed that there could either be a more regulated, nationalized governmental solution – or the nation could opt for free market forces to discipline Medicare inflation. President Richard Nixon launched in February 1971 a free market "national health strategy" of *managed care organizational expansion*.

The term *managed care* implies healthcare system controls through close monitoring of healthcare providers to tightly scrutinize “where and when patients receive their healthcare” (Weitz 2001, pp. 425-427). Widely recognized by their administrative units as “HMOs” or “Health Maintenance Organizations,” these are pre-paid insurance provider groups, paid through “a fixed yearly fee in exchange for a full range of healthcare services.”

Starr (1982, pp. 396-397) said that Nixon conferred with industrialist Henry J. Kaiser (who had refined earlier models of health purchasing cooperatives during World War II) and reviewed plans adopted by Governors Reagan (California) and Rockefeller (New York) before urging Congress to incentivize the mass expansion of HMOs to become by 1980 the dominate form of health insurance. According to Moran (2005, p. 1419), managed care plans came to define health insurance, despite a “backlash against the most restrictive (HMO) forms.”

While both Medicare and Medicaid were enacted in 1965, Starr (p. 370) noted they “reflected sharply different traditions.” Medicare’s connection with Social Security and its “uniform national standards for eligibility and benefits” contrasted it with Medicaid’s “stigma of public assistance.” Medicaid rules vary widely in all 50 states, as well as in what kind of coverage is provided and how much reimbursement physicians would receive – leaving Medicaid often underfunded and poorly resourced by the medical community.

Despite documenting chronic underfunding, a precipitous decline in medical residencies, labor strife amongst Charity’s house staff and nurses, and the near-total breakdown of the hospital’s physical plant as the result of deferred maintenance, Salvaggio (1992, pp. 193-248) said that Charity Hospital improbably ascended from its possible closure after the passage of Medicare through a series of events, mishaps and interventions that likely would have otherwise felled a less venerable institution.

Freund and McGuire (1995, p. 283) documented the practice of *patient dumping* – when "for-profit hospitals frequently refuse to serve patients who cannot pay or transfer them – often in medically unstable conditions" to public or non-profit hospitals. The practice was outlawed by Congress in 1987. Salvaggio (1992, p. 251) also found that Charity also endured the custom of *patient skimming*. This routine involved the acceptance – indeed, the active *recruitment by neighboring private hospitals of patients away from Charity* – by admitting them for costly, but financially reimbursable trauma care to nearby Tulane and Hotel Dieu hospitals.

Salvaggio (p. 203) said that even with Medicaid reimbursement, most area private hospitals actively discouraged admittance of the indigent patients Charity regularly treated – prompting a successful class action lawsuit demanding free care at private hospitals (under their Hill-Burton charity care responsibilities). As part of the settlement, Charity also received additional Medicare and Medicaid funding to reopen closed beds and recruit nursing staff, as well as to ensure maintenance of its overburdened emergency department. Charity's substandard obstetrics, gynecology and pediatrics care; latent segregation and uneven treatment of poor patients, especially women of the period, demanded more corrective action (Ward 1986, p 10).

Louisiana Governor John McKeithen increased substantially Charity's budget during the 1968 to 1972 period – reversing the fiscal bleeding enough to keep the hospital from completely closing its inpatient units. Salvaggio (pp. 200-202) noted a significant capital outlay of the period was the 1969 installation of new electrical transformers to stem persistent power problems. A major water main break in 1970 that flooded Charity's basement for one day prompted the replacement of inundated switchgear components. McKeithen also unsuccessfully attempted state legislative passage of a statewide "vice tax" from coin-operated amusements, as well as an excise tax on the sale of whiskey with the proceeds dedicated to Charity hospitals.

Its woes notwithstanding, Charity Hospital still garnered notable acclaim amidst its substantial complexity and inherent shortcomings. Observed Ward (1986):

Charity Hospital was widely believed to provide the best services for gunshot wounds or emergency care. It also offered excellent treatment for such challenges as premature infants, contagious diseases, and trauma care (the medical inheritance of the indigent) (p. 10).

Lovell (2011b) noted that “under Louisiana’s populist legacy, Charity hospitals continued to expand ... at a time when other states were dismantling their public hospitals.” Charity could not however ignore Medicare and Medicaid’s soaring costs.

Starr wrote (p. 377) even as the federal commitment to funding Medicare and Medicaid substantially deepened; *its direct delivery became increasingly privatized*. Aside from Veterans healthcare “and various other special categories” – the advent of Medicare and Medicaid “undermined the rationale for municipal, veterans’ and other government hospital services.”

Stolzenberg (2000) reviews the “special category” of “safety net” hospitals:

Public hospitals have demonstrated their value to the nation’s healthcare system by filling service gaps and caring for vulnerable populations, thereby earning the title “America’s Safety Net System.” This title clearly implies that the public hospital will always be there when other institutions cannot, are not, or do not want to be there. The title also suggests that the public hospital system is rarely a system of choice but is merely the default provider when the primary system fails to meet a need. Despite these negative connotations, the public hospital system, with all its problems, has a definable mission and in many respects has carved out for itself a specific niche in the nation’s healthcare system. While there has been much debate surrounding the problems of the system, there has, until recently, been little argument about the need for its continued existence... (p. 347)

Charity and its inspired public hospital system are among “the special categories.” A hold-over remnant of Keynesian economics in a country of private enterprise, Charity continued shouldering its indigent healthcare burden long enough to view what was perhaps the dawn of a renewed state commitment, fortuitously aligned with new federal support for safety net hospitals.

In the last five years, the state has used its Charity Hospital system like a money machine.

Peter Shinkle, *The Advocate* (Shinkle 1994)

LSU ... is steeped in knowledge about the Charity system, where it has trained doctors for decades. But the law properly stresses that patient care, not medical training, must be LSU's top priority.

Editorial, *The Advocate* (1997)

The Louisiana way in medical treatment for the less well-off has no parallel in the United States, but that unique status hasn't served as protection.

Adam Nossiter, *The Advocate* (Nossiter 2003b)

Chapter Two **From Medicare and Medicaid Until Hurricane Katrina**

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The Louisiana Health Care Authority (LHCA) oversees Charity Hospitals; proposes the end of the name ‘Charity’ and to close New Orleans’ Charity Hospital

Conveying the grave condition of Charity Hospital in the late 1980s, Roberts and Durant (2010), citing Salvaggio (1992) called for Charity’s reform:

Charity was closer to death in 1990 than it was following the hurricane of 1799 or the great fire of 1809, or during the terrible post-Civil War years. The question is whether or not it will rise like the phoenix from its ashes as it has in the past. Perhaps a better question is, *‘should it rise?’* Or can Louisiana develop more efficient and humanitarian means to care for its truly indigent ill and train its future physicians? ... (pp. 307-308)

As hospital conditions worsened, questions arose over the need to change Charity’s administrative governance to afford it a more focused management. In 1936, the State Hospital Board was created to oversee Huey Long’s vision of a statewide network of Charity hospitals (LSU Health Care Services Division / LSU-HCSD 2011a). Aside from the 1940s when Charity was under outside management, the State Hospital Board was responsible for Charity system hospitals until 1970, when the Department of Health and Human Resources was created. Seeking to streamline oversight, Charity in 1988 was placed under the control of the Department of Health and Hospitals (DHH). Yet Charity’s woes worsened (Salvaggio, pp. 138-139, 284).

“A new concept of governance” to transform state-owned general hospitals, the Louisiana Health Care Authority (LHCA) passed into law in 1989 under Governor Buddy Roemer (Roberts and Durant, p. 44). The LHCA was charged with “developing long-range plans to revitalize the entire statewide charity hospital system” (Salvaggio, p. 291). Taking over nine Charity hospitals in 1991 from the Department of Health and Hospitals (apart from Shreveport, which was run by LSU), LHCA’s nine member board, appointed by the governor and confirmed by the state senate, had “the ability to independently set policy, funding and sell bonds for the charity hospital system” (Yacoe 1991).

Presenting its “strategic plan” before the 1991 Regular Louisiana Legislative Session, The LHCA highlighted key problems facing Louisiana’s public hospitals – including the prospect of some system facilities ceasing operations. It detailed both broad and specific categories: fiscal woes, loss of residency slots due to budget shortfalls, long waits for medical procedures, and the flight of experienced healthcare professionals. It also found that even as Charity hospitals generated the bulk of Louisiana’s Medicaid budget, Medicaid patients themselves were fleeing the system – with their Medicaid funds – furthering imperiling the safety net system (Louisiana Health Care Authority / LHCA 1991, pp. xviii-13).

The LHCA report set out several overarching goals to address what it viewed as the crisis facing Louisiana’s Charity Hospital system. Emphasizing “replacement and modernization of physical plant,” the report called for the imminent replacement of New Orleans’ Charity Hospital, Baton Rouge’s Earl K. Long Memorial Hospital and Pineville’s Huey P. Long Memorial Hospital. Charity and Huey P. Long in particular, the LHCA report said “should both have been replaced thirty years ago.” It remarked that the renewal of Big Charity Hospital could be the keystone in the development of a “New Orleans Medical Center Complex.” LHCA’s report also extolled in its first priority the goal of planning and design work to replace aging and neglected charity hospitals in Independence, Bogalusa and Lake Charles; system-wide installation of modern medical equipment and upgrades; streamlined funding, governance and management; more comprehensive resource allocation and integration of medicine and academic training residencies across the entire state hospital system; and enhanced relationships with counterparts in both the state welfare system, the state psychiatric care system and private healthcare providers. The LHCA said that much of this change would either be ongoing or completed within five years from the date of its strategic plan (LHCA 1991, pp. 20-31).

Much as the LHCA's strategic plan detailed the Charity Hospital system's deficiencies and challenges, it also extolled Charity Hospital and its distinctive public safety net healthcare system as "a model for the nation" – Indeed, it branded it "*The Louisiana Model*":

Every state faces the question of how to provide a safety net of health care for those without insurance and how to provide clinical training experience for physicians and other health professionals. Few states have answered this question more simply or more comprehensively than Louisiana. The concept underlying Louisiana's hospital system is a considerable improvement on those of many states. Elsewhere, a patchwork of local public hospitals, usually in urban areas, provides uneven access to care and incomplete integration with medical education. Louisiana's approach has several beneficial features that are the envy of many... (LHCA 1991, pp. 31-32).

Despite heralding the Louisiana Model as one worth emulating, the LHCA said that for the health system to realize its full potential, it had to *rebrand* itself away from the institutional identity on which its own extolled model developed – by removing the name "Charity":

The hospitals, which currently are known as the "Charity system," represent Louisiana's principal mechanism to deliver health care for the uninsured and others with inadequate access, and to provide clinical training opportunities for new physicians and other health care professionals. Both roles will remain critical elements of public policy in the state. Despite the System's clear and important purpose, its popular name leads to misunderstanding. That name should be changed (to) the Louisiana Medical Centers (LHCA 1991, pp. 17-18).

While Salvaggio (1992, p. 196) recorded a 1966 failed attempt to "remove the word *charity* from the titles of all state charity hospitals," twenty-five years later, the LHCA put forth its rebranding as its *first task* toward the hospital system's revitalization. It argued:

The "Charity system" (fails to describe its) critical role played in medical education (and) suggests that the hospitals are part of the state welfare system ... (They) are not "free" and are not available to our citizens through "charity." They represent a form of health insurance that is paid for by all Louisiana taxpayers. ... If "Charity system" is a misnomer now, the "charity" image will be even less appropriate in the future (LHCA 1991, p. 18).

Though Roberts and Durant (2010, pp. 48-49) echoed the LHCA's characterization that the name "charity" failed to adequately describe the hospital system's modern role, they also offered two key counterpoints on the rebranding of New Orleans' Charity Hospital. First, *Charity's physicians and medical residents actively resisted the proposed name change.* Charity's "physician training at the hospital is world-renowned and the medical community recognizes Charity Hospital ... not "MCLNO" (Medical Center of Louisiana at New Orleans) as a prestigious training ground for doctors..." Secondly, Roberts and Durant record throughout their work that although all but the downtown New Orleans flagship hospital would ultimately shed the *Charity* name,¹⁶ they aptly observed *Louisianans resisted doing away with Charity's identity* – and suggested they would not do so – unless a major change in the system occurred:

It appears that the longstanding label and image of these facilities as "charity hospitals," has become ingrained in the culture of Louisiana and thus, will be difficult to change without major alterations in the structure and character of the public healthcare system (p. 281).

Charity came under the threat of closure in 1991 with the loss of its hospital accreditation (Kazel 1991). The LHCA nevertheless immediately set out to implement its proposal toward rebranding the state hospital system away from the *Charity* name by seeking to close its iconic but disheveled flagship. In 1992, the LHCA purchased the former Hotel Dieu hospital and renamed it "University Hospital" (Laborde 1993). The "University Hospital" name seemed to imply *that it would now become LSU Medical School's private practice hospital.* Salvaggio (1992, pp. 193-196) noted that LSU as early as the late 1960s sought to shed its reliance upon what it viewed as an outdated hospital facility. LSU also built a considerable expansion of its medical school between its original location next to Charity and Hotel Dieu.

¹⁶ Roberts and Durant recorded that 'Big Charity's' main hospital building was renamed "the Reverend Avery C. Alexander Charity Hospital" under a 1991 Louisiana State Legislative resolution – to recognize the late civil rights activist and state representative who stalwartly defended social welfare programs and Charity hospitals (p. 48).

Tulane University, for many of the same reasons LSU sought a new practice hospital, built its own hospital downtown, apart from Charity in 1975 (Salvaggio 1992, pp. 193-196). In contrast to catering to the specific desires of LSU doctors wanting to *keep separate their Hotel Dieu private practice patients, while relegating their medically indigent patients to Charity*, Roberts and Durant (2010, pp. 47-48) said renaming Hotel Dieu as University Hospital had more to do with making a clear break from “Charity” by underscoring its *teaching hospital status* under the MCLNO brand name. This decision however left many LSU physicians wanting. Roberts and Durant said the LHCA, backed by the gubernatorial administration of Edwin Edwards, announced publicly that the main reason for ordaining Hotel Dieu as the new *University Hospital* would address medical accreditation issues by “(facilitating) the movement of patients, regardless of financial status, from the dilapidated Charity Hospital campus” that was neglected by the lack of appropriations on social welfare programs and facility maintenance.¹⁷

Stating it would close Charity within 5 years, the LHCA asked the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to “let Charity Hospital operate with safety defects that would take \$20 million to fix” (Pope 1993b). Criticism flared however, that the state would “gamble” on patient’s lives by refusing to spend money to meet the fire code (de la Houssaye 1993). Charity lost its accreditation in 1993 (*New Orleans City Business / CB* 1994).

With promises to address code deficiencies, JCAHO accreditation of Charity was restored by early 1994 (CB 1994). Roberts and Durant (pp. 49-50) said the LHCA’s attempt to construct a separate LSU Medical School “critical care tower” adjacent to University Hospital – apparently intended to placate still disaffected LSU private practice faculty – ran up against the threatened loss of federal funds, as well as uncertainty posed by a national health reform attempt, putting on hiatus more than \$1 million already spent in its construction planning and design.

¹⁷ LSU-HCSD (2007c): “Forty-five Years of Studies: Construction of a New Public Hospital in New Orleans, p. 1.

While the LHCA had independent statutory authority to execute purchase contracts and even its own agency fiscal increases, its wanton excesses as other state agencies faced budget cuts brought widespread criticism. LHCA's original purchase of the private Hotel Dieu hospital – at a cost of \$58.5 million – was criticized “because the purchase process was not subjected to regular capital outlay procedures and the price of the debt was high” (Alexander 1993). Ignoring calls from the State Treasurer and one of Louisiana's two U.S. Senators to curb agency spending, LHCA's creation of “a new \$120,000-per-year job to oversee the merger” of Hotel Dieu and Charity Hospital campuses and its departmental addition of 450 employees led to widespread calls for the LHCA to be abolished (*The Advocate* 1994a; Shuler 1994a; Shuler 1994c; *The Advocate* 1994b). The agency ultimately was abolished in 1997.

Anticipation in governmental and healthcare circles originally was that the LHCA would become *the* departmental vehicle to revitalize Louisiana's venerable yet neglected and severely underfunded Charity Hospital system. Roberts and Durant (2010, pp. 44-54) said that the LHCA's failure to be the agency of Charity's institutional renewal occurred because the LHCA micromanaged decisions “for personal and political reasons” while utterly failing in its policy oversight of Charity Hospitals through “poor leadership and irresponsible behavior...”

Roberts and Durant's account does not mention the LHCA's lack of leadership in contending with *the main funding source for Charity hospitals of the period: the federal Disproportionate Share Hospital (DSH) program*. Commonly identified by its acronym (and pronounced as “dish”), DSH funds were first created by Congress in 1981 to support hospitals that treated a disproportionate share of the uninsured. Enacted to shore up mostly public safety net hospitals that saw the exodus to private hospitals of patients having qualified for Medicare and Medicaid, Charity likely could benefit, if it could return to its priority programmatic status.

Disproportionate Share Hospital (DSH) funds enrich private providers at Charity expense

Fishman and Bentley (1997, pp. 31-36) said targeted support for certain hospitals treating people usually ineligible for Medicaid – yet still poor and uninsured prompted Congress to “(mandate) an explicit payment adjustment...” Originally intended as a temporary measure, DSH funding became a permanent federal budget item in 1990.

While the DSH program was originally enacted as part of legislation to correct inflationary deficiencies in Medicaid payment reimbursements, because program requirements were “broad and vague, many states ignored (them)” (Mechanic 2004, p. 5). Spivey and Kellermann (2009) said the DSH program was originally conceived as a federal-state shared Medicaid responsibility.¹⁸ While the federal government would contribute the bulk of designated DSH funding reimbursement, significant state resistance toward making even modest matching payments from which designated hospitals could then receive full reimbursement prompted Congress to *mandate* that states make matching DSH fund payments:

When most states ignored their obligation to make (DSH) payments, Congress ... deemed certain hospitals to be DSH providers and established methods to force states to make DSH payments to those hospitals (p. 2599).

Mechanic detailed how several states, including Louisiana, managed to overcome putting up their own money to provide a match for federal DSH reimbursement:

In the late 1980s several states, starting with West Virginia, determined that it would be permissible to collect donations from hospitals, use the donations to draw down federal matching funds, and make DSH payments to those same hospitals without actually putting up state dollars (p. 6).

Fishman and Bentley noted also that “states became very creative in increasing their Medicaid funding via provider-specific taxes (and) intergovernmental transfers...” (p. 36).

¹⁸ E.g., a 28% state/federal match means the state puts up \$28 (the amount which is advanced to it from a participating DSH hospital such as Charity) and the feds \$72 to equal \$100 for a DSH provider.

Mechanic (2004, p. 7) said by 1992, DSH payments made up 36 percent of Louisiana's program. Spivey and Kellermann (2009, pp. 2599-2600) said nationally "between 1990 and 1996, federal DSH payments ballooned from \$1.4 billion to more than \$15 billion annually..." with Louisiana in particular taking advantage, ranking fourth per capita in DSH payments.

Wall, et al (2002) said from 1989 during the Roemer administration through 1994 in the Edwards administration, the state Medicaid budget went from \$1.1 billion to \$4.2 billion:

Louisiana discovered the golden egg laid by the Medicaid goose ...
With its large numbers of poor people Louisiana had no difficulty in meeting the "disproportionate share" criterion... (p. 409)

Notice however that it was Louisiana's *Medicaid budget* – not Louisiana's Charity hospitals – that overwhelmingly benefitted from the program intended for safety net hospitals. Indeed, Coughlin, Ku and Kim (2000, p. 148) noted this aspect of *public hospitals being shorted*:

When public hospitals have net gains, it is possible that they do not get to keep their gains. That is, the net DSH gains experienced by state hospitals may be returned to the state treasury ... states often reduce other subsidies to those hospitals that offset the gains."

The advantage of matching DSH funds with Medicaid reimbursement is significantly greater than just earning reimbursement from Medicaid funds alone. The excess revenue comes both from the disproportionate share of hospital care provided by an eligible hospital, and a "per patient per day" charge available because Medicaid recipients received care (Pope 1993a).

Substantial Louisiana DSH fund payments resulted from the state "taking care of a disproportionate number of poor people in its charity hospital system." This added "up to about three times the actual cost of care for the patients" (Shuler 1994b). "Hundreds of millions of dollars" of DSH payments were made annually – but "instead of allowing public hospitals to keep that huge amount of federal tax money, [state government] forced state hospitals to 'donate' those millions" to the Department of Health and Hospitals (DHH) (Shinkle 1994).

Wall, et al (2002, pp. 409-410) found meanwhile that “the quality of medical care for Medicaid recipients did not improve – what did were opportunities for politically connected individuals to make handsome profits ...” Wall, et al specifically cited *Times-Picayune* reporter Chris Adams’ 1995 “Medicaid Madness” investigation into the phenomenal growth of private psychiatric facilities that received substantial Medicaid reimbursement for questionable expenses – enriching several former state officials and Edwards’ gubernatorial campaign contributors.

Adams detailed how DSH funds, generated wholly from Charity Hospital system care, *were re-appropriated to benefit private psychiatric facilities:*

In the arcane rules that govern Medicaid finances, a few carefully placed words can mean millions of dollars. That’s what happened in 1993, when a three-sentence provision inserted into the state’s Medicaid guidelines pumped \$7.6 million into a group of politically connected, high-profit private psychiatric hospitals ... Because most of the new private psychiatric hospitals were almost exclusively treating Medicaid patients, and most of the large public hospitals in the Charity Hospital system had thousands of non-Medicaid patients, the new provision represented a windfall for the private hospitals (Adams 1995b).

Columnist James Gill of *The Times-Picayune* quipped that “anyone who has had the feeling from time to time that we might be living in a Charles Dickens novel can forget it”:

Not even the formidable Dickens imagination could have conjured up the sinister, money-grubbing caricatures of humanity that populate the latest story of Louisiana’s political class (Gill 1995).

Engendering charges that “the state has used its charity hospital system like a money machine ... \$1.7 billion (was taken) out of the public hospital system” for a whole host of Medicaid programs “including some that enrich(ed) private companies” (Shinkle 1994). Roberts and Durant (2010, p. 54) meanwhile, citing information from a former LHCA official, *said approximately \$2 billion in funds was shifted from the Charity Hospital system “to fund other items in the overall (state) budget.”* Charity, unfortunately, would not recoup this loss.

Facing an end to the golden egg era of DSH funds, Gov. Edwards proposes a Charity HMO

New federal rules were enacted to end profiting off of DSH funds. Facing a \$750 million Louisiana Medicaid loss, Governor Edwards proposed that the Charity Hospital system “would be dismantled” and “the state would begin paying a set amount to insurance companies – such as health maintenance organizations – to provide health care coverage for the poor” (Shuler 1994d). With a year left in his last term, Edwards’ bid to convert state Charity Hospitals into a health maintenance organization (HMO) would become the latest twist in which Charity assets would be maximized – while promising little for Charity’s institutional longevity. Critics cried foul against Edwards’ apparent administrative probity in developing “a plan for the delivery of health care to Louisiana’s poor people ... being hatched in secret without an opportunity for input or discussion among the people who will pay the bill” (*The Advocate* 1994c).

The state’s argument to support a new Charity Hospital HMO plan seemed to employ a variation of the old DSH funding scheme to put up as little state funding match as possible – except this time professing reform, by promising an alternative to the very Medicaid program its own administration ran up extraordinary costs upon:

The state is hoping for federal help out of a \$750 million state health-care financing shortfall in return for experimenting with an alternative to the costly Medicaid program. The \$750 million fuels \$3 billion of Louisiana’s \$4.5 billion health-care program” (Shuler 1994e).

With uncanny parallels to the discarded “public option” proposal that was originally part of President Obama’s 2010 Patient Protection and Affordable Care Act (PPACA), the LHCA fifteen years earlier sought enactment of “The Louisiana Safety Net Plan for Managed Care.” LHCA Chairman Dr. Arnold Lupin said it proposed to establish “a ‘medical home’ for Medicaid and indigent populations in the state and for populations with special health needs” by incorporating use of the state’s Charity Hospital system (Shuler 1995a).

More than six months of debate ensued over the Charity HMO proposal, with objections arising from virtually every quarter. “Some legislators ... complained that moving to the HMO system will only take dollars away from health care and put them in the pockets of insurance companies who are seeking big profits.” Private hospitals decried that the private insurance market would be put at an unfair advantage (Shuler 1994e). One legislator also warned that employers might drop their insurance coverage (Shuler 1995f). State Insurance Commissioner Jim Brown echoed the private provider sentiments: “Some private HMOs are wondering whether there would be enough of a client pool left” for them (Shuler 1995d).

In another twist, the relationship between Charity and the HMO would also be wholly defined by a medical neoliberal administration in the form of a public private partnership:

The LHCA will have to contract with a private firm to handle HMO administrative functions for the first two years because the health care authority does not have the in-house capacity to do the job – [at a cost of] about \$30 million annually (Shuler 1995c).

The outsourcing cost of the Charity HMO administration later was raised to cost \$40 million. LHCA officials also provoked some ire with their demand to approve the contract in “21 days instead of the regular 45 days allowed for the procedure. The idea is to have the public HMO ready to go by July 1” – the beginning of the new fiscal year. Meanwhile, the required federal approval for the proposal remained uncertain (Shuler 1995e).

Charity’s HMO contract cost was revised upward again to \$45 million. The escalating cost coupled with the expedited timeframe to solicit and review proposals heightened suspicions of renewed administrative corruption favoring politically well-connected firms. State Representative Melissa Flournoy exclaimed: “It looks like it’s been cooked from the very beginning. That’s why people want to blow up the health care authority.” In response, state legislators proposed the LHCA’s abolition (Shuler 1995g).

Governor Edwards faced almost total revolt for his Charity HMO proposal. His own legislative floor leaders, “some members of the Legislative Black Caucus ... and the Acadiana Caucus (were) vocal in their dislike for parts of the plan.” Election-year politics and the uncertainty of what the federal government would do with the DSH program seemingly led everyone to dissent against the proposal. *The Advocate* also said that the state requested “13 deviations from regular Medicaid rules” in order to advance the HMO plan (Shuler 1995h).

Federal officials meanwhile remained steadfast against forgiving Louisiana’s Medicaid shortfall, even after “Gov. Edwin Edwards, lawmakers and state health officials went to Washington on bended knee ... imploring ... to let Louisiana skip out on following new Medicaid rules,” saying they weren’t to blame for past excesses. The Congressional closure of loopholes in the DSH funding program now required “Louisiana ... to use its own money to pay the state’s 28 percent match – not federal dollars” (Zganjar 1995).

While respective state and federal officials shared the same Democratic political party affiliation, larger events also impacted Louisiana’s plans – as a troubled attempt toward implementation of *national healthcare reform* was simultaneously underway. Some national Democrats even suggested that Louisiana “get out of hospitals” (Coates 1994).

Federal officials rejected both the Charity HMO, and a bailout of Louisiana’s \$750 million Medicaid shortfall – leading Governor Edwards’ to end his quest (Shuler 1995j and k). Republican Congressman Robert Livingston of Metairie, chair of U.S. House Appropriations Committee, urged top federal health officials to kill Louisiana’s Medicaid salvage proposal:

Our beneficiaries and our taxpayers cannot be served if they are subjected to a new system which would become fiscally insolvent and could be administered by those same people who created the current situation, which is replete with allegations of fraud and mismanagement (Shuler 1995i).

Unable to bail out Louisiana's Medicaid program through creation of a Charity Hospital system HMO, out-going Governor Edwards' administration actions to tackle a looming \$750 million budget deficit confirmed widespread public skepticism that past Medicaid spending largely enriched private medical providers at the expense of Medicaid recipients:

Officials with the state Department of Health and Hospitals (DHH) made an initial \$130 million in cuts to the state Medicaid health care program ... (yet) people on Medicaid will continue to receive the same level of in-patient hospital services they now receive, although the hospitals will be paid less (McMahon and Shuler 1995).

To address the remainder of the \$750 million shortfall, state health administrators returned to utilize the same DSH mechanisms – and money – which generated the hundreds of millions of dollars in excess Medicaid program expenditures. Indeed, officials suggested a large chunk of the match funds still remained in the state budget, cycling through Louisiana state government coffers, without *any* expected loss in revenues! While millions of dollars of federal DSH funds would no longer be matched in the way they were because of new Congressionally-mandated spending restrictions, Edwards' administration officials argued the level of budget cuts required to balance the state's remaining \$3 billion Medicaid budget was now much lower – meaning that meaningful programs would not see once feared cuts (Shuler 1995m).

The first bill seeking transfer of Charity hospitals to LSU failed – but only because of LSU's opposition, not for any lost love of the widely viewed-as-corrupt LHCA (Shuler 1995g). *The Advocate's* Shuler also confirmed that the LHCA engaged in the “double counting” of Medicaid dollars. “Because of that double counting ... the state never really had a \$4 billion Medicaid program from which cuts were to be made.” Shuler incredulously observed:

It seems there was some recycling of Medicaid money involved ... Maybe that's why \$1 billion cannot be found on paper anywhere. It's the cut that never was (Shuler 1995m).

Bobby Jindal saves Louisiana Medicaid by shrinking it; Jindal leaves unaddressed the continued diversion of millions of dollars in DSH funds from Charity hospitals

The November 1995 election of Republican Governor Murphy J. “Mike” Foster signaled the end of the LHCA’s administration of the Charity Hospital system. Though it would take another year to dissolve the agency, the LHCA’s demise would be just one of several significant healthcare policy shifts impacting Charity during Foster’s two terms in office.

Within days of his gubernatorial inauguration, Foster selected 24-year-old Rhodes Scholar Piyush “Bobby” Jindal for Secretary of the Department of Health and Hospitals (DHH). Calling him “a genius,” Foster addressed Jindal’s youthfulness as an asset for DHH:

I am not a gambler. I am a very conservative person. And, I am very, very comfortable that this is not a gamble. This man is going to go into (DHH) and engender a lot of respect (Shuler 1996a).

Jindal was employed after his university studies for the consulting firm McKinsey and Company (Konieczko 2008). He was a healthcare advisor to U.S. Representative Bob Livingston (Shuler 1996a). Espousing both neoconservative *and* neoliberal viewpoints, Jindal pledged “to transform the public health system” away from the state-run Charity hospitals. Jindal said:

Neither the Medicaid nor other working poor populations will be denied necessary health care services. (However) neither group should receive services unavailable to state workers or individuals with private insurance ... There are no sacred cows ... (DHH’s) mission will require a shift of focus from being a health care provider to a wise purchaser of services (Shuler 1996b).¹⁹

Jindal also vowed to “aggressively seek recovery of an estimated \$26.6 million in Medicaid overpayments made to 15 hospitals providing care for the state’s poor.” Specifically targeted were two private psychiatric facilities run by former Lieutenant Governor Bobby Freeman, and a drug treatment program with ties to former Louisiana House Speaker Pro-tem Sherman Copelin housed at New Orleans General Hospital (Shuler 1996c).

¹⁹ See Klein (2007, pp. 14-15). *Neoconservatism and neoliberalism* extols privatization of public services.

DHH Secretary Jindal's administration's first few months provoked widespread outcry. Nursing homes still in business after stepped up enforcement of state and federal regulations faced reduced payments. And citing the need to trim costs, DHH moved "toward making Medicaid recipients pay a small fee each time they receive health care services" (Shuler 1996d). Patients chafed at a proposed charge of "\$25 to be admitted to the hospital" (Shinkle 1996). In response, the state legislature nixed the hospital admission fee (*The Advocate* 1996).

Jindal attempted worker layoffs at several state-run psychiatric facilities (Shuler 1996e). He instituted a system of rationing in substance abuse programs to allow "more people to be served per year, helping to relieve waiting lists" (Shuler 1996g).

Amongst policymakers however, Jindal gained wide renown. Vowing that Medicaid would not grow beyond a designated threshold, Jindal pledged "the state (would) not fund any new initiatives or add to optional programs until we can control spending" (Shuler 1996f). Jindal's pledge, coupled with "accepting a cap on federal Medicaid payments for two years," prompting federal officials to work out a deal which "averted a catastrophe" of massive budget cuts in Louisiana's Medicaid program. Attending a news conference announcing the deal, LSU Medical Center Chancellor Dr. Mervin Trail said "we dodged a nuclear explosion" (Gyan 1996).

Congressional critics were quick to point out Louisiana Medicaid was able to finesse a substantial bailout because U.S. House Appropriations Chairman Bob Livingston was from the suburban New Orleans suburb of Metairie. "What Louisiana is getting is a very sweet deal," said Congressman Henry Waxman of California. "It is very special treatment. It is pork barrel money." Recounting Louisiana Medicaid's maximization of DSH funding, Congressman John Dingell of Michigan said "[this] is an indefensible Medicaid giveaway ... apparently based on the philosophy that no bad deed should go unrewarded" (McKinney and Shuler 1996).

The Advocate acknowledged the Congressional criticisms as justified. It editorialized that indeed, Louisiana “pled guilty as charged, threw itself on the mercy of the court and got off easy.” “Easy” however, was a \$400 million cut in Medicaid – instead of “an immediate cut of \$1.5 billion” from the Fiscal Year 1996-1997 budget. *The Advocate* said:

The sins were committed by past administrations. But the massive cuts in services would fall on the 900,000 Louisianans who rely on the state for health care. The poor and the sick are not the bad guys ... Louisiana can't expect another reprieve ... We got off easy. Let's not blow our second chance (*The Advocate* 1996).

DHH Secretary Jindal's administration of Louisiana Medicaid substantially ended outright fraud and advance payments to private providers, “recouping \$35.4 million” refunded under threat of state litigation (Shuler 1998). He left the program two years after his appointment with a fiscal surplus – earning him national acclaim and an appointment to “(lead) the staff of (the National Bipartisan Commission of the Future of Medicare charged with heading off an) impending financial crisis in federal health programs for the elderly” (*The Advocate* 1998).

Jindal did not alter the basic formula to utilize the Charity hospital system's dominant capacity – to provide healthcare for the uninsured – by generating federal DSH match contributions. Indeed, DHH continued siphoning millions of dollars for private hospitals and other Medicaid providers. And with less overall funding, Charity system hospitals now faced the prospect of significant *budget cuts* even as its DSH “money-machine” functions continued.²⁰

Before leaving Louisiana's capital for the nation's capital, Bobby Jindal assisted Governor Foster in abolishing the LHCA – and transferring the Charity Hospital system to Louisiana State University's (LSU) medical school. Previously in 1976, LSU had converted Shreveport's Charity Hospital, the former Confederate Memorial Medical Center, into what is now known as the LSU Health Sciences Center (LSUHSC) at Shreveport (LSUHSC-S 2011).

²⁰ See McMahon (1996a and 1996b); Shuler (1996h); Walsh (1996b) and Weiss (1996).

LSU assumes administration of Charity hospitals; and faced a continued loss of DSH funds

Louisiana House Appropriations Chairman Elias “Bo” Ackal of New Iberia first proposed “turning over the state’s charity hospitals to the LSU Medical Center” to provide an alternative to DSH funding. LSU Medical Center Chancellor Merv Trail said “there’s a potential for an academic health center such as ours to be a source of matching funds, but the hospitals would have to come under our governance” while pledging to “fight any attempt to implement the plan if any medical school money is at risk” (Shuler 1995b). Though abolition of the LHCA and transference of Charity hospitals to DHH was overwhelmingly passed in the Louisiana House of Representatives as the centerpiece of its 1995-96 state budget, its proposed use of LSU Medical Center “in-kind matching” funds “to produce ... federal funds for Medicaid” was rejected by the State Senate after the LSU Board of Supervisors opposed the measure (McMahon 1995; Shuler 1995L). LSU System President Allen Copping demanded funding guarantees before it would administer all ten of Louisiana’s Charity hospitals (Myers 1995).

Roberts and Durant (2010, p. 54) noted that LSU’s early reticence of taking on budgetary administration of a Charity Hospital system it medically dominated since the 1930s came in part from its desire to just exercise control of New Orleans’ Charity and University hospitals – but the legislature insisted LSU “accept all nine of the LHCA hospitals or none of them.” Governor Foster, who originally favored “setting the free market loose on the 260-year-old Charity Hospital system,” welcomed LSU administration (Walsh 1996a).

Tulane University Medical School officials originally challenged LSU’s administration of Charity system hospitals, after “expressing dissatisfaction at the prospect of having their teaching programs controlled by LSU, their direct competitor” (Redfearn 1996). Following negotiations, Tulane endorsed the LSU Charity system oversight proposal (Zwolak 1997).

LSU's reputation that it had what it took to run a successful academic medical center is showcased with its LSU Health Sciences Center in Shreveport. Added onto Shreveport's charity hospital in 1975, it is now LSU's largest with over 500 staffed beds.²¹ LSU-Shreveport has also been praised for having the best ratio of insured/uninsured patients, the most diverse patient base and the greatest integration of public and private medicine practice (LSU Health 2010; McDonald 2002). Yet it also has the ability to self-generate its budget without having to return funds to the state, and retains self-generated funds in accounts that went across budget years.

LSU Shreveport has a solid, up-to-date capital infrastructure and does not need legislative approval for its operations. With a combined medical school and charity hospital administration and budget, its faculty practice only in its hospital, thus referring their significant book of *private patients* to LSU Shreveport, reinforcing fiscal sustainability (McDonald 2002).

Former chancellor and surgeon Dr. John McDonald noted that LSU Shreveport has had the ability to treat rich and poor alike without segregating their healthcare, which he argued made the institution one of a kind in Louisiana (McCauley 2002). He noted however that this had not always been the case; and that *the state's elites* are responsible for the 'two-tier' system:

The most tragic aspect of the history of medicine in Louisiana has been the segregation of public and private care. For almost 200 years now it has been philosophically accepted in Louisiana that the poor get their care in one place and the affluent get their care in another. Further, that care has been qualitatively different, and that has been acceptable to the state's power structure. I submit that this philosophy is unacceptable. It is akin to advocating separate but equal schools. Not only is it morally wrong, it does not work. It separates the teacher from the practitioner and the student from best practice. The clinical investigator cannot supplement income ... I do not know of a single world-class medical center that does not have some access to private patients (McDonald 2002).

²¹ Shreveport's Charity hospital, founded in 1876, was renamed Confederate Memorial Medical Center following its 1953 building dedication. It was renamed LSU Shreveport Medical Center in 1976 (<http://lsuhscshistory.org> 2011). LSU Board of Supervisors member Dr. Jack A. Andonie said LSU Shreveport has 550 beds (Andonie 2011); while the 2010 LSU Health Annual Report says there are 459 licensed beds – both sources indicate 90% + occupancy.

Amidst expressed fears of privatization and the closure of all the public hospitals except those in Shreveport and New Orleans, LSU School of Medicine dean Dr. Robert Marier voiced support for the Charity system. Testifying before Louisiana's House Appropriations Committee:

The state's charity hospitals, under public stewardship for more than 260 years, won't be handed over to a big for-profit corporation if Louisiana State University is put in charge. We want to make it emphatically clear that there are no deals to privatize the hospitals. We intend to manage the hospitals as a safety-net system (Walsh 1997a).

Louisiana House Bill 1162 authorized the LSU takeover of Charity hospitals and the abolition of the LHCA. The state senate voted 31-7 for passage, despite fear that the proposal would not work – or that Charity's historic mission would be subverted (Shuler 1997). A Constitutional Amendment also passed “(giving legislators) ultimate control of the hospital system” (Walsh 1997b). Louisiana voters affirmed it in 1998 (Louisiana Constitution 1998).

Change of administration of Charity system hospitals from the LHCA to LSU immediately brought forth absorption of all LHCA employees and property into LSU. “The LSU Medical Center (also transacted) a cooperative endeavor agreement with Tulane University Medical Center for the administration of the Medical Center of Louisiana at New Orleans (Charity Hospital) and Huey P. Long Medical Center” in Pineville (Legislative Fiscal Office / LFO 1997). LSU also sought to resurrect some delayed LHCA projects, including construction of “a critical care tower on South Johnson Street alongside University Hospital” (Walsh 1997c).

While LSU pledged to uphold Charity's safety net system, it also *sought to discard Big Charity as the physical center of its medical enterprise*. It additionally promised to overcome historical restrictions as applied to Charity system hospitals limiting them to patients without insurance, prohibitions against discharge of employees protected by Civil Service and automatic qualification without means-testing of the uninsured for free hospital care (Pope 1997).

In an editorial, *The Advocate* acknowledged that the resulting bill transferring the Charity Hospital system from the LHCA to LSU overcame many of their initial concerns. While praising LSU's ability and the certainty of public oversight, "some nagging concerns" remained:

We also wonder if LSU can run the hospitals with no increase in state funding, as the Foster administration promises, without sometimes scrimping on needed medical services to poorer citizens. Finally, there is no guarantee that LSU officials, after their long allegiance to their (graduate medical education) mission, can change their attitudes to keep patients foremost in their minds (*The Advocate* 1997).

The new LSU Health Care Services Division (LSU-HCSD) administration of the Charity Hospital system engendered praise for having "brought stability to a system that had been bedeviled by short-staffing and political interference" (Pope 1998). Yet LSU also faced immediately the dilemma of the continued flight of Charity-generated DSH funding.

Concluding that all assets left by the LHCA included unspent DSH funds, LSU took ownership of "\$86 million in cash the charity hospitals had on hand at the end of the 1996-97 fiscal year" – even as Governor Foster "assumed the same money reverted to the state general fund and counted it as part of a \$135 million surplus for 1996-97" (Redman 1998).

Having spent the entirety of the surplus to pay down long-term state indebtedness, the Governor's Office sought a legal opinion: The Louisiana Attorney General ruled in favor of the Governor and against LSU "because of an accounting error..." (Redman 1999a).

Shortly after suffering the loss of the \$86 million, "top officials with the LSU Medical Center warned ... they might have to shut down as many as 15 percent of the beds in the state's charity hospital system to cope with budget pressure (in the 1999-2000) fiscal year." While stating that emergency care "(wouldn't) be jeopardized ... patients with conditions that are not life-threatening may not get treatment." LSU officials said such a drop in patients would also negatively impact Charity's graduate medical residencies (Redman 1999b).

Miraculously, the feared cuts did not occur, due in part to “the state’s expected \$4.4 billion share of a national \$206 billion settlement of tobacco litigation” which Governor Foster said “health care and improvements to the (LSU) operations of the state’s charity hospitals probably would be the best way to spend the money...” (*The Times-Picayune / T-P* 1998).

LSU faced other challenges. Big Charity was nearly closed in 1999 when a deadline for mandatory installation of fire sprinklers passed (Scallan 1999). The state legislature ultimately intervened with legislation which gave “high-rise structures used as state hospitals or prisons until Jan. 1, 2005 to install the sprinkler systems” (Anderson 1999). The legislature provided funding in 2002 to complete the project (Louisiana House Bill 2 (HB 2) 2002, p. 50).

In the midst of the 1999-2000 Fiscal Year, DHH Secretary David Hood proposed cutting \$30.5 million from Charity hospitals (Ritea 2000). However, “the Joint Legislative Committee on the Budget approved tapping money in some special agency funds to prevent some \$90 million in pharmacy program and charity hospital cuts ...” (Shuler 2000a). Even so, New Orleans’ Charity Hospital’s HIV-HOP outpatient clinic curtailed free distribution of several vital medications and limited their formulary, leaving patients compromised: “Those with private insurance (were) no longer able to get prescriptions filled through the clinic” – severely impacting one patient whose “insurance policy will pay 80 percent of his drug bill cost, but only after he pays the entire cost” – effectively barring the patient from his medicines (Pope 2000a).

During the remainder of Governor Foster’s term, LSU endured several additional rounds of budget cuts. Charity hospitals in Bogalusa, Independence and Lake Charles barely escaped permanent closure. LSU Health Sciences Center-New Orleans Chancellor Merv Trail said, “LSU did not take over these hospitals to close them. It will be a decision made by this legislature and administration” (Shuler 2000b).

Only through state legislative intervention was Charity Hospital's system budget often safeguarded (Pope 2000b). DHH often retaliated by shutting down parish health units and laying off personnel – which usually sent patients into Charity system clinics and emergency rooms (Shuler 2000c). In response, the Legislature approved authorization “giving the charity hospital system more flexibility in managing its funds” (Shuler 2002a).

LSU was also told that Charity system hospitals now had to pay for healthcare for prisoners. *The Advocate* reported “the prisoner-care shortfall cropped up when U.S. Medicaid officials said the state could not tap federal (DSH) health-care dollars to treat inmates” (Shuler 2002b). This situation worsened when \$48.4 million in state health spending cuts ballooned into a proposed \$168 million financial hit in the largest areas of Medicaid spending – leading one LSU official to predict a “health care Chernobyl” – equating the fiscal outcome to the infamous 1986 Ukrainian nuclear reactor meltdown (Shuler 2002c).

In an effort to calm budgetary chaos and produce a common DSH payment rate for state and private hospitals alike, the state legislature enacted Senate Concurrent Resolution 27 of 2002 to prompt development of a common “payment methodology” for LSU-HCSD and LSUHSC-Shreveport Charity hospitals as well as for private provider Medicaid reimbursement under DHH administration (LSU-HCSD 2003, p. 17). The report reviewed past legislative efforts and proposed creation of a payment system “based upon current costs and inclusive of annual adjustments for inflation.” The legislative committee report recommended “that the manner in which additional DSH funding is structured and implemented be consistent with ... meeting the health care needs of the state's medically indigent and uninsured and to improve overall health outcomes for Louisianans” while recognizing possible cuts in federal DSH funding (Louisiana Senate Concurrent Resolution 27 (SCR 27) Report 2003, pp. 2-6).

The report called for a profound break from what many in the healthcare community saw as years of inequitable DSH reimbursements. It recognized the preeminent and historic role played by Louisiana’s Charity Hospital system – and proposed for the first time a dedicated set of financial and medical benchmarks that would afford greater predictability in DSH funding – while also affording non-state hospitals (especially rural providers) DSH funding reimbursement for the first time (SCR 27 Report 2003, pp. 2-6).

Ignoring the legislative findings, the Foster administration *took advantage of another increase* in federally-designated safety net hospital DSH funds, meant expressly for Charity:

The federal government passed a bill allowing for enhanced DSH payments to state owned safety net hospitals. This enhanced payment is limited to Fiscal Years 2003 and 2004 and would allow for up to 175% of costs to be reimbursed. This enhanced funding is also designed to allow state safety net hospital(s) additional capital for investment and infrastructure (LSU-HCSD 2003, p. 17).

Louisiana DHH already received additional Medicaid incentive payments to “ease budgetary pressures to cut the program (by) temporarily raising the federal matching rate for Medicaid – the Federal Medical Assistance Percentage or FMAP” *without needing to divert safety net hospital DSH payments*. Louisiana’s enhanced FMAP rate increased to 74.58 for October 2003 to June 2004 (Ku 2003). This increased Louisiana’s Medicaid program spending to take advantage of the enhanced 2.95% federal match under FMAP (LHR 2003, p. 46).

Yet DHH forced Charity system hospitals to lose its enhanced DSH funding – *and forced Charity to bear an additional system-wide budget cut, together totaling \$274.7 million:*

State match generated from the use of the “175% overpayment option. For FY 03-04 and FY 04-05, the state may pay public hospitals 175% of their indigent care costs under federal Medicaid-DSH rules. To generate this overpayment, Medicaid will pay to state hospitals and DHH will recoup from them \$274.7 million. After paying the state’s matching share, DHH will net \$196.8 million for use in the Medicaid program... (Louisiana House Fiscal Division / LHFD 2003, p. 48).

Federal and LSU officials cried foul, “arguing that the (DSH funding) was not intended to be used for anything besides the state’s charity hospitals” (AP 2003; Shuler 2003g). Under the special federal match rate of 175%, “the charity system (was) eligible to collect \$671 million ... but the Legislature capped the hospitals’ revenue at \$345 million ... the rest (was) diverted to (DHH) ...” -- *leaving an additional \$52 million unaccounted for* (Moller 2003).

State legislators decried the cuts endured by Charity system hospitals – but did not succeed in restoring the lost funds in the same budget year. The spending cuts totaled \$66.5 million, with 291 people losing their jobs (Shuler 2003c). New Orleans’ Charity Hospital endured the largest cut: \$27 million and 59 jobs lost (Moller 2003). Nine operating rooms, the diabetic clinic, Charity’s home health department and the urgent care W-16 walk-in clinic were shuttered. (Butler 2003) “W-16 alone saw 40,000 patients each year, and its closure was disastrous for the emergency room” (Reckdahl 2004).

This round of austerity also came at the time LSU began to gain wider authority to manage its own budget, without what they viewed as onerous legislative restrictions. Act 906 of the 2003 Regular Legislative session proclaimed the end of “Open Access” – Louisiana’s historic commitment to the poor to receive free hospital care without means testing, circa 1926:

Any bona fide resident of the state of Louisiana who is medically indigent or medically needy shall be eligible to be admitted for any form of treatment by any general hospital owned and operated by the state of Louisiana (Revised Statute 46:6, LSU-HCSD 2004, p. 3).

Act 906 “(provided a means-tested) definition of “medically indigent” as any person below 200 percent of the federal poverty level and uninsured ... requiring that persons above this income threshold be responsible for contributing toward the cost of their care” (LSU-HCSD 2004, p. 15). It also allowed LSU to “reduce hospital spending by up to 35 percent of the previous year’s actual expenses without legislative approval” (Barrouquere 2003).

Though commanding a legislative majority, critics vowed to make the passage of Act 906, as well as the DHH diversion of DSH funds meant for Charity hospitals an issue in forthcoming 2003 state legislative and gubernatorial election contests. Senator Don Cravins of Arnaudville worried that LSU would not “keep their commitment to the people of Louisiana they made when they took over the charity system...” (Barrouquere 2003). Senator Diana Bajoie of New Orleans said “the change would prompt people who truly need care to stay away from the hospitals” – worsening the situation for emergency departments (Shuler 2003c). Senator Joe McPherson of Woodworth “said lawmakers were “misled” when they were told flexibility would allow the hospitals to better serve the needy.” LSU System President William Jenkins retorted: “Flexibility is important for us, but at the same time without funding that flexibility has made it a very difficult challenge for us” (Shuler 2003d). Indeed, the massive Charity system budget cuts threatened seven Tulane and LSU medical residencies with dissolution: “Three (of these) programs received warning letters from the Accreditation Council for Graduate Medical Education, a board that certifies all U.S. medical resident programs” (Butler 2003).

The future of the Charity Hospital system dominated Louisiana’s gubernatorial contest. Republican candidate Dan Kyle advocated Charity’s dissolution by privatization (Dyer 2003). Democrats Claude “Buddy” Leach and Richard Ieyoub vowed to keep all the hospitals open. Most of the rest of the candidates however, be they Republican or Democrat, supported the original Charity flagship facilities’ operation; but differed on details of their mission to serve the poor and the level of administrative control the remaining ones should be placed under. *The Advocate* observed: “All the major candidates for governor agree that LSU’s teaching hospitals in New Orleans and Shreveport should be preserved. But the fate and role of the other seven hospitals in urban and rural communities is another question” (Shuler 2003e).

The fate of Charity hospitals were a deciding factor in the 2003 LA. Governor's race

The two leading candidates in the 2003 Louisiana Governor's race shared remarkably similar views on the fate of the Charity Hospital system. Democratic Lieutenant Governor Kathleen Babineaux Blanco suggested that urban non-state hospitals "are saying just pay us for indigent care. If you give us the same amount as charity hospitals, we will take care of it and the state doesn't have to worry about bricks and mortar." Meanwhile the former DHH Secretary and Republican Party's choice Bobby Jindal, under whose watch LSU became the administrative operator of the Charity Hospital system, "(advocated) local governance of the state hospitals..." (Shuler 2003e). Jindal lead the voting in Louisiana's multi-party primary. Blanco came in second. Blanco "was the target of negative advertising" by Richard Ieyoub, a fellow Democratic Party challenger who charged that Blanco would close Charity hospitals (*The Advocate* 2003). Ieyoub then endorsed Blanco, after she pledged to keep the Charity system open (Frink 2003).

In a case of political turn-about, Blanco ran television commercials charging that Jindal sought to dissolve the Charity system. They "featured Evan Howell, a former staff neurologist who served at Lallie Kemp (Charity) Medical Center ... while Jindal was cutting the DHH budget" (Frink and Dyer 2003). Blanco narrowly won the election (Nossiter 2003b). Adam Nossiter opined in *The Advocate* that Blanco:

Throughout the primary, for instance, (Blanco) was distinctly lukewarm on a hot-button issue for Democrats, the state's charity hospitals ... A campaign statement released by her back in May said: "The Charity Hospital System is clearly broken. We can no longer afford to financial support a two-tiered health-care system in this state." But standing on the Capitol steps this week, at a boisterous rally with health-care professionals, she said firmly: "I stand here in full commitment to our state's charity hospital system. Over 1 million Louisiana citizens depend on our charity hospital system as their primary means of getting health care. These citizens cannot be abandoned" (Nossiter 2003a).

Governor Blanco's reform panel grapples with Charity's centrality in state healthcare

The enormous role played in securing the election of Louisiana's first female governor by voter concerns about future of the Charity Hospital system cannot be overstated. Had Kathleen Blanco not shifted her original lukewarm position to favor Charity hospitals, there would have been very little to distinguish herself from her primary opponent Bobby Jindal. Supposed conservative voter hostility to her gender otherwise cancelled out any conservative voter hostility to Jindal's Indian national heritage and complexion.²² In a curious bid, an effort was made to keep in place Governor Foster's DHH Secretary David Hood (Shuler 2004b). Yet Hood's view, that "the Charity Hospital system died in 1965 when Medicaid and Medicare were invented by Congress – We have just not had the funeral yet" (Shuler 2003a) was soundly repudiated by Louisiana voters. Whatever misgivings Charity Hospital supporters had about Blanco, advocates now thought LSU had a solid chance to modernize the iconic network.

Governor Blanco's choice for DHH Secretary, internal medicine specialist Dr. Fred Cerise, received wide acclaim. He previously served as administrator of Baton Rouge's charity hospital, the Earl K. Long Medical Center (Shuler 2004c). Cerise set out to organize a statewide health reform summit held March 2004 in a downtown New Orleans hotel (*The Advocate* 2004).

Continued federal scrutiny over the diversion of Congressionally-earmarked Charity Hospital DSH funds as well as the drastic cuts to Charity's system budget threatened to up-end the entire state budget by nearly \$800 million. Secretary Cerise admitted the diversion was wrong – but "as head of the state health agency" he appealed to the Center for Medicare and Medicaid Services (CMS) to uphold the spending (Shuler 2004d). CMS ruled in favor of DHH, on the pledge that there would be no additional Charity Hospital cuts (Madigan 2004).

²² Author comment: Some commentators have suggested that Jindal *was a victim of racism* in his first gubernatorial bid. Whatever the validity of that assessment, Jindal went on to win four years later an unprecedented first primary victory by one of the largest margins in Louisiana history, overcoming several well-financed white candidates.

Thanks in part to increased oil prices, LSU-run Charity hospitals were fully funded for 2004-2005 (Moller 2005b; LHFD 2004, pp. 2-3).²³ It was also fully funded in the 2005-2006 fiscal year, even with the loss of 175 percent federal DSH match. Indeed, the State General Fund's contribution was \$68 million higher than 2004-05 fiscal year (LHFD 2005, p. 11).

Governor Blanco's "Health Care Reform Panel" prompted the creation of "permanent regional health care consortiums" born out of the summits organized by DHH Secretary Cerise. Launched by Senate Health and Welfare Committee Chair Joe McPherson and House Health and Welfare Committee Chair Sydnie Mae Durand, the regional health consortiums sought to capitalize on "grass roots input into the problems of, and possible solutions for, the health care system in Louisiana." Established in the nine defined regions surrounding Charity hospitals, invitations to participate were advertised by DHH in conjunction with the Louisiana Senate district offices of each region represented. Notably, participation was expanded beyond just healthcare industry representatives to also include patient groups and healthcare workers. Members' terms were slated for three years with "consortium members ... selected by plurality vote of each region's legislative delegation" (Louisiana SCR 95 2004, pp. 1-2).²⁴

Rather than diminish the role played by Charity system hospitals, Governor Blanco and DHH Secretary Cerise *emphasized its centrality, yet also its overburdened capacity* in providing healthcare for the uninsured. With surveys finding "the Charity Hospital System is the First Line of Defense for many" (EP&P Consulting 2004), Cerise emphasized:

Current demand for care is greater than the system can accommodate. In addition to its service obligation, this system provides the environment for much of the medical education enterprise in the state. Chronic underfunding of maintenance has produced serious facility problems in several regions of the state... (Cerise 2004a).

²³ Louisiana is the third largest oil producer in the U.S., allowing it to earn severance taxes based on the price of oil.

²⁴ The author was appointed to a three-year term for the Region 1 Health Care Consortium (representing healthcare consumers in Jefferson, Orleans, Plaquemines and St. Bernard parishes) in October 2004.

The public conversation which unfolded from Governor Blanco and DHH Secretary Cerise's health care reform initiative attempted to couple Louisiana's poor health indicators with the state's high rate of poverty, rather than just blame either the impoverished or the inadequacy of the public health system which predominately served them. The state's poverty and health indicators nevertheless were grim. Louisiana indeed was ranked 4th highest in the U.S. in the rate of poor residents as well those with family incomes below 200 percent of the federal poverty level for family size; and was 49th or 50th in state-by-state rankings during the period in overall health status. Yet state officials also pointed out, in an unprecedented level of self-criticism, that though over one million Louisianans were covered by Medicaid in 2003, restrictive policies effectively limited participation to "children, pregnant women, age 65 and older, and people with disabilities." Louisiana, said DHH, had "the second lowest (Medicaid) income threshold of any state" – 13 percent of federal poverty level (Cerise 2004b, pp. 2-6).

A report from metropolitan New Orleans' – "Region 1 Consortium Update" offered a starker comparison. "The big picture problem in Region 1 is a large underserved population that suffers with poor health status – among the worst in the nation." Almost 28% of New Orleans residents in 2004 lived in poverty, with "approximately 50% of non-elderly adults ... uninsured and over half of the children are on Medicaid ... (with) minorities ... the most uninsured segment ..." (Stephens 2005, p. 3). The report also noted:

Further exacerbating this problem was the closure of services at the Medical Center of Louisiana (Charity Hospital). This has reduced the primary care capacity to less than 20% of what is needed to adequately cover the needs of the uninsured alone. These cutbacks have resulted in six month waiting periods for medical clinic appointments, and have further extended the already overburdened emergency rooms of our region. For example, the average service time in the Emergency Room (at Charity) is now eight to twelve hours (Stephens 2005, p. 4).

Region 1's "Care for the Uninsured Committee,"²⁵ in issuing its report to the regional consortium, placed the leading emphasis on "(protecting) resources allocated for the Medical Center of Louisiana (Charity Hospital) as the major provider of care for the uninsured in the region." It also extolled many of the professed aims of the Governor's Health Care Reform Panel, including expanded health insurance access and integration of primary care and mental health services – while leaving MCLNO/Charity as the epicenter of care to be accessed and improved upon (Williams and Ott 2005).

As friendly to Charity Hospitals as the Blanco/Cerise administration seemed to be, justifications to abandon or move from them by redirecting its main DSH funding away from the Charity system sometimes echoed the previous Foster/Jindal administration. A DHH discussion paper that would form the basis of the Governor's Health Care Reform Panel recommendations proposed a "Louisiana DSH Demonstration ... to place all of the state's DSH allotment in a pool." The paper cited as justification "(the) high rate of uninsured residents" ... "an oversupply of hospital beds compared to the rest of the nation" and "a growing number of uninsured are receiving episodic care in private hospital emergency departments, most of which do not have a coordinated, associated outpatient clinic network." This concept paper proposed underwriting private insurance coverage at the expense of the public hospital system (DHH 2005a, pp. 3-6).

DHH Secretary Cerise however stopped the wholesale diversion of Charity Hospital system DSH-operating funds to private providers. Freed for the first time from the threat of Charity Hospital's dissolution since assuming administration of the Charity system, LSU began asserting more directly what it could do to "leverage educational resources to provide access" and "organize indigent care to provide training opportunities" to further its "dual mission" of graduate medical education and safety net healthcare (LSU-HCSD 2004, p. 6).

²⁵ The author was Co-Chair with Clayton Williams of the 19-member committee.

LSU proposes building a new hospital – and closing Charity

Clark (2010a) said LSU's administration of the Charity Hospital system since 1997 defied the usual operational and financial obstacles to provide a successful safety net network:

Louisiana's state hospital system is an unusually comprehensive access-to-care model in a particularly poor state ... (LSU has made) Louisiana's access-to-care model a workable avenue for providing healthcare services for its low-income population. (LSU's) disease management programs help patients control chronic conditions and reduce preventable admissions and emergency department visits. An enhanced medication assistance program compliments disease management efforts by helping patients secure the drugs they need to adhere to treatment protocols and avoid health crises... (p. 122).

Louisianans, whether or not they were patients, concurred by a wide margin that the Charity Hospital system was vital. A late 2003 Baton Rouge *Advocate* poll found:

Louisiana voters ... made it clear they want to preserve the state's charity hospital system. Eighty-seven percent of those interviewed said Louisiana should continue its charity hospital system instead of closing the hospitals and paying to have needy patients cared for at private hospitals (Shuler 2004a).

A similar poll conducted by *The Advocate* in late 2004 found similar results:

Support for the charity system crossed all demographic regions, with [no support ranking] less than 81 percent [Baton Rouge and Acadiana areas]. The greatest support came from respondents in the New Orleans metropolitan region at 91 percent and next north Louisiana at 86 percent ... [and also commanded] 84 percent among white respondents and 89 percent among black respondents (Shuler 2005a).

Despite a high regard for LSU's improvements and the Charity system overall, "lawmakers simmering frustration with long waits and closed beds" reached a boiling point, prompting legislators to threaten LSU with *higher education cuts* if Charity hospitals didn't receive higher consideration. Some charged LSU "(favored) its educational missions above providing hospital services to the indigent." State Senate Finance Committee Vice-Chair Joe McPherson said, "You all need to get your priorities straight" (Moller 2005a).

Six years after it took over the Charity Hospital system from the Louisiana Health Care Authority, LSU commissioned its first comprehensive infrastructure assessment. Citing long-standing deferred maintenance, LSU found its “public hospitals ... physical condition so bad that they need more than \$300 million in repairs just to keep them open ... (with) the total cost of all recommended improvements ... is \$1.1 billion” (Shuler 2003f).

The two-year study proposed building entirely new hospitals in Baton Rouge, Pineville and New Orleans. The 2003 LSU hospital facility assessment, conducted by Washer-Hill & Lipscomb and Adams Project Management (ADAMS), found other Charity hospitals in fair condition; though it questioned whether the smallest facility in the safety net network, Lallie Kemp Medical Center in Independence, should remain open. The 2003 study also urged LSU *not* to add a “critical care tower” as was originally planned for University Hospital, the old Hotel Dieu Hospital the state purchased in 1992 as Charity’s replacement (Shuler 2003f).

In preparation for a push in the state legislature to secure capital outlay funding for new replacement hospitals, LSU commissioned its own poll to determine the depth of public support:

The poll found that, when given a choice, 83 percent of those surveyed said they favor having the state continue the LSU-run public Charity Hospital system over closing the hospitals and having “needy patients” cared for in private hospitals. Only 7 percent favor private hospital care. The rest gave no answer (Shuler 2005b).

More than 66 percent of respondents said that private hospitals *would not provide the same level of care for the uninsured* (Shuler 2005b). Critics, including the Louisiana Hospital Association, called for the closure of all Charity hospitals “except those attached to medical schools in Shreveport and New Orleans.” Even Governor Blanco, who otherwise publicly backed LSU’s new hospitals initiative, endorsed “community-by-community assessments of the future of the Charity hospitals within them,” prompting LSU to step up lobbying efforts (Shuler 2005c).

A newly enacted “hospital provider tax” purportedly designed to more equitably distribute DSH funds to private hospitals that treat the uninsured, also placed additional pressure onto LSU. They charged that “private hospitals get a higher reimbursement rate,” whereas LSU Charity system hospitals Medicaid reimbursement was arbitrarily capped, producing what they lodged was an unjust disparity that will annually cost LSU over \$100 million (Shuler 2005c).²⁶

Closure and replacement of Charity and University Hospitals, known together as the Medical Center of Louisiana at New Orleans (MCLNO), was proposed in a May 2005 report:

Due to years of deferred maintenance, lack of reinvestment in facilities, and changes in privacy regulation, MCLNO is housed in hopelessly outmoded facilities. Without action, MCLNO will likely lose its facility accreditation. The loss of this accreditation will cause MCLNO to fail to meet its mission of providing healthcare access to the uninsured, resulting in the redistribution of the area’s medically indigent to New Orleans’ other hospitals at a potentially higher cost to the state, and could possibly cause the evaporation of key health profession education programs in New Orleans (ADAMS 2005, p. 7).

The report said that a new hospital that would emulate “the Shreveport model” of academic medical centers. One option was new construction located next to University Hospital (known as the “South Option”) and converting the 1970s campus into outpatient clinics. Adams Management however recommended “that LSU-HCSD seriously consider locating the replacement facility north of Tulane (Avenue) with an address facing Canal Street” allowing for “the necessary future expansion” and “(providing) a better image and better transportation access” (ADAMS 2005a, pp.3-4, 7) – the same location planned for the post-storm LSU UMC.

Structural deficiencies cited overwhelmingly focused on Charity’s campus. Consultants urged that any “potential reuse of Charity” be for “non-hospital uses” and recommended “avoiding any research related or major educational functions” (ADAMS 2005a, p. 216). Issued just three months before Hurricane Katrina, *the report urged Charity Hospital’s demise.*

²⁶ The hospital provider tax was delayed then repealed entirely. See HB 131 (2005 FES) and SB 246 (2006).

It was an amazing spirit of people in the community doing the right thing, trying to open up this landmark institution to be a beacon light for the recovery of New Orleans.

Dr. James Moises, quoted by Lolis Eric Elie, *The Times-Picayune* (Elie 2006)

If I have anything to say about it, we're not going to rebuild Charity.

Jerry Jones, Louisiana Office of Facility Planning and Control (FPC) quoted by Jan Moller, *The Times-Picayune* (Moller 2006a)

Katrina was not the only catastrophe for the poor of New Orleans. The event has been used as an opportunity to close the doors of Charity Hospital...

Lt. Gen. Russel L. Honoré (2008, p. S6)

Chapter Three **Hurricane Katrina and Charity Hospital's forced closure**

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Charity Hospital's patients, staff and families weather Hurricane Katrina; LSU left all hospitals to fend for themselves; Federal health response compounds LSU's failure

A day after Hurricane Katrina's August 29, 2005 landfall, electrical switchgears located in the respective basements of Charity and its sister campus University Hospital were inundated by floodwater. Conditions at both hospitals rapidly deteriorated. In a matter of hours, the largest medical complex in Louisiana and one of the largest public safety net hospitals in the nation was transformed from a modern medical center into a Third World facility hobbled without electricity, air conditioning and running water. As in much of New Orleans, Charity and University hospital's patients, staff and their families were literally marooned for days awaiting rescue. Some patients died awaiting rescue. Everyone endured great hardship and discomfort as the languid summer heat *swamped* the hospital inside as floodwaters swelled outside.²⁷

Surviving Hurricane Katrina's winds, only to succumb to its encroaching floodwaters, several framed accounts are filled with heroism and humanism amidst fatalism. Barkemeyer (2006) recalled caring for infants at University Hospital without access to electricity or sanitation. Baldwin, Robinson, Barlow and Fargason (2006) outlined the interstate transfer of these same neonates. Gray and Hebert (2007) recounted sanitary improvisation at Charity and other area hospitals when New Orleans' municipal water services were shut off just a few days after Hurricane Katrina's landfall. Kline (2007), deBoisblanc (2006) and Van Meter (2006) balanced out the challenges and frustrations with camaraderie and humor abounding in improbability. Van Meter in particular recounted an evacuation scene:

Later, semi tractor-trailers backed up the ambulance ramp to evacuate the remaining Charity Hospital patients. To everyone's amazement, Charity's 120 psychiatric patients cooperated very well by standing in lines in the hospital's front lobby as they waited to be loaded into military trucks that had backed up to the front steps" (p. 253).

²⁷ Amongst numerous in-depth news reports documenting Charity and University hospital's crisis, representative were ones by *The Associated Press* (2005a), Sternberg (2005) and Freemantle (2005).

About 200 patients evacuated from Charity and 167 from University Hospital. Three had died because of post-storm conditions (United States House 2006, p. 286).²⁸ Loewenberg (2005) contrasted the evacuation response between Charity Hospital and Tulane Medical Center:

One of the most dramatic, and horrible, examples of the inequality of the disaster was that of Charity Hospital, where 600 patients and medical staff were trapped for more than 4 days behind torrents of sewerage and contaminated water, cut off from electrical power, clean water, and medical supplies. While Charity, the largest public hospital in Louisiana, went without relief ... the private facility across the street, Tulane University Medical Center, hired 20 private helicopters to evacuate its 1400 patients and family members (p. 881).

Loewenberg noted however that this inequity was no direct fault of Tulane, as chair of Tulane School of Medicine Dr. Lee Hamm, went by boat immediately to confirm the deplorable conditions at Charity and University Hospitals with *Associated Press* journalists – only to find that no immediate state rescue response was forthcoming (p. 881). Van Meter (2006) also noted that Tulane received “some of our sicker Charity Hospital patients...” (p. 253).

Several observers suggested that much of what actually happened could have been avoided – had disaster plans simply been read and followed. Said Loewenberg:

Government officials had warned about the disastrous results of a major storm for years. A particularly detailed briefing was given (2003) by a group of scientists at the Center for the Study of Public Health Impacts of Hurricanes at Louisiana State University (p. 882).

Franco, Toner, Waldhorn, Maldin, O’Toole and Inglesby (2006) and Brevard, Weintraub, Aiken, Halton, Duchesne, McSwain, Hunt and Marr (2008) noted that the 2001 flooding of Houston’s Hermann Memorial Hospital in Texas during Tropical Storm Allison was referenced in the LSU Health Care Service Division’s disaster preparedness plans. Federal officials concurred, *finding that LSU failed to uphold its responsibilities for hospitals under the state emergency operations plan* in advance of Katrina (United States Senate 2006, p. 600).

²⁸ Eight patients total died; three at Charity / University were wholly attributable to post-storm conditions.

LSU's inadequacy in disaster preparedness left both its own Charity and University / MCLNO complex as well as other non-LSU hospitals to fend for themselves. Guin, Robinson, Boyd and Levitan (2009, pp. 51-53) noted that 25 New Orleans metropolitan area hospitals with 2,500 patients and 11,000 staff and their own family members – even the three not requiring evacuation assistance – “were overwhelmed with the needs of their own patients and largely unable to provide assistance to others.” The Louisiana Superdome special-needs clinic, run by the New Orleans Health Department, relocated to the adjacent New Orleans Arena for more space – but quickly was inundated with acute admissions. Aid and evacuation stations were erected on Interstate 10 near the 17th Street Canal and the Causeway interchange. Another improvised (and chaotic) triage center was staged at the Louis Armstrong New Orleans International Airport for transfer to Air Force evacuation flights. Guin, et al (p. 47) also noted that search teams²⁹ made 65,000 rescues to areas outside of the floodwaters – but often just to places like roadway overpasses, where people were marooned for up to 5 days without shade or provisions – until the full-scale U.S. military evacuations were completed.

The Federal Emergency Management Agency's (FEMA) only ‘man on the ground’ in advance of Katrina, Marty J. Bahamonde, observed the Superdome “shelter of last resort”:

The Superdome had opened as a special needs shelter, but on (the day before Hurricane Katrina's scheduled landfall), as thousands of residents were unable to evacuate, the Superdome became a shelter of last resort for anyone left in the city. By noon, thousands began arriving and by midday, lines wrapped around the building ... I met with the National Guard inside the Superdome to discuss a range of things including the expected arrival of a FEMA Disaster Medical Assistance Team (DMAT) from Houston. The National Guard also told me that they expected 360,000 “meals ready to eat” “MREs” and 15 trucks of water to arrive that night ... Instead of 360,000 MRE's only 40,000 arrived. Instead of 15 trucks of water, only 5 arrived, and the medical team did not arrive either (Bahamonde 2005, p. 2).

²⁹ Guin, et al said the U.S. Coast Guard and other military, the LA. Dept. of Wildlife and Fisheries and many independent persons made rescues with limited air and water craft, to any available spot of dry land or roadway.

The first team to reach the Superdome shelter, New Mexico DMAT, arrived one day after Hurricane Katrina's landfall, and was immediately swamped with meeting the medical needs of 20,000 people (Bahamonde 2005, pp. 3-4). Guin, et al (2009, p. 75) said only one federal DMAT, Oklahoma 1, arrived in advance of the storm to provide immediate healthcare. A special report of the U.S. Senate Committee on Homeland Security and Governmental Affairs, entitled *Hurricane Katrina: A Nation Still Unprepared*, recognized that "Charity Hospital in New Orleans, rendered inoperable by flood water, was one of only two major trauma centers in the entire state" (U.S. Senate 2006, p. 399). Guin, et al (p. 75) summarized its findings:

- Activation of the National Disaster Medical System (NDMS) was severely hampered by "a limited number of federal medical teams (that) were actually in a position prior to landfall to deploy into the effected area" – and only one was in place before the storm.
- "The federal government's medical response suffered from a lack of planning, coordination, and cooperation, particularly between the U.S. Health and Human Services (DHHS) and the Department of Homeland Security (DHS)" (inclusive of FEMA).
- Federal medical agency providers lacked "adequate resources or the right type or mix of medical capabilities to full meet the medical needs ... of large evacuee populations..."
- "Although FEMA eventually deployed virtually all of its (NDMS) resources ... there was a greater need for such teams than could be filled, and those teams that did deploy experienced difficulties..."
- No "federal medical supplies were repositioned in the Gulf region;" it was impossible to fill "a last-minute request from the City of New Orleans" before Hurricane Katrina made landfall.³⁰

Though not officially called upon by the federal Department of Homeland Security until after that agency realized the enormity of Hurricane Katrina, the U.S. Department of Defense (DOD) under the command of "Lieutenant General Russel Honoré was already *leaning forward* pro-actively and moving assets and personnel into (the storm impacted) region" (Keating 2005, Broderick 2006). Charity Hospital would also be seen as a key military asset.

³⁰ Instead of the required 12 hours delivery, supplies from the Strategic National Stockpile took 3 days (AP 2005e).

The attempt to reopen Charity Hospital by its workers and the U.S. military is thwarted

Charity's patient evacuation was completed on September 3, 2005 – five days after Hurricane Katrina's landfall (Freemantle 2005). Charity's Emergency Department (ED) chief doctors subsequently were summoned by U.S. Army Special Forces units under the command of Captains Jason Howard and Robert Byerley, staged at the Morial New Orleans Convention Center, to assume its medical operations. Lead personnel from both groups returned September 6 to find that all of the first floor doors of Charity were left open and unsecured!³¹ Charity's ED doctors and military forces promptly agreed to embark on a plan to assess whether the hospital could be reopened, and once given clearance, proceed to do so (Moises 2009b, p. 115).

More than 150 soldiers under the command of General William Caldwell IV, Commander of the U.S. 82nd Airborne Division, accelerated the restoration of Charity by its ED doctors, nursing staff and medical residents (Evans 2009). Noting that “a building and not a tent” was needed for doctors to treat patients, Captain Howard said the 82nd Airborne's decision to support Charity Hospital's reopening was based on solid strategic evidence:

- 1) The first floor of the hospital was not compromised by flood water, only the basement was. This made it easiest to salvage.
- 2) The location and elevation of Charity Hospital was high enough and well located that if the levees broke again, patients and employees could be easily rescued by a large truck and evacuated via the nearby interstate. This was not so for the other hospitals.
- 3) Charity Hospital was also centrally located so that (Emergency Medical Services) could stage from there on dry ground so they could better provide medical support to the surrounding areas.
- 4) Charity Hospital suffered the least amount of damage compared to all of the hospitals in the area.
- 5) When the building was surveyed by a team of physicians who had set up several (field) hospitals, they were all in agreement that Charity was easily salvageable, (and) that it could be up and running within a few weeks (Howard 2006).

³¹ See Gratz (2011): “...participants in the post-storm cleanup described seeing signs of outright sabotage.”

U.S. military efforts to reopen Charity were authorized under *Emergency Support Function (ESF) Annex #8 – Public Health and Medical Services*, pursuant to the Department of Homeland Security’s *National Response Plan* on disasters and mass casualty incidents. Its first use of ESF-8 since its creation in response to the 9/11 terrorist attacks, the U.S. military formally received clearance from the Department of Health and Human Services and FEMA to restore hospital facilities in this “presidentially-declared” disaster (Lister 2005; ESF-8 2003 and 2008).

As called for under ESF-8, the U.S. Army Corps of Engineers evaluated Charity’s structural integrity and found it structurally sound. Howard said he then consulted with an “industrial hygienist” about the floodwaters then standing in Charity’s basement “(deciding) it was no where as bad as what was in the city streets.” Four million gallons of floodwater were pumped from Charity’s basement, Howard said, with the help of the crew of the Navy Battleship *Iwo Jima*, and by German engineers (Howard 2006). The USS *Iwo Jima*’s Damage Control team finished “dewatering” Charity’s basement September 14; and went on to drain floodwaters from the basement of the former Baptist Hospital Uptown and other facilities (Jones 2005). The Naval Mobile Construction Battalion 40 (NMCB) also made continual structural and environmental assessments of Charity – and boarded more than 300 windows in advance of Hurricane Rita’s landfall September 20, 2005 (Louisiana House Concurrent Resolution 8 (HCR 8) 2005).

Airline Ambassadors International (AAI), a non-governmental organization of airline employees affiliated with the United Nations assessed Charity’s new role in military operations:

Airline Ambassadors (AAI) assisted the [U.S. Army Special Forces] as they conducted interagency coordination during Katrina relief. AAI provided Special Forces with (a) 2 megawatt generator to keep Charity Hospital functional ... After Charity Hospital was cleaned up and pumped out (of floodwaters) ... Charity Hospital turned out to be a military asset that provided training for Special Forces medics. Reopening Charity Hospital was critical to the health care strategy of the entire southern [part of the U.S. impacted by Katrina] (AAI 2008).

One of the first people who had originally arrived at Charity to affect the rescue of its patients and hospital personnel, Staff Sergeant John A. Johnson, Prime Power Electrician, 205th Engineering Battalion U.S. Army, testified to his role in Charity Hospital's restoration:

Beginning on about September 7, 2005, I played a leadership role in restoring power to Charity Hospital, and in assisting in the cleanup of Charity in an effort to make it ready for possible quartering of soldiers. Between September 7 and September 19, 2005, I personally witnessed and participated in the complete restoration of the first and second and parts of the third floor of Charity Hospital ... Among the work done by me and others, we rerouted power from the basement, which was flooded when I arrived, and restored power to the first floor of Charity. We powered up the entire emergency room. We also used a backup generator to power up floors 3 through 19, and saw the generators successfully do that... (Johnson 2009, p.2).

Johnson estimated that there had been over 200 people involved, including the Coast Guard, Navy Seabees and various state National Guard units, as well as many civilian volunteers. Johnson said under Howard's command, the 21st Chemical Company attached to the 82nd Airborne oversaw the removal of all perishable refuse from Charity Hospital – and meticulously cleaned and certified Charity's emergency room and intensive care units as well as other floors for medical use. Johnson remarked: "I can attest from personal knowledge that the emergency room was cleaner than it was before (Hurricane) Katrina" (Johnson, pp. 2-4).

LSU Health Sciences clinical assistant professor of emergency medicine and ED physician Dr. James Moises said the "spotless" clean up of Charity's first three floors was "essentially complete by September 21." He said that electric power, sanitation services and air conditioning was also restored to the hospital (Moises 2009a, p.4).³²

While initially granted authorization by LSU officials to proceed with Charity's clean up, ED doctors were warned not to admit patients. General Caldwell nevertheless expressed confidence about the necessity of standing up Charity for patient care (Moises 2009b, p. 118).

³² Photos of Charity's restoration taken by its workers and U.S. military personnel are in Appendix A.

Within days of the restoration of Charity's first three floors being fully completed, Sergeant Johnson had requested and "arranged for the delivery of powerful state of the art generators from General Electric, which would have the capacity to provide power to floors 3 through 19 on a longer-term basis" – only to have "LSU officials, in my presence, refused to accept the generators, and as a result, General Electric took them away." LSU, backed by state officials, ordered an end to all efforts to reopen Charity Hospital (Johnson 2009, pp. 2-5).³³

LSU officials also warned its workers not to return. Indeed, Charity Hospital security intimated that if they did, *the workers would be charged with criminal trespassing*. Charity Hospital was then permanently closed by September 30, 2005 (Moises 2009b, p. 121).

Military commanders who questioned the closure order were told by Louisiana Governor Kathleen Blanco their help was no longer needed. Lieutenant General Russel Honoré, Commander of Task Force Katrina, remarked:

"Ma'am, we got the hospital clean, my people report ... if you want to use it," I recalled telling Governor Blanco. Her reply to me: "Well general, we're not going to open it; we're working on a different plan" (Burdeau 2009).

General Caldwell said Charity was ready to reopen after three weeks of intense restoration. Said Caldwell: "We were actually thinking of having a ribbon-cutting ceremony, give 'a thumbs up' and turn it over to the health care professionals" (Burdeau 2009).

Reflecting on reasons state officials wanted to keep Charity closed, Honoré said:

This is about business, man. This is about rich people making more money. This is not about providing health care (Burdeau 2009).

Former Charity doctor James Moises *said it was about getting a new medical complex*:

It was their orchestrated plan. It was 'How can we manipulate the disaster for institutional gains?' (Burdeau 2009).

³³ YouTube A/V interview: http://www.youtube.com/watch?v=E2QCUslXFDU&feature=player_embedded.

For her part, Governor Blanco told *The Associated Press* she didn't recall speaking with General Honoré about Charity's closure – nor did she even know about their efforts to stand up the hospital for medical use (Burdeau 2009). Nevertheless, it was well known that Blanco had refused to permit Joint Task Force Katrina to exert full control over the Louisiana National Guard and other post-Katrina efforts during the same time period as the Joint Task Force Katrina-backed attempt to reopen Charity Hospital (Bowman, Kapp and Belasco 2005).

Tensions between the Bush Administration and Governor Blanco flared in the storm's aftermath, heightening the failure of emergency response that stranded tens of thousands until the cavalry under Honoré's command came. U.S. Representative Tom Davis, Chairman of the Select Bipartisan Committee to Investigate the Preparation for and Response to Hurricane Katrina, said:

We all acknowledge the heroic efforts that (the Department of Defense), National Guard, and Coast Guard personnel made, efforts that saved many, many lives. The mobilization was massive and, at least once the call went out, swift. But we also need to acknowledge that there were problems with the military response ... There were problems ... with an early and persistent disconnect between DOD and state and local authorities... (Davis 2005).

Congressman Davis went on to frame the boundaries of conflict on disaster response “with regard to the National Response Plan's *Catastrophic Incident Index* – the annex that authorizes federal agencies to act when state and local capacity even to know what they need is compromised by the sheer size of the calamity.” Yet Davis also cites a statement by the National Governors Association – stating that *governors* should lead any disaster response (Davis 2005).

Major General Bennett C. Landreneau, Adjutant General of the Louisiana National Guard, testified that it was under Governor Blanco's command and that DOD's Joint Task Force Katrina under the command of Lt. Gen. Honoré was “one of working partners” – directly coordinating with Governor Blanco their hurricane response (Landreneau 2005, p. 3).

Louisiana returns \$340 million in emergency FEMA aid meant to repair Charity Hospital

The lengths to which the U.S. military sought to restore Charity Hospital's most vital functions cannot be overstated. In addition to being granted advance authorization under the ESF-8 provisions, "FEMA authorized expenditures up to \$1 billion" for the military to transport and distribute relief supplies and set up medical facilities. In turn, "Department of Defense (DOD) granted commanders a 'blank check' to do whatever was necessary to help the people of Mississippi and Louisiana" (U.S. Senate 2006, p. 425; Wombwell 2009). According to a Congressional Research Service assessment of early Department of Defense Katrina-related appropriations, FEMA reimbursed the DOD \$4.6 billion (Bowman, Kapp and Belasco 2005).

A possible attempt by the Department of Defense to allocate substantial monetary resources to cover necessary repair costs of Charity Hospital was initiated – *but declined* by Louisiana state officials in September 2005. Under normal FEMA Public Assistance program guidelines, the federal agency would pay 75 percent of project costs and a state would be responsible for 25 percent. Under special expedited rules, FEMA pledged "to reimburse state agencies and local governments for costs involved in lifesaving emergency work related to Hurricane Katrina" *reimbursing 100 percent of all eligible costs* (FEMA 2005).

Louisiana's Department of the Treasury received \$352 million during the third week of September 2005, adding to \$105 million already on hand for a total of \$457 million in FEMA-approved disaster assistance. Louisiana's Department of Health and Hospitals (DHH) officials however expressed confusion over what the funds were intended to reimburse. DHH officials said if they accepted the funds without accounting for actual expenditures, the state would be charged interest, and potentially blocked from future FEMA Public Assistance funding – so DHH promptly returned to FEMA almost \$340 million (Maggi 2005).

In a departmental press release, DHH acknowledged numerous questions from the public, but said that its handling of the FEMA “overpayment” – which DHH said never actually reached their coffers – was disclosed to Governor Blanco, as well as to the Legislative Auditor and the state inspector general’s office. DHH Secretary Dr. Fred Cerise cited the federal Cash Management Improvement Act of 1990 that “only allows state agencies such as DHH to get federal reimbursement for actual expenditures, not for anticipated needs” (DHH 2005b).

DHH interdepartmental electronic communications revealed that “Charity hospitals might also be included in this \$350 million dollar request” (Reynolds 2005). The communications also indicated that the funding was being arranged as part of a mid-year state budget adjustment, known as a BA-7, to account for the expenditure of funds within state government. The communications do not indicate whether the funding request was being made on behalf of the U.S. Department of Defense – though its Louisiana counterpart known as the Military Department was seeking to line up “\$350 (million) on the Military’s BA-7 for (the Office of Public Health)” (Dusse 2005). DHH said in its press release that the agency “received \$352 million from FEMA, but spent only \$9.6 million on (Office of Public Health) special needs shelters that were opened throughout the state, overtime pay and medical supplies”(DHH 2005b).

Under ESF-8 provisions both DHH and LSU have federally-mandated state-directed responsibilities during emergencies and disasters. Both state administrative bodies came under fire for their lack of professional competency (Rainey, Scardina and Updike 2005, pp. 131-132). Yet nagging questions also loomed that questioned the state’s assertion that Charity Hospital could not be made suitable for medical use. LSU-HCSD chief Don Smithburg said “Charity Hospital would cost \$340 million to repair” (Moller 2005d). This was the same amount which the U.S. military *apparently attempted to give Louisiana officials for Charity’s reopening.*

The healthcare consequences of Charity Hospital's forced closure

After rebuffing Task Force Katrina's efforts to reopen Charity Hospital, LSU had attempted to retain the U.S. Navy hospital ship *USNS Comfort* to become Charity's substitute. The ship had arrived at the Port of New Orleans September 29 after spending nearly three weeks on the Mississippi Gulf Coast treating more than 1,800 people in Hurricane Katrina's aftermath. The 800-bed floating trauma center however saw no more than 100 patients during its two week New Orleans stay. Charity Emergency Department (ED) Dr. James Aiken said he was "very concerned" that the *Comfort's* departure would leave "New Orleans without a fully functioning public hospital as residents began to return" (*The Associated Press / AP* 2005c; Moller 2005d).³⁴

Following the closure of Charity Hospital and the *Comfort's* departure, Charity's remaining medical staff practiced medicine in several makeshift locations. First, six tents were set up outdoors as an urgent care MASH unit five blocks away in a parking lot from the Charity campus they had restored just days before. More serious trauma cases were treated in a joint Army Special Forces-Charity ED unit inside the Morial New Orleans Convention Center (Young 2005). Dr. Peter DeBlieux, director of resident training at Charity, responding to the provision of "E-MED" emergency medicine tents, rather than just reopening the hospital:

Now my fear is the entire country will think it's appropriate to care for our patients in a tent. I don't think the rest of the country appreciates we are seeing people in a tent (Connolly 2005).

DeBlieux said the unit, dubbed "The Spirit of Charity," saw about 150 patients daily. Because of the makeshift nature of E-MED tents, it failed to meet federal health standards – and hence was unable to receive Medicare, Medicaid or private insurance reimbursement. The unit's funding was drawn instead from Charity hospital system state budget allocations for its physical building – monies that LSU officials acknowledged were running out (Connolly 2005).

³⁴ For healthcare consequences related to Charity's closure that prompted internal displacement, see pp. 111-115.

After Charity's closure, just 250 out of nearly 4,000 Charity and University hospital employees remained working, with the rest placed on unpaid furlough (Connolly 2005).

Displaced health professionals warned that these job losses could become permanent – and would compromise the very recovery of the city:

We read in the paper that the governor wants to keep as many people as possible in the state; that the mayor wants to repopulate the city soon and start building business again. I could not agree more. But not addressing Charity Hospital / MCLNO and leaving employees' employment status in limbo is not the way to do this (Danos 2005).

Two months after Charity's closing, over 2,600 hospital employees would be fired (Moller 2006c). LSU and Tulane graduate medical education programs were destabilized, leading to the reassignment of 550 medical residents and fellows. The Delgado Charity School of Nursing and other schools, in addition to LSU allied education and dentistry programs were also impacted by the displacement of 2300 nursing and allied health students (LSU-HCSD 2005).

And "The Spirit of Charity" was forced to wander again, as the Morial New Orleans Convention Center sought to prepare the site where the tent hospital stood for pre-storm booked conventions (Callimachi 2006). They moved to a once-flooded department store next to the Louisiana Superdome (still used as outpatient clinics); while a mothballed hospital in Jefferson Parish was reopened as a temporary 40-bed Level 1 trauma center. LSU-HCSD spent nearly \$5 million for the makeshift facilities, which were later reimbursed by FEMA (Louisiana Public Records Act request 2006; United States General Accountability Office / U.S. GAO 2006a, p. 6).

Charity Hospital's closure in the months and years following Hurricane Katrina underscored its utter centrality to southeast Louisiana healthcare, both public and private. Charity's Level 1 trauma center was the only one on the Gulf Coast – forcing remaining hospitals to receive patients with medical conditions rarely experienced (Barringer 2006).

Coupled with the near-total closure and / or destruction of area nursing homes and rehabilitation facilities, the few remaining open hospitals quickly filled with patients that would not be so easily discharged (Barringer 2006). A severe shortage of nurses, aides, home hospice and service workers compounded the crisis (DHH 2006). A veritable Katrina *Doctors' Diaspora* – “the largest single displacement of doctors in U.S. history” – added pressure to those remaining (American College of Emergency Physicians / ACEP 2006). This loss of health workers, federal officials said, resulted in “staffed hospital beds (inside New Orleans’ city limits) that were about 80 percent *less* in February 2006” than before the storm (U.S. GAO 2006a, p. 35).

Charity’s closure also compromised trauma services beyond New Orleans -- especially in Baton Rouge – the latter where many evacuees endured lengthy wait times that threatened to adversely affect patients’ health (ACEP 2006). Many primary care practices and outpatient clinics citywide, already decimated by flood damage and the dislocation of their patient bases, lost the only hospital which would accept their referrals (Ferdinand 2006).

The *finances* of remaining private and non-state hospitals also hemorrhaged due to the virtual overnight inundation with patients that Charity would have normally seen. Charity’s sudden closure sent shock waves of pain – even on those which had proclaimed this iconic but neglected hospital to be outmoded (Zigmond 2006; Larkin 2007, p. 58; Sternberg 2007).

Testifying before a U.S. House subcommittee on post-Katrina healthcare, Colorado U.S. Representative Diana Degette remarked about the private providers’ apparent underlying stance when it comes to Charity Hospital – and especially its care for the uninsured:

I asked the panel of the private hospitals if their long-term business plans included providing care to the population previously served by Charity; and everybody got a look of shock on their face and said no, that was not in their business plan for assuming the care of Charity’s patients in the long term (Degette 2007, p. 7).

Diane Rowland, Executive Director of the Kaiser Commission on Medicaid and the Uninsured, characterized Louisiana healthcare as “a two-tier system” with private hospitals and providers serving those with insurance and Charity system hospitals serving the uninsured – and that the closure of Charity after Hurricane Katrina had a profoundly negative impact on both:

Our household interview survey (revealed) the fact that 90 percent of our respondents did not feel there were enough services, hospitals, clinics, medical facilities in the New Orleans area to meet their needs and that it was one of the most troubling factors in their decision of whether (to return or stay) in New Orleans (Rowland 2007, p. 21).

Though licensed at 714 beds in two campuses at the time of Hurricane Katrina, there were 300-500 regularly staffed beds between Charity and University hospitals (LSU-HCSD 2005; Hartley 2012). Before Katrina, Charity had 70 ED beds and University 14 (Moises 2009a, p. 1). Charity also had a 128-bed psychiatric “Crisis Intervention Unit” (BKA 2007). Pre-Katrina, Charity had more than 160 outpatient clinics on its MCLNO campus (Smithburg 2007, p. 176). Another 21 free clinics apart from LSU were situated throughout metro New Orleans (Partnership for Access to Healthcare / PATH 2003). Six years later, 76 safety net clinics³⁵ are open, including ones run by LSU-HCSD inside LSU Interim Hospital and other locations (Greater New Orleans Community Health Connection / GNO CHC 2011).

Charity’s sister facility, University Hospital, once declared “unsalvageable,” *reopened* in late 2006 as *LSU Interim Hospital* (Smithburg 2005, Moran 2006). Staff shortages initially led to only 60 of 150 beds available for its opening (Moller 2006c). Its Level 1 trauma center did not return until February 2007 (LSU-HCSD 2007f, p. 19). Six and a half years later, LSU Interim has 255 staffed beds with 38 intensive care unit beds (Hartley 2012). FEMA has reimbursed LSU \$101 million of the hospital’s total repair costs (FEMA 2011).

³⁵ “Safety net” indicates access to free inpatient and outpatient healthcare, exclusive of prescription drugs and certain tests, for those with incomes of 200% of the federal poverty level for family size, qualifying under either under the 1115 Medicaid waiver (DHH 2010) or LSU-HCSD Free Care (LSU-HCSD 2011b).

Nowhere has the impact of Charity's closing been more acute than with inpatient psychiatric care. The closure of the hospital's psychiatric Crisis Intervention Unit (CIU) – once the city's largest facility – left Orleans Parish Prison's 60-bed psych-ward to become the default provider and the largest place for inpatient psychiatric care (Stephens 2007). A clinician noted:

Without Charity Hospital and the VA Medical Center, the psychiatric public sector bed capacity was reduced 96% four months after the disaster; one year later the reduction remained at 70% (Calderon-Abbo 2008, p. 305).

Years after Charity's closure, the inundation of area general hospital emergency rooms with mental health patients continues to be a seemingly insurmountable obstacle. Such patients often remain for weeks and crowd out other acute care patients. Within the first year of the storm, hospitals effectively were closed to new admissions – even as ambulances and police continued to drop off emergency patients (Potash and Winstead 2008, p. 122).

The American College of Emergency Physicians said psychiatric care was “deficient before the storm (and) now close to non-existent” – and that Charity's closed psychiatric CIU was “the number one cause for the mental health crisis” in New Orleans (ACEP 2006, p. 3). Three years after the storm, 20 beds were staged *in trailers* outside LSU Interim as a “Mental Health Emergency Room Extension (MHERE) (Egglar 2008). This makeshift unit received more than 350 people in September 2010 alone “with a mental health crisis” (Tebo 2010).

Baton Rouge Mayor Melvin “Kip” Holden noted that his city was also adversely impacted with the loss of “900 of the state's 2,100 licensed beds when New Orleans was evacuated” (Holden 2005). Baton Rouge mental health professionals “reported a 72 percent increase in patient volume at their three mental health clinics, 100 additional cases per month of patients in mental health crisis presenting to area emergency rooms” ... and a near doubling of “commitment orders for mental health treatment” (Potash and Winstead 2008).

A study conducted in early 2006 of all Tulane University faculty and staff (including administrators) found “a significant burden of (Post Traumatic Stress Disorder) PTSD symptoms was present 6 months following Hurricane Katrina among a large group of adults who had returned to work in New Orleans” – and this was from a workforce, researchers said, that had “universal health coverage and the benefits of an employee assistance program” (DeSalvo, Hyre, Ompad, Menke, Tynes and Munter 2007). Meanwhile a study of LSU Interim ED patients surveyed right after the hospital was reopened found a PTSD prevalence of 38.2 percent – *ten times higher than the national PTSD prevalence* of 3.6 percent (De Wulf, Mills, Levitan, Macht, Afonso, Avegno and Mills 2007). In a 2007 survey by the Henry J. Kaiser Family Foundation, access to mental health services *declined* – and “that three out of four people support the restoration of Charity Hospital as a primary health care resource for the poor” (Shields 2007).

New Orleans had “15.8 suicides per 100,000 persons in 2009 – well above both the pre-Katrina rate of 9.8 and the national rate of 10.96” (UNITY for the Homeless of Greater New Orleans / UNITY 2010). A rash of suicides at Orleans Parish Prison, compounded by inadequate staffing and procedures, underscore the need for more outside treatment options (T-P 2009b).

Heightened levels of violence also have come define the post-storm landscape. Incidents such as the killing of two children by their uncle, who suffered from schizophrenia, led New Orleans Police Department Crisis Commander Cecile Tebo to observe:

This is what happens when a city does not provide in- and out-patient services for people with mental illnesses (Urbaszewski 2011).

Tebo has long warned of “the ticking time bombs” of people suffering from debilitating mental illness and lacking mental health resources, who are “poised to harm themselves or someone else.” She also said that many in prison wouldn’t be there if proper treatment options were made available (Tebo 2007).

Some public education, healthcare and homeless advocates have sounded the alarm that the failure to replace the mental healthcare services once provided by Charity Hospital has heightened disaster-induced PTSD – leading to enhanced rates of chronic homelessness and an intractable wave of crime since Hurricane Katrina (UNITY 2010; Andrews 2011).

Following demands from New Orleans Mayor C. Ray Nagin and the City Council to restore or replace Charity’s psychiatric CIU, the state and LSU announced in 2007 a slight expansion of inpatient mental health services, with 20 additional adult psychiatric beds each at DePaul Hospital and the New Orleans Adolescent Hospital (NOAH) (Nagin 2007; Hong 2007; Calderon-Abbo 2008, p. 307). The state also evaluated whether Charity could be reopened for just its psychiatric CIU – finding that Charity’s “deficiencies are correctable” (Blitch Knevel Architects / BKA 2007a and BKA 2007b).

Despite the expansion of adult psychiatric beds, mental health capacity remains strained. Planners for the proposed replacement of Charity Hospital acknowledged that the current 38 beds “are nearly 100 percent occupied and the unit is frequently on ‘diversion’ status” – and that 22 additional beds for 2015 “rapidly will be filled” (Verité 2011, p. 17).³⁶

Health professionals from around the nation decried Charity Hospital’s closure. Robert E. Suter, President of the American College of Emergency Physicians (ACEP) wrote to LSU:

The emergency medical services provided at Charity Hospital are an essential public service that needs to be restored and maintained to avoid further tragedy (Suter 2005).

Charity’s workers never waned, though their patience frayed. Dr. DeBlieux said:

Within 2 weeks after the storm, our entire residency contingency and many of the academic faculty were back in the building salvaging, in hopes of delivering care in that facility. The leadership at the state level told us to stand down. They did not think that was a salvageable enterprise. It was very difficult [to accept] (Flynn 2006, p. 311).

³⁶ See *Epilogue* for the 2012 status of LSU Health system budget cuts, furthering the loss of Charity Hospital.

Senator Coburn and others demand that Charity be reopened and independently evaluated

LSU officials, under fire for keeping Charity closed in the wake of Hurricane Katrina, confronted head-on their critics. Dr. Michael K. Butler, Chief Medical Officer of LSU's Health Care Services Division (LSU-HCSD), in a letter to the ACEP's Suter, caustically remarked:

The first casualties of [Hurricane] Katrina were truth and sound reasoning. Much misinformation has been promulgated in the media, and from well-meaning staff and providers (Butler 2005).

Butler replied to Suter that Charity cannot be revived, despite the attempt to do so:

People now think that Katrina was a hospital renovation improvement project which will "magically" convert Charity to be appropriate for [Emergency Department] work when it wasn't appropriate prior to the storm. The "cited" experts and their reports have not materialized. We are concerned, more than you, about retaining our faculty, our education programs, and our patients. We understand you are concerned about the specific emergency department program and your concerns are noted. Promulgation of rumors and innuendo is not appropriate or productive. We are concerned about 87 residency programs with 800-plus residents (Butler 2005).

LSU's expulsion of its doctors and military personnel from Charity Hospital also reached the halls of Congress. U.S. Senator Tom Coburn, a practicing physician, received complaints from members of the Oklahoma National Guard that Charity could have reopened. During a hearing October 6, 2005 before a U.S. Senate subcommittee, Coburn suggested that LSU was taking advantage of the storm to get a new Charity replacement (Moller 2005d).

Senator Coburn (2006) wrote LSU-HCSD's Chief Executive Officer Don Smithburg, expressing his awareness of New Orleans' "decimated hospital infrastructure" and urged that Charity be reopened, to "provide a temporary solution to a crisis situation." Coburn stated that he was impressed with "the heroic efforts of the medical staff to clean the rest of the hospital – without pay or credit." He then reiterated that assessments made by the U.S. military certifying that Charity could be used for interim medical care not be summarily dismissed (Coburn 2006).

Senator Coburn also called for an independent review of Charity's medical viability:

I understand that in order to allow military personnel in to clean up the place, the Army Corps positively assessed the hospital for its structural soundness. In addition, the 82nd Airborne, (the Occupational, Safety and Health Administration), and the (U.S.) Public Health Service have all visited the hospital and informally assessed its soundness. I understand that these reports were preliminary. However, their positive outcomes (underscore) that a full and professional evaluation be conducted. So far, the only "comprehensive" assessment of the Charity Hospital facility was conducted by Louisiana's consulting engineer from Atlanta, Walter Adams. As a member of the U.S. Senate Homeland Security and Government Affairs Committee (HSGAC), I strongly recommend that the LSU system commission a completely independent evaluation of the facility (Coburn 2006).

LSU-HCSD's Chief Executive Officer Don Smithburg responded to Senator Coburn, referencing the Adams Project Management assessment. Smithburg expressed appreciation for the doctors' attempt to reopen Charity, while reiterating that LSU had no intention of reopening:

Like you, we have heard views expressed that it would be a relatively easy matter to clean and reopen Charity Hospital. However, it would be derelict for us to act on anything other than the best evidence available ... We appreciate the help and concern from others who are well-intended and motivated by a shared concern for patients and education. In fact, it is a testament to the dedication of our LSU physicians that many are willing to endure all manner of adverse conditions, whether obvious or hidden, in order to continue serving the New Orleans population. But, our fiduciary duty to our patients, medical staff, and the community requires us to make decisions based on written assessments by qualified engineering experts... (Smithburg 2006).

Smithburg warned Coburn that unseen damage and dangerous mold and other hazards lurked behind Charity's walls.³⁷ He ignored skepticism of Adams Management's impartiality. Nor did he mention Adams' recommendation two years before Katrina for "the replacement or relocation of the Charity campus ..." with "a new replacement 600-bed health-care center (to) become the centerpiece of a bold, new Medical Center of Louisiana" (*This Week at MCL* 2003).

³⁷ Photos taken by LSU of Charity's storm destruction and medical response are in Appendix B.

Despite LSU's proclamation of closure, Charity's workers make a last public stand for reopening; FEMA disputes LSU's amount of Charity's storm damage reimbursement

LSU-HCSD's chief Donald Smithburg proclaimed to the LSU Board of Supervisors that Charity and University hospitals "were issued their 'death warrant' by Katrina" (AP 2005b). This contention that *it was Hurricane Katrina that had done in Charity Hospital* – while LSU and the state long sought the hospital's closure in advance of the storm – particularly rankled Charity's Emergency Department doctors. Nearly three months after being barred from reopening their unit along with Charity's first three floors, *The New York Times* reported:

The state officials who manage Charity say Hurricane Katrina dealt this Huey Long-era landmark a deathblow and want it torn down. In its place, they say, they want to build a hospital with a "new mission," one that treats both public and private patients and relies less on government money. But doctors who work there sharply disagree with that plan. They say Louisiana officials are using the storm as an excuse to achieve the state's long-sought goal of demolishing Charity, and then moving away from a promise that has long been made to the city's poor (Nossiter 2005).

Federal Emergency Management Agency (FEMA) infrastructure specialist David Fukutomi previously suggested that federal rules under the Stafford Act allowed funds to be applied to replacement construction, noting that LSU and the State of Louisiana could take advantage of "a fantastic opportunity to implement a vision for the future" (Connolly 2005). Adam Nossiter's *New York Times*' reportage showcased for a national audience Charity's ED doctors' contention that the hospital was not damaged beyond repair and could had been reopened on an interim basis to address New Orleans' post-Katrina vital health needs. Signaling a shift that set up a new phase of contention between those favoring and opposed to reopening Charity, *The New York Times*' report now quoted FEMA's Fukutomi expressing skepticism about LSU and the state's "very impressive public relations campaign to publicize their desires" to keep Charity closed and reapply its replacement value toward a new facility (Nossiter 2005).

Indeed, FEMA was fully aware of the clean-out of Charity Hospital by both its workers and military units under the command of Joint Task Force Katrina, as authorized under the National Response Plan: “FEMA funded all of these emergency protective measures in an expedited manner as it was assumed Charity Hospital could be re-opened to provide critically-needed medical and emergency services care to the New Orleans area” (FEMA 2009, p.11). In contrast to the state’s \$257.7 million damage assessment, FEMA said its late 2005 assessment found Charity sustained storm damages of \$23.9 million (FEMA 2009, pp.12-15).

In what was described as “a 2-hour tongue lashing,” Charity Hospital ED members quoted in the December 2005 *New York Times* report were summoned to a January 2006 meeting by LSU-HCSD chief Donald Smithburg and HCSD Chief Medical Officer Dr. Michael Butler. The workers were warned against continuing their public dissent against Charity’s closure – or, suggested Butler, there would be grave consequences of “Biblical proportions” – meaning the potential loss of their medical emergency department operating contract and other actions. The most outspoken member, Dr. James Moises, weeks after the meeting, formally resigned his Charity clinical appointment in protest (Moises 2009b, pp. 134-137, 168). His continued public dissent, joined by medical residents, sparked continued public resistance to Charity’s closure.³⁸

While it is thought that some Charity workers continued to dissent behind the scenes, for 100 medical personnel, joined by former patients, New Orleans City Council President Oliver Thomas and the grandson of Charity’s architect, their last *public* expression was held March 25, 2006 outside Charity’s shuttered ED ambulance ramp.³⁹



³⁸ The author joined with Moises in this public resistance. A list of organizations calling for the reopening of Charity Hospital – as well as saving the Lower Mid-City New Orleans neighborhood from demolition for the proposed University Medical Center replacement are provided in Appendix C.

³⁹ Reporting by Haber (2006) and Martel (2006); Commentary by Elie (2006) and LSU-HCSD (2006d)

Though Charity Hospital's doctors could no longer publicly dissent against LSU and the state's abandonment of Charity Hospital *and* keep their jobs, their attempted disaster recovery efforts to restore healthcare by reopening Charity Hospital had significantly influenced FEMA's challenge on reimbursement for actual storm damages versus pre-storm *and* post-storm facility neglect (FEMA 2009, pp. 11-12). Clashing with LSU and the state's unyielding response to keep Charity closed at all costs – only an unprecedented political intervention would convince FEMA to approve releasing the funds for Charity's full replacement cost.⁴⁰

LSU often cited a March 2006 U.S. General Accounting Office (GAO) report to back its decision to keep Charity closed by not spending tens of millions of dollars on an outdated facility.⁴¹ Yet that report also suggested, in the same cited paragraph, that LSU faced “a complicated decision” because of Charity and University hospital's centrality as a healthcare safety net – and that *not* reopening “could have significant implications for health care service delivery in post-Katrina New Orleans and for statewide graduate medical education and Level 1 trauma care” (U.S. GAO 2006b, p.10). Six months later in a follow-up GAO report:

As we reported, the availability of health care services – which includes those provided within and outside of a hospital facility – is one of the factors that can affect whether and how quickly residents return to an area after a disaster (U.S. GAO 2006c, p. 2).

The September 2006 GAO report reflected more deeply the absence of Charity and University hospitals. While it said bed capacity across metro New Orleans had rebounded to “a sufficient number of staffed inpatient beds” – it did not qualify that most of the beds were at *private* facilities. And further, finding *any* empty psychiatric beds remained next to impossible; and retaining nursing staff was almost as challenging. Without Charity Hospital, emergency room occupancy was 96 percent for adult critical care beds (U.S. GAO 2006c, p. 13-14).

⁴⁰ See Gallegos (2009) and U.S. Department of Homeland Security (2009a-b) – and further described below.

⁴¹ E.g., Webster (2007): “SPECIAL TREATMENT: Reopening Charity Hospital's first three floors possible”

In its assessment of the LSU and FEMA dispute, the September 2006 GAO report detailed initial FEMA repair estimates of storm damage to Charity Hospital were raised slightly to \$27 million, while LSU's storm repair estimates rose to \$257 million. The significant gap in costs was gauged primarily between LSU and the state's desire to be fully reimbursed for what they termed "whole building repair" versus just storm damage repair. LSU's addition of a "cost escalator," built into the estimates to account for the rise in cost of post-Katrina building materials and labor, led LSU and the state to claim that the needed repair costs exceeded the 51 percent FEMA threshold *for a full building replacement* (U.S. GAO 2006c, pp. 19-21).

FEMA responded that "LSU (could) select a few projects at Charity Hospital and put them out for bid" to serve as a baseline for real costs. The GAO said LSU demurred on this request, *deeming it potentially wasteful spending on an obsolete facility they had no plans to resurrect* even "to perform the functions for which the hospitals were being used immediately prior to the disaster." LSU suggested federal regulations allowed for the costs of code upgrades, combined with storm damage that the costs rose above the fifty percent FEMA replacement threshold (U.S. GAO 2006c, pp. 19-21). Curiously, *LSU did repair University Hospital with full FEMA funding* under the agency's emergency services regulation that it originally offered to LSU and the state, *if Charity was allowed to be reopened* (Darcé 2006; FEMA 2011).

Representing LSU and Governors Blanco, then Jindal in negotiating FEMA's Charity storm damage determination was Jerry Jones, head of the Office of Facility Planning and Control (FPC) under the state Division of Administration. As designated by a Blanco executive order (remaining in effect as of this writing), no repairs or rebuilding of damaged facilities are allowed without Division of Administration sanction (Blanco 2006). Jones unabashedly noted: "If I have anything to say about it, we're not going to rebuild Charity" (Moller 2006a).

Governor Blanco and Jerry Jones' resolve not to reopen Charity was met with significant opposition. The New Orleans City Council unanimously demanded Charity's reopening (R-06-143 2006). A 2006 Louisiana state legislative resolution also called for the reopening of Charity Hospital – specifically its first three floors – on an interim basis until its replacement could be constructed; and that the facility is independently evaluated “to determine the advisability of repairing or restructuring the entire facility...” (Louisiana HCR 89 2006).

Though Charity never reopened for medical care, Charity's maintenance shop, laundry building and power plant returned to service the LSU Interim Hospital.⁴² Meanwhile the independent group recognized by the state legislature, the Foundation for Historical Louisiana, contracted and funded a \$600,000 study completed by RMJM Hillier in August 2008 – which found that Charity could be revitalized to become a 21st century LSU academic medical center.⁴³

As previously referenced, FEMA rejected Adams Management's storm assessment of Charity on behalf of LSU and the state. FEMA's stated concern was Adams' *format*, since it was presented as a summary document from which FEMA said it could not verify the findings as qualified for storm reimbursement. FEMA, in conjunction with state officials and LSU, launched a “scope alignment” process to better evaluate Charity Hospital's storm damages. Over an 18-month period beginning in late 2006, the state's selected contractor, Blich/Knevel and Associates and FEMA “scoped” out the damage. (FEMA 2009, pp. 13-14) Responding to calls for the state and LSU to reopen Charity, Jones replied:

We're trying to show and convince FEMA this damage was done by the storm. And if we go in there and start occupying the facility FEMA may say, 'You're OK,' and that there's no need for all these repairs (Webster 2007).

⁴² Confirmed thru participant observation. Charity's Laundry Building (405 LaSalle), Maintenance Shop (433 LaSalle) and Entergy facility (Gravier and South Claiborne) all were reopened by LSU Interim Hospital's opening.

⁴³ See <http://www.fhl.org/fhl/news/presvalerts/charityhospitalsyn.shtm>; and list in Appendix C.

Initially FEMA and the state FPC agreed to a process of review which served both parties interests. FEMA upheld its original claims of Charity’s damage without contestation; the state in particular justified Charity’s continued closure, as well as effectively delayed by nearly two years the release of independent state legislative-authorized evaluative findings that might call for Charity’s reopening. Intriguingly, the state’s contractor, Blich/Knevel and Associates (BKA) also conducted two evaluations of Charity’s psychiatric Crisis Intervention Unit (CIU) – *finding that it could either be reopened under limited repairs bringing Charity’s first three floors and 128-beds into operation for \$38 million; or reopen after a total upgrade to current life codes for about \$50 million (BKA 2007).* Blich/Knevel and Associates’ finding that Charity’s “deficiencies are correctable” ran contrary to the state’s contention that Charity could not be returned to use as a hospital of any sort.

It became evident by the spring of 2008 that the joint FEMA/FPC “scope alignment” process of Charity Hospital to determine eligible storm damages was going off its procedural track. After stopping joint evaluations that April, in July 2008 the state filed a claim with FEMA revising upwards the cost of replacing Charity to almost \$492 million. FEMA in turn raised its Charity repair estimates from \$23 million to \$150 million. In response, the state planned to appeal (FEMA 2009; FPC 2009; Moller 2008d).

While FEMA expanded its award, it would not relent on its core contentions: 1) that Charity’s damages had not met the 51 percent criteria for full replacement; 2) that the state hadn’t adequately secured Charity Hospital against post-storm elements or new damage – nor did it attempt to make even minimal fixes such as roof and window repairs to limit further damage; and 3) that the state was trying to claim as storm damage years of deferred maintenance and facility neglect (FEMA 2009, pp. 9-10; Moller 2008a; Moller 2008b).

LSU overcomes FEMA through the political intervention of Cao, Landrieu and Obama

Louisiana state officials acknowledged the urgency of settling the FEMA issue, as well as the climate of profound distrust between them and FEMA officials. Dr. Fred Cerise, LSU's vice president for health affairs and medical education, referenced FEMA's Charity damage award should at least match what the state legislature had already pledged:

The biggest issue we've got to resolve is the FEMA issue. If we can come to the \$1.2 billion [LSU University Medical Center] project with \$800 million in equity, that makes it much easier to get the bond folks into the conversation (Moller 2008c).

Jerry Jones of the state FPC addressed the issue of trust between it and FEMA:

It's like they don't trust us, that we're trying to beat the system and we really aren't. Pretty much throughout this disaster that's how FEMA's treated us (Moller 2008a).

To meet FEMA statutory guidelines, the state filed an appeal March 11, 2009 of FEMA's \$150 million award to settle all matters. The state contended that in denying the state's assessment that damages exceeded 51 percent of replacement costs, or almost \$492 million, FEMA, said the state, had responded with "various vague, unspecific and factually ... unsupported reasons" (Moller 2009a; FEMA 2009, p. 30).

On May 8, 2009, FEMA's acting regional administrator denied the state's first appeal. The state then filed a second appeal – but with the proviso that "FEMA take no action on the appeal request" until the state could determine whether a substitution of binding arbitration could occur (FEMA 2009, pp. 30-31). State officials had previously sought this possibility from their U.S. Congressional delegation (Moller 2008c). The near-constant advocacy of senior Louisiana U.S. Senator Mary Landrieu, as well as from newly-elected New Orleans Congressman Anh 'Joseph' Cao – was about to yield *the political intervention* that LSU and the FPC had long hoped for – *to have FEMA pay for Charity Hospital's replacement.*

LSU had already reached two significant milestones since Hurricane Katrina:

- Reclamation of LSU Health Sciences Center-New Orleans campus was in full swing;⁴⁴
- The United States Department of Veterans Affairs (VA) not only agreed to create side-by-side medical centers with LSU in Lower Mid-City New Orleans – the deal received the VA’s full financial commitment by 2008.⁴⁵

To be sure, significant challenges remained for the LSU University Medical Center project – not the least of which were several lawsuits challenging Charity’s closure, violations of the National Historic Preservation Act (NHPA) and the National Environmental Policy Act (NEPA), and a lawsuit against New Orleans Mayor C. Ray Nagin for permitting the expropriation of property in Lower Mid-City for the proposed VA Medical Center without public hearings. Grassroots activism that was originally sparked by Charity’s workers had almost died out in late 2006, but re-emerged in 2007, reigniting the “Save Charity Hospital!” movement.⁴⁶

The 2009 inauguration of President Barack Obama however was the watershed moment for LSU and the state in its quest to total out Charity Hospital for its full replacement value, in order to fulfill its new *University Medical Center*. Previously cool relations with FEMA and other federal agencies warmed considerably for the state. Widely assailed for its unyielding and incomprehensible bureaucracy, FEMA’s ineptitude under the leadership of Michael Brown, along with much of the rest of the federal response, resounded as part of the failure of the Bush Administration. Along with the Iraq War and 2008 economic crisis, FEMA’s mishandled response in advance and following Hurricane Katrina also paved the way for Barack Obama’s election victory (Lipton 2008; *New York Times* 2008; Stolberg 2008; Lipton 2011).

⁴⁴ See the LSU Health Science Center-New Orleans’ recovery progress websites: <http://www.lsuhscc.edu/biweekly/>, <http://www.lsuhscc.edu/DailyUpdates/> and Chancellor Larry Hollier’s *Notes*: http://www.lsuhscc.edu/chan_notes/

⁴⁵ See LaPlante (2006); LSU Louisiana Recovery Authority (LRA) Presentation (2006); Lynch (2007).

⁴⁶ A list of reopen Charity groups are in Appendix C; Also confirmed by direct participant observation.

As a signal of FEMA regime change, Janet Woodka, former legislative director for Senator Landrieu, was appointed as Gulf Coast recovery czar (United States Department of Homeland Security / U.S. DHS 2009a). Tony Russell was also named to head up FEMA's Louisiana Transitional Recovery Office, replacing "embattled" director Jim Stark, Said Russell:

We are going to collaborate as full partners. We are never going to be an adversary. Any hint from my staff or myself of being an adversary will not be tolerated. That is in the past (Johnson 2009).

But before the ice thawed completely, in remarks before a U.S. House Committee considering FEMA's operations, now retired Lt. General Russel Honoré, Commander of Joint Task Force Katrina, reiterated his contention that the state took advantage of Hurricane Katrina to close Charity Hospital. He charged state officials "used FEMA as a get-out-of-jail-free-card" – and that "the state of Louisiana needs to pay for its own damn medical center" (Tilove 2009a). Honoré later shifted his position to *being in favor* of FEMA funds to replace Charity – though *he never waived on his contention that Charity could've reopened* (Tilove 2009c).⁴⁷

First term New Orleans Congressman Anh 'Joseph' Cao, following Honoré in his testimony before the U.S. House Committee, blamed FEMA for fiddling "about the value of doorknobs and toilets" as other New Orleans-area hospitals took up in Charity's absence care of the uninsured – and flirted with *bankruptcy* in the process. Later Cao met with Honoré and said that Charity had facility accreditation issues before Hurricane Katrina. Reopen Charity Hospital advocates however produced evidence that the hospital had earned JCAHO (Joint Commission for the Accreditation of Health Organizations) certification *before* its permanent closure by LSU and the State of Louisiana one month after the storm (Tilove 2009a).⁴⁸

⁴⁷ See Honoré (2008) *Journal of Public Health Management and Practice*, p. S-6; Honoré, Moises, Harden, Walker, Washington and Ott (2009); Honoré (2010) (C.V. citing works which said Charity could have reopened).

⁴⁸ See: Honoré, Moises, Harden, Walker, Washington and Ott (2009); Cao (2009); FPC (2009, p. 7) – attesting that Charity was a JCAHO (Joint Commission for the Accreditation of Health Organization) certified facility.

Congressman Cao arranged for a special Congressional site visit and hearing held June 1, 2009 in the first floor lobby of Charity Hospital. It was cast as an effort “to break loose the backlog of FEMA recovery projects still pending after the 2005 hurricanes” (Bolar 2009). The location of the special U.S. House Committee on Transportation and Infrastructure hearing unmistakably accented the main issue – that “under the federal Stafford Act, FEMA is obliged to pay the full cost of replacing Charity if, as LSU contends, it was more than half damaged in the storm.” The hearing also was one of the first public opportunities to showcase Senator Mary Landrieu’s new arbitration system, passed into law as part of original Obama American Recovery and Reinvestment Act legislation, designed to speed up the resolution of FEMA public works claims – “of which Charity is by far the largest” (Tilove 2009b; Hammer 2009).

The special Katrina-Rita arbitration panel was set up to expedite settlement of FEMA claims as an alternative to the federal court system. Unlike regular federal proceedings, appellant bodies are barred from the process of discovery, have pre-determined time limits for filings and answers, and any decisions rendered are binding without further appeal. A panel of three administrative law judges of the United States Civilian Board of Contract Appeals (U.S. CBCA) would hear cases. After a series of procedural motions and filings from both the state and FEMA throughout the fall of 2009, the FEMA arbitration proceedings were held January 11-15, 2010.⁴⁹

In a key procedural ruling issued before the start of the proceedings, the U.S. CBCA panel ruled unanimously December 9, 2009 that the state could introduce evidence *not* previously presented, as well as call outside witnesses. More crucially, the panel also overturned the previous FEMA standard for undoing public assistance amounts determinations – which was only possible if FEMA’s actions were “arbitrary and capricious” (Moller 2009d; U.S. CBCA 2009). Through this ruling LSU and the state overcame a previously insurmountable FEMA rule.

⁴⁹ See 44 CFR Part 206 (2009); U.S. DHS (2009b); Moller (2009a-d); Shuler (2009); U.S. CBCA (2010, 2011).

Much as the three judge panel affirmed the new arbitration process to trump previous FEMA agency procedures and appeals of FEMA public assistance determinations, it did not rule on an attempted citizen intervention (Intervention 2009) seeking to also submit outside evidence and “consideration of facts, arguments ... when time, the nature of the proceeding and the public interest permit.” The intervention was lodged on behalf of “parties with a fundamental interest in the outcome of the FEMA appeal” including former Charity Hospital patients who were plaintiffs in a suit against LSU, along with two community health advocates.⁵⁰ LSU System legal counsel Ray Lamonica, who as lead attorney for the state would later successfully argue *for the inclusion* of outside evidence on behalf of LSU and the state in its pursuit of its FEMA arbitration claim, said the arbitration panel “should not consider any information or evidence other than the documentation FEMA and the state provided” (Barrow 2009; Intervention 2009).

The FEMA arbitration hearings produced few variations from prior months of filings and stated contentions. FEMA stated that the state was seeking full replacement value on a facility they called deficient before the storm. FEMA also challenged the actual level of asset protection following the storm to prevent deterioration of Charity. Lamonica contended that the state engaged in good asset protection. He said that FEMA’s 18-month scoping process had major shortcomings, foremost its ‘room-by-room’ evaluation failed to take into account mechanical systems that served entire hospital areas – hence the state’s “zone” method of estimating damages was more factual. Lamonica reasserted that the state deserved to receive full replacement value because storm damage exceeded 51 percent of Charity’s replacement value. He also scored rhetorical points by noting that “it takes an act of Congress to get something done” – in this case the arbitration process could resolve this matter instead of the bureaucracy of FEMA (U.S. CBCA 2010b).

⁵⁰ The author was one of the two community health advocate intervenors represented.

Per the actual nature of the arbitration process, a curious departure occurred from usual federal court and even regular Civil Board of Contract Appeals proceedings. After noting that this special FEMA arbitration was the result of the American Recovery and Reinvestment Act, Judge Stephen Daniels said that the 3-judge panel had reviewed carefully the respective statements from FEMA and the state of Louisiana's Office of Facility Planning and Control – and that *these proceedings would not require sworn testimony*:

We are here this week to supplement the documentary record and to gain a better understanding of it by taking testimony from people, and in likeness as to the appropriate amount to be paid to Facility Planning and Control. We'll hear from witnesses called by both Facility Planning and Control and FEMA. Because this is an arbitration hearing, not a judicial proceeding, the witnesses will not be asked to testify under oath. We do expect the witnesses to tell us the truth in response to questions asked of them, however. We need all the truthful information we can get in order to resolve the case (U.S. CBCA 2010a, pp. 4-5).

Charity Hospital's Director of Facility Planning Robert Arnold was asked under questioning by FEMA attorney Chad Clifford whether Arnold had turned away General Electric generators for providing permanent electric power back-up to Charity Hospital – *as attested in a sworn affidavit* by U.S. Army electrician Staff Sergeant John Johnson. Arnold said he had not – though he also intimated in his testimony *that the generators might not had even been delivered*:

Q: Now you're saying to your knowledge, Mr. Arnold, you're now claiming that this sworn statement from a respected veteran and current member – Armed Forces member is not – you – don't have personal knowledge as to whether or not generators were brought and rejected?

A: Not to my knowledge, no.

Q: Is it possible that they were and you simply don't know?

A: Unlikely.

Q: Unlikely. Were you the main person for LSU working –

A: I was on the ground from that Thursday until today.

(U.S. CBCA Transcript 2010a, pp. 91-92; Moller 2010b).

Arnold also said he wasn't "personally aware" that LSU had ordered an end to Charity's disaster recovery operation, the removal of U.S. military units and Charity's workers (U.S. CBCA 2010a, p. 93). Under this special FEMA arbitration proceeding, Sergeant Johnson was never called to elaborate in person on his contrasting *sworn* testimony.

The proceedings did offer some variation from contentions that both FEMA and the state contended were true. Arnold testified for example that Charity's basement had been drained of floodwaters by the time that the U.S. military left the facility in late September; and that power had been restored to most parts of the building, not just from temporary connections, but *from upgraded electrical switchgears located on the hospital's upper floors* – contradicting the state's formal request for arbitration drafted by the Office of Facility Planning and Control:

The major mechanical, electrical, and plumbing (MEP) systems in Charity Hospital were located in the basement which was totally inundated by contaminated and corrosive floodwaters *for more than 40 days*. Unlike more modern constructed facilities, this facility was constructed in 1939 when it was a common practice to put critical MEP in the least utilized spaces. The critical MEP of this hospital sustained its entire operations; it was the heartbeat that allowed the hospital to function. The contaminated floodwaters incapacitated all utility infrastructure of the entire building, not for a few days or weeks, but for months... (*Italics indicate their emphasis*) (FPC 2009, pp. 8-9; U.S. CBCA 2010a, pp. 28, 52-53, 57-63).

Issuing their ruling just twelve days after the conclusion of their hearings, the U.S. Civilian Board of Contract Appeals ruled *unanimously* in favor of granting \$474,750,898 to the state for the full replacement value of Charity Hospital. It said that FEMA's representatives "were less experienced and less credible" than the state's experts. Since FEMA essentially acknowledged it had been verifying the state's findings of damages through eighteen months of the joint FEMA/BKA scoping process, the 3-judge panel found that the state knew better of Charity's storm damage situation, since it produced detailed analyses (U.S. CBCA 2010c, p. 4).

Though Louisiana officials plainly acknowledged they had long sought a Charity Hospital replacement before Hurricane Katrina, their testimony and presented evidence to the panel claimed that they made conscientious efforts to retain the hospital's accreditation. Even if the measures taken were "at a sub-optimal level before the storms occurred" – the judges said they could not be repaired cost-effectively from the storm damage they had incurred. A major determining factor, which raised the level of storm damage considerably above the 51-percent qualifying threshold, said the panel, was the probability that Charity's potable water "piping on the upper floors had been contaminated..." The judges doubted FEMA contentions that with a system flush and cleanse safe drinking water could be assured. BKA's contention was that:

When the basement flooded, toxic wastes inundated the piping system for potable water, up through an indeterminate number of floors. The system had been modified over time, and because as-built drawings were lost in the flood, the number and location of dead ends was unknown. The BKA engineers determined that the entire system had been compromised and had to be replaced ... On the whole, the record supports the (state Office of Facility Planning and Control) position as to disaster-related damage (U.S. CBCA 2010c, pp. 3-4).

Though the FEMA arbitration panel dismissed FEMA's contentions on the scope of storm damages and the levels of asset protection by the state FPC following Hurricane Katrina, it did agree with FEMA's cost "estimate (as) the best approximation available of the cost of replacing Charity Hospital with a new facility" – affirming reopen-Charity advocates' contentions of the cost of revitalizing the building within its Art Deco shell.⁵¹ The panel said:

The panel understands that differences of opinion exist in New Orleans as to whether the public is better served by rebuilding Charity Hospital in its present location or by constructing a new hospital elsewhere in the city. This issue is not relevant to our determination in this case, and we did not consider it in the course of our deliberations. How to proceed with the rebuilding or new construction is a matter for decision by other authorities (U.S. CBCA 2010c, p. 5).

Any hopes in trying to reopen Charity Hospital now appeared to have evaporated.

⁵¹ See RMJM Hillier (2008); Roberts and Webster (2010); Sack (2010); and Shuler (2010a).

I think we have a clean sheet to start again. And with that clean sheet we have some very big opportunities.

Joseph Canizaro, Member, Bring New Orleans Back Commission (BNOB), quoted by Gary Rivlin, *The New York Times* (Rivlin 2005)

Hurricane Katrina essentially right-sized the overbuilt hospital system...

Pricewaterhouse Coopers “Report on Louisiana Healthcare Delivery and Financing System” (PwC 2006, p. 6)

[Charity Hospital’s closure] created a significant barrier to return for displaced residents in need of medical care.

Chris Kromm and Sue Sturgis, Institute for Southern Studies (ISS 2008, p. 26)

Discussion

Was Charity Hospital’s closure a case of “Disaster Capitalism?”

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Charity was closed when New Orleans was virtually emptied of its populace; Its patients were the heart of the Katrina Diaspora; Fears of exclusion from recovery decisions

Nossiter’s 2005 *New York Times* report on Charity also broached another controversy – whether, by keeping Charity Hospital and other institutions serving the city’s poor closed, that the entire cultural and economic complexion of New Orleans could be permanently transformed:

As one of the two oldest hospitals in North America – it was founded in 1736, the same year as Bellevue Hospital in New York – Charity has from the beginning been a symbol of a social commitment to the poor, and its wards are empty at a moment when thousands of poor New Orleans residents are struggling to return home and fear that government has abandoned them. In many ways, the debate over its future parallels that of New Orleans itself, as it chooses whether to become a more middle-class city or return to earlier traditions (Nossiter 2005).

The closure of Charity Hospital slowed recovery of the region and blocked the return of many of New Orleans’ poor, elderly and most vulnerable residents who relied on Charity for care (Connolly 2005; Eaton 2007). Months after the storm, many displaced residents were scattered around the nation; having lost their homes, schools, community and their main source of healthcare, while navigating the whirling tempest of *the Katrina Diaspora*.

Roberts and Durant (2010, pp. 226, 243) noted that since the Civil Rights movement, Charity system patients have been predominantly African American. Citing LSU figures, in the 2004-2005 year, Charity/MCLNO* black patients constituted over 70 percent of the total.⁵²

Table 2: Charity/MCLNO* Inpatient Admissions/Outpatient Encounters by race, 2004-05

Inpatient	Admissions (Percent)	Outpatient	Encounters (Percent)
Black	16,549 (70.2%)	Black	331,320 (75.9%)
White	5,548 (23.6%)	White	84,521 (19.3%)
Other	1,465 (6.2%)	Other	20,834 (4.8%)

Source: Roberts and Durant. 2010. *A History of the Charity Hospitals of Louisiana*. p. 243. Table by K. Brad Ott
*Totals include both Charity and University hospitals of the Medical Center of Louisiana at New Orleans (MCLNO)

⁵² LSUHSC Planning, Program Development and Governmental Affairs, Baton Rouge, LA. FY 2004-2005.

Table 3: Charity system* Inpatient Admissions / Outpatient Encounters by race, 2004-05

Inpatient	Admissions (Percent)	Outpatient	Encounters (Percent)
Black	33,161 (58.2%)	Black	888,515 (55.6%)
White	20,758 (36.4%)	White	660,646 (41.3%)
Other	3,088 (5.4%)	Other	50,051 (3.1%)

Source: Roberts and Durant. 2010. *A History of the Charity Hospitals of Louisiana*. p. 243. Table by K. Brad Ott
*Totals include nine LSU hospitals including New Orleans (but excluding LSU-HSC Shreveport)

VanLandingham (2007, p. 1614) said “New Orleans was essentially emptied by Hurricane Katrina at the end of August 2005.” Guin, et al (2009) adjusted VanLandingham’s austere-stated population amounts and departure by another few weeks – 12,000 people rode out the storm at the Louisiana Superdome; 25 area hospitals held 2,500 patients and 11,000 staff and their families; another 130,000 didn’t leave until a week after the storm, with 65,000 of those being rescued. Guin, et al said that with the close of the evacuation by mid-September 2005, “an estimated 10,000 people remained in Orleans Parish” (pp. 34, 45, 51).⁵³

A RAND Corp study said the city’s December 2005 population was about 91,000; and projected it at 155,000 by March 2006 (McCarthy, Peterson, Sastry & Pollard 2006, pp. xi-xiii). It often swelled on the weekends to 275,000 as displaced residents cleaned up (Connolly 2005).

Fears arose that decisions about the future of the city would be made absent the most impacted storm victims. New Orleans public housing and public schools reports noted *that the lack of stakeholder participation significantly impacted policy outcomes* (Rose and Tuggle 2010, pp. 2-3; Perry and Schwam-Baird 2010, p.6). Proponents of privatization to supplant Charity Hospital’s public health mission also admitted the widespread absence of public participation – but were more circumspect about the impact (Louisiana Public Health Institute/LPHI 2005, p. 6). At the time of Charity’s September 2005 closure, the city was virtually emptied of its populace.

⁵³ The Louisiana State Medical Examiner said 1,464 people died between August 28 and October 1, 2005 (Guin, et al, p. 45). Another 2,300 “excess deaths” were recorded in a study comparing *Times-Picayune* obituary listings from the first six months of 2006 with 2004 (pre-storm): Stephens, Grew, Chin, Kadetz, Greenough and Burkle (2007).

The Bring New Orleans Back Commission attempts to capitalize on the Katrina Diaspora

Just days after the last of the mass evacuations from New Orleans were completed, about 60 corporate and political leaders met in Dallas with Mayor C. Ray Nagin to plot out the city's future (Scott 2005). The 17-member Bring New Orleans Back (BNOB) Commission, formed out of the Dallas meeting, held its first public session one month after the storm (Donze and Varney 2005). Commission member Jimmy Reiss, Chair of the Regional Transit Authority, voiced what many African Americans and advocates for the poor were the worst fears:

Those who want to see this city rebuilt want to see it done in a completely different way: demographically, geographically and politically. I'm not just speaking for myself here. The way we've been living is not going to happen again, or we're out (Cooper 2005).

Largely *void of its populace at the time of Charity's late September closure*, the city's population status in the months following the storm remained a paramount issue. The BNOB Commission, joined by the Urban Land Institute (ULI), proposed a building permit moratorium and permanent land buyouts in areas flooded greater than four feet in depth (ULI 2005). A Brown University study found that "if nobody was able to return to (these) damaged neighborhoods – New Orleans is at risk of losing 80% of its black population" (Logan 2006, p. 1; Dao 2006). BNOB commissioner and developer Joseph Canizaro observed:

As a practical matter, these poor folks don't have the resources to go back to our city just like they didn't have the resources to get out of our city. So we won't get all those folks back. That's just a fact. It's not what I want; it's just a fact (AP 2005d).

The outcry over the BNOB Commission proposal granting just four months for residents to decide on their neighborhood viability before being "green-spaced" dominated the headlines (Donze and Russell 2006). Mayor Nagin joined the New Orleans City Council in ultimately *rejecting* implementation of BNOB Commission / ULI land use provisions.⁵⁴

⁵⁴ Nossiter (2006); Rivlin (2006) and Powell (2007).

In contrast, BNOB Commission co-chairs Mel Lagarde, head of the Hospital Corporation of America's Delta Division, and Barbara Major, director of the St. Thomas Health Clinic (Scott 2005), along with BNOB "Health and Social Services Committee" chair and attorney Kim Boyle (Henderson 2009) recorded virtually no public outcry over Charity Hospital's closure. Much the same way the BNOB Commission attempted to couch its land use planning in the language of safety and equity, its Health and Social Services Committee proclaimed "the need for courageous conversations to change the delivery of health and social services" (BNOB Health 2006a, p. 4). As would be the case with most post-storm "health reform" initiatives, the BNOB Commission *ignored* the attempt of Charity's workers and the U.S. military to restore hospital services, and formulated the transformation of the healthcare landscape from one which held Charity Hospital as its historic epicenter. The BNOB Health and Social Services Committee effectively recommended Charity's continued closure in order to realign its public healthcare mission and financial resources toward corporate medicine; while also endorsing LSU's academic medical center model (BNOB Health 2006a; Webster 2006).

Nelson, Ehrenfeucht and Laska (2007, p. 27) posed that the BNOB Commission deliberations, though nominally open to the public, "were not designed to include nonprofessional residents." The BNOB meetings "out of perceived necessity, occurred before most people returned, residents had to seek them out, and engaging residents as participants was not a priority. Subsequently many residents opposed the BNOB Commission's proposals."

In comparison with the land use deliberations, few patients, non-health professionals or others without a pecuniary interest participated in the BNOB Commission's Health and Social Services deliberations. BNOB participants overall were predominately white males.⁵⁵

⁵⁵ BNOB Health (2006b): Attendance substantiated via review of a BNOB "Members and Meeting Participants" list. Also see Lake to the River Foundation for Legal Aid & Disaster Relief (2005); Nolan (2006a); RAND (2010).

It has been said many times that “Hurricane Katrina ... laid bare deep, social, economic and cultural divisions that have long plagued New Orleans” (McKiven 2007, p. 742). McKiven’s critique of the political advantage taken (or lost) during New Orleans’ 1853 yellow fever epidemic presaged the parade of “reform” initiatives abounding in New Orleans in the months and years following Hurricane Katrina’s August 2005 landfall. For example, backers of the BNOB / ULI plan to shrink the city’s inhabitable footprint attempted to forge lines of support based on avoiding “racial polarization” and supporting “the common good” toward creating a new city that would be more equitable and humane for the displaced to return – while clamoring *for the active silencing or disregarding of active dissent to discourage community disunity in a time of crisis* (Cowen 2006). These appeals also attempted to extol the fear of avoiding “real estate speculators and unchecked market forces” (Nolan 2006a). Curiously, *the leading supporters of the BNOB plans were real estate interests and developers* (Davis 2006).

The idea of viewing a catastrophe as a chance for societal reordering *and* investment opportunities has been heightened in recent decades by what Naomi Klein (2007) calls “*disaster capitalism*.” She defines the term in its broad scope as the use of a disaster or major event for the deliberate re-engineering of economic, political and community spheres while affected populations are internally displaced; by its “military speed and precision” and in its “treatment of disasters as exciting market opportunities” (pp. 5-6). Klein quotes New Orleans’ developer and BNOB commissioner Joseph Canizaro’s response to a *New York Times* reporter on the city’s future in the wake of the storm: “I think we have a clean sheet to start again. And with that clean sheet we have some very big opportunities” (p. 4; Rivlin 2005). Klein lambasted “using moments of collective trauma to engage in radical social and economic engineering” when most disaster survivors seek the opposite: *to rebuild, not remake* their homes and communities (p.8).

Considering Charity's closure as a human rights violation of the internally displaced

In virtually any other global setting, failure to open a working hospital would have sparked a United States government condemnation. Federal authorities apart from FEMA however never seriously contested the forced end of Charity's disaster recovery operation.

News of Charity Hospital's forced closure, together with reports of the abandonment of Orleans Parish Prison inmates to drown in their cells, the mass firings of teachers and municipal workers, and demolition of public housing while its residents were internally displaced aroused notice of human rights activists and organizations from around the world.⁵⁶

The American Civil Liberties Union's (ACLU) National Prison Project, investigating charges of some Orleans Parish Prison inmates being left to drown in their locked cells, also uncovered "the criminalization of mental illness" as a result of the closure of Charity Hospital's psychiatric Crisis Intervention Unit's (CIU). In the ACLU's 2007 follow-up report:

Perhaps the biggest blow to the region's mental health system is the loss of Charity Hospital ... With so few psychiatric services available to the public, mentally ill people are being funneled into the criminal justice system. Some families have grown so desperate that they have sought to have their mentally ill relatives arrested in the hopes of getting them psychiatric care... (ACLU 2007, p. 22).⁵⁷

Even with significant improvements to community-based treatment programs under the purview of the Metropolitan Human Services District, the combination of inpatient hospital unit closures (particularly the New Orleans Adolescent Hospital (NOAH) and outpatient program budget cuts has continued to hobble the mental health system (Levin 2010). Indeed the city has just half the inpatient beds, with double the need, since the storm (Hudson 2009).

⁵⁶ National Economic and Social Rights Initiative / NESRI (2008); Institute for Southern Studies / ISS (2008); The Brookings Institution (2008); Center for Constitutional Rights / CCR (2009); Amnesty International / AI (2010); Advisory Group on Forced Evictions / AGFE (2010); Advocates for Environmental Human Rights / AEHR (2011). Two additional reports with human rights and Charity Hospital analysis include Quigley (2008) and Luft (2009).

⁵⁷ *Abused and Abandoned: Orleans Parish Prisoners in the Wake of Hurricane Katrina*, ACLU (2006).

Underscoring the impact of the loss of Charity’s psychiatric CIU has had on the criminal justice system, Orleans Parish Sheriff Marlon Gusman, in a sworn affidavit in support of a lawsuit to reopen Charity, said the closure of the CIU added to his “incredible burden”:

As Sheriff of Orleans Parish, I have been confronted with the incredible burden of dealing with mental health issues in the criminal and prison systems. While the prison in New Orleans has a facility for mentally ill inmates and can treat inmates who are suffering from mental health issues, before the storm police officers could take people whom they suspected were exhibiting criminal behavior as a result of mental problems to Charity Hospital. Since the closure of Charity’s Crisis Intervention Unit, police officers have limited options as to where they can take people with mental health problems outside of jail (Gusman 2008).

The ACLU report indicated that in addition to Orleans Parish Prison’s 60-bed psychiatric unit, “300 prisoners in the general population receive psychiatric medication.” Many of these prisoners have been declared incompetent to stand trial by reason of insanity, or not mentally competent to stand trial. The lack of outside psychiatric beds often results in prisoners languishing for months “and in some cases years” at Orleans Parish Prison and other jails. Once able to enter Louisiana’s only forensic mental hospital, the Feliciana Forensic Facility, many prisoners then cannot leave because of the lack of community outpatient group and nursing home placements willing or able to accept them (ACLU 2007, p. 22). The ACLU report noted:

Without community mental health services and a functioning emergency system for acute psychiatric care, mentally ill people will continue to be incarcerated for behavior that is a product of their illness, and will spend increasingly long periods of time in jail, rather than in a proper therapeutic setting (ACLU 2007, p. 23).

NESRI’s report on Charity Hospital’s closure cited Article 25 of the United Nations Universal Declaration of Human Rights: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services...” (NESRI 2008, p. 2).

Principle 18(2) of the UN's Guiding Principles on Internal Displacement states:

At the minimum, regardless of the circumstances, and without discrimination, competent authorities shall provide internally displaced persons with and ensure safe access to: a) Essential food and potable water; b) Basic shelter and housing; c) Appropriate clothing; and d) Essential medical services and sanitation.⁵⁸

Charity Hospital's closure "created a significant barrier to return for displaced residents in need of medical care." With Charity's psychiatric CIU closed, Orleans Parish Prison's 60-bed unit was the largest inpatient facility "(contradicting) Guiding Principle 28, which calls on authorities to establish conditions allowing (internally displaced persons) to return home "in safety and with dignity" (ISS 2008, p. 26).

The AGFE report highlighted the inherent loss of healthcare *space* with LSU's choice to restore the smaller University Hospital rather than the much larger Charity facility:

University Hospital has just one-fourth of Charity Hospital's capacity. This forces many uninsured, underinsured and poor residents of New Orleans to travel long distances to receive treatment at one of Louisiana's other public hospitals. In fact, many residents simply forego needed medical care. More than one in three New Orleans residents postpone needed medical care and one in four report that they had no doctor, clinic, or pharmacy to turn to for needed care (AGFE 2010, p. 43).

Amnesty International's report echoed the ACLU and ISS reports on the loss of mental health care, but also emphasized Charity's closure as a disproportionate loss for the working poor and the uninsured:

Charity served a largely poor, predominately minority population through inpatient care, a network of outpatient clinics and the busiest emergency department in the city. Nearly three-quarters of its patients were African American, and 85 percent had annual incomes of less than \$20,000. Over half of the indigent care provided by (Charity and University hospitals) was for patients without insurance, representing two-thirds of the care to the uninsured in the city (AI 2010, pp. 17-18)

⁵⁸ NESRI (2008, p. 4); ISS (2008, p. 33) AI (2010, p. 27).

The forced expropriation and demolition of the Lower Mid-City New Orleans neighborhood for the proposed LSU/VA Medical Center, resulting in the internal displacement of hundreds of residents and dozens of businesspeople and their enterprises, have been according to the AGFE mission no less human rights violations than the internal displacement and forced relocation of public housing residents. Citing the U.S. as a signatory of the International Covenant on Economic Social and Cultural Rights (ICESCR), the AGFE mission reiterated that under articles IX and XXIII of the 1948 American Declaration of the Rights and Duties of Man, “every person has a right to own such private property as meets the essential needs of decent living and helps to maintain the dignity of the individual and of the home” (AGFE 2010, p.36).

Both the AGFE and CCR reports also referenced that planning for the LSU/VA project was accomplished without the effective consultation of those facing forced internal displacement as the result of the plans – in violation of human rights covenants (CCR 2009, pp. 20-21; AGFE 2010, pp. 28, 34-45, 49).⁵⁹

Walter Kalin, Representative of the U.N. Secretary General on the Human Rights of Internally Displaced Persons, and Brookings-Bern Project on Internal Displacement observed the U.S. governmental response before, during and in the aftermath of Hurricane Katrina:

The U.N. Human Rights Committee, a body of independent experts entrusted with the task of monitoring the implementation off the International Covenant on Civil and Political Rights, when examining the report submitted to it by the USA, expressed its concerns “about information that the poor, and in particular African Americans were disadvantaged under the reconstruction plans” and recommended to the U.S. “review its practices and policies to ensure the full implementation of its obligation to protect life and of the in matters related to disaster prevention and preparedness, emergency assistance and relief measures ... that the rights of the poor, and in particular African Americans, are fully taken into consideration in the reconstruction plans with regard to access to housing, education and healthcare” (Kalin 2008).

⁵⁹ The author contributed testimony and documents for the NESRI, CCR, AGFE and AI reports.

More than six years after Hurricane Katrina, there *remains an unprocessed conversation about human rights that first arose when the BNOB Commission plan to leave fallow much of the city of New Orleans that flooded deeper than four feet failed to take hold.*

The conversation is rooted in the fact that most white residents were able to immediately return to the city and determine the course of their storm recovery while many African Americans remained internally displaced for months and even years.⁶⁰ It also remains within the still contested terrain of a “recovery” climate set up by the mass firing of mostly African American female certified public school educators from New Orleans’ public schools, facilitating mass the arrival of privately-managed “non-profit” charter schools to occupy new school buildings constructed with public disaster relief funds; closure and demolition of the city’s public housing developments, to be replaced by market-rate, privately-managed apartments; *and the closure of Charity Hospital.* This *disaster capitalist paradigm* has contributed to the continuing internal displacement of our poorest citizens and the profound abridgement of their human rights.⁶¹

Indeed, predominate is the mindset of those who proclaim *that storm “recovery” has ended.* This is epitomized best by New Orleans Mayor Mitch Landrieu’s often spoken response:

We are no longer rebuilding. We are now creating. Let’s stop thinking about rebuilding the city we were and start dreaming about the city we want to become (Davis 2010; Landrieu 2011).

The 118,000-fewer African American residents and 24,000 fewer white residents according to the 2010 U.S. Census seem to represent the *failure* of recovery. In fact many represent what Robertson dubbed “a shadow city” of people wanting, but unable to return.⁶²

Also caught up within the shadow city, this thesis author suggests, is Charity Hospital.

⁶⁰ See Louisiana Family Recovery Corps (2007); Hill (2008); RAND (2010, p. 3); Robertson (2010); Krupa (2011).

⁶¹ See Reed (2005); Ouroussoff (2006); Hill (2008); Penner and Ferdinand (2009); Davis (2010); Perry and Schwam-Baird (2010); Mildenberg (2011).

⁶² See Louisiana Family Recovery Corps (2007, pp. 4-5); Plyer (2010); RAND (2010, p. 3); Robertson (2010-11); Gill (2011).

LA. Health Care Redesign Collaborative also attempted to capitalize on Charity's closure

Klein (2007) suggests disaster capitalism has transformed the provision of crisis relief and social reconstruction to reflect *neoliberal* values – that is to instill classic *private* free market economic attributes through the marshalling and reallocation of once *public* resources:

Disaster capitalists have no interest in repairing what was. In Iraq, Sri Lanka and New Orleans, the process deceptively called “reconstruction” began with finishing the job of the original disaster by erasing what was left of the public sphere and rooted communities, then quickly moving to replace them with a kind of corporate New Jerusalem – all before the victims of war or natural disaster were able to regroup and stake their claims to what was theirs (p. 8).⁶³

Emboldened by acceptance of the BNOB Commission Health and Social Services Committee recommendations, advocates of “Louisiana healthcare redesign” laid the groundwork for a massive reworking of the state public hospital system along medical neoliberal lines. U.S. Department of Health and Human Services (U.S. DHHS) Secretary Michael Leavitt joined Louisiana Governor Blanco’s administration with consent of the state legislature in 2006 to launch the *Louisiana Health Care Redesign Collaborative*. Its chief aim was the redirection of federal Medicaid DSH financing, garnered predominately by Charity system hospitals and clinics to care for the poor, toward funding *vouchers for the purchase of private health insurance*.⁶⁴

Like the BNOB Commission, the “Collaborative” held its meetings in public, yet the public sparsely attended. The Collaborative’s decision-making body included healthcare and hospital administrators, private foundation interests and health lobbyists, Blanco administration health officials, state House and Senate Health and Welfare committee chairs, along with LSU graduate medical education and LSU Health Care Service Division (LSU-HCSD) officials.⁶⁵

⁶³ For international examples following disasters, see Bello (2006) and Srinivas (2010).

⁶⁴ See Leavitt (2006); U.S. Department of Health and Human Services / DHHS (2006); Center on Policy and Budget Priorities / CBPP (2007); Solomon (2007); DeSalvo and Sorel (2009); Clark (2010b).

⁶⁵ Review of Collaborative attendance lists, board members and affiliations; and minutes of meetings, 2006.

LSU-HCSD officials professed support for “the broad objectives” of the Collaborative, including the proposed “medical home” outpatient model, and use of “health information technology” and “electronic medical records.” But they cautioned that Collaborative deliberations had not addressed “the unlikely prospect of being able to effectively achieve zero *un-insurance*,” and challenged the redirection of DSH funds away from the Charity system:

Retention of DSH funds for safety net providers will still be needed in the event that reforms are only partially successful [as] patients who depend on the safety net are as important as those we can move into insurance programs (Comments from Collaborative members 2006).

Like the BNOB Commission, many Collaborative sessions revolved around mapping out a redesigned healthcare system that was *without* Charity Hospital. Much to the displeasure of the Bush administration and private healthcare interests, state legislative authorization of the Collaborative limited any healthcare redesign to the New Orleans area (HCR 127 2006).

Ultimately, state officials *rejected* the federal scheme of replacing Charity Hospital system coverage with insurance vouchers, saying it would cost \$500 million more per year than having Charity care just in the New Orleans area – and cover only 80 percent of those eligible. If extended statewide, state health officials said the cost could double and leave nearly 500,000 people that use the Charity system without coverage (Moller 2006e; Moller 2007c).

Many healthcare redesign supporters in response called for *dissolution* of LSU-run Charity, apart from their teaching hospitals in New Orleans and Shreveport. Citing Louisiana’s poor health standing in national rankings, researchers, private foundations and medical lobbyists issued papers detailing the woeful state of Louisiana healthcare pre- and post-storm. ⁶⁶

⁶⁶ E.g., Louisiana Hospital Association / LHA (2003, 2006); Louisiana Public Health Institute / LPHI (2005); RAND Health Research (2005); BNOB Commission (2006); Louisiana State Medical Society / LSMS (2006); Council for a Better Louisiana / CABL (2006-2008, 2010); Public Affairs Research Council of Louisiana / PAR (2006-2008); Pricewaterhouse Coopers / PwC (2006); Tulane University (2006-2008); Blueprint Louisiana (2007, 2011); American Association of Retired Persons / AARP (2008); The Heritage Foundation (2008).

Though many critics attributed the entirety of the state's poor health outcomes to the "inefficient" Charity hospital system, very few of them acknowledged the data that showed *private medicine* was far more responsible than Charity for failing to improve these woeful indicators. For example, the nation's highest Medicare costs with the worst health outcomes occurred *not at Charity, but in private settings*.⁶⁷ Oddly, Charity had been also criticized by the same forces for *causing* the "two-tier" system because of its disproportionate care for the uninsured, often the same patients *excluded* from private healthcare. Based on 2005 inpatient discharges, just 2.6 percent of Charity/MCLNO patients were covered by private insurance, 12.6 percent on Medicare, 21.5 percent on Medicaid, and 63.3 percent uninsured (Verité 2010, pp. 8-9). Costs would be *much higher* if uninsured patients' only access was via private providers.⁶⁸

Paradoxically, the sternest admonitions *against* changing or devolving Charity's inspired statewide safety net hospital network came from the same LSU apparatus whose closure of Charity Hospital sparked the Collaborative in the first place. LSU responded to research reports suggesting that it concentrate on its *educational rather than safety net healthcare missions*, divest some or all of its public hospitals to local control, and generally recast its public operations entirely under free market outlines. Much in the spirit of its 1997 acquisition of the Charity system from the Louisiana Health Care Authority (LHCA), LSU extolled the virtues of Charity's public system being far superior to the vagaries of private insurance coverage⁶⁹

⁶⁷ Amongst the few non-state sources to acknowledge this was Pricewaterhouse Coopers (PwC) (2006, p. 6) PwC also said that there were "too many hospital beds in the private sector"; "Hurricane Katrina essentially right-sized the overbuilt hospital system..." PwC curiously offered no private sector reforms; yet called for significant cuts in the Charity Hospital system under assumptions that private providers would then care for all Charity's patients – an unlikely outcome. For example see "Making Profits and Providing Care..." Horwitz (2005).

⁶⁸ e.g., Moller (2006d): Louisiana spent almost \$935 million in Fiscal Year 2006-07 for Charity hospital safety net care serving 850,000 residents lacking insurance; "Blue Cross and Blue Shield of Louisiana spends more than three times that amount to finance care for about 1 million policyholders," said BCBS/LA CEO Gery Barry.

⁶⁹ LSU-HCSD on PriceWaterhouse Coopers (2006a); Medical Homes (2006b); the Leavitt proposal on healthcare vouchers (2006c) & PAR (2007a); Blueprint Louisiana (2007b) reports' on the Charity Hospital system.

LSU's contradictory exhortations about Charity notwithstanding, legions of healthcare lobbyists and foundation reformers in New Orleans in Hurricane Katrina's aftermath said that a "medical home" was possible now that Charity was closed. An independent community clinic network did arise in a laudable attempt to meet healthcare needs once met by Charity's 160 pre-storm primary care clinics. They prided themselves on reframing the entry point away from hospital emergency rooms. Lovell (2011b) observed this discourse as "ripe terrain for modernizing and rationalizing healthcare provision," but it cannot ever hope to replace Charity:

This network has provided New Orleans a nationally-heard narrative of redemption, not only from disaster; but from corruption, collective ineptitude, widespread poverty and supposedly antiquated ideals of pre-Katrina healthcare embodied in Charity Hospital. But primary care clinics cannot meet the tertiary care needs of an already chronically ill, disabled and aging New Orleans population.

In fairness, what would become "504 Health Net" did not physically close Charity Hospital, LSU and the State of Louisiana did.⁷⁰ Yet few of the 504 providers have honestly addressed the reasons for Charity's closure. Indeed, several supported the Louisiana Health Care Redesign Collaborative attempt to reallocate Charity's operating funds toward the purchase of private insurance vouchers. And their collective failure to demand the full restoration of Charity's safety net hospital and clinical services limits their own viability to fully serve Charity's former patients, too many of whom remain without a medical home since the storm.

Interest in reopening Charity Hospital persists years after its closure primarily because the healthcare that it provided has never been fully replaced (Walsh and Moller 2006).⁷¹ Yet LSU continues to divest itself from areas of healthcare "not core to (its graduate medical education) mission" and which no other entity public or private can adequately or expeditiously fill (Cerise 2005, p. 13; Spiegel 2007). Without Charity, *many have become medically homeless*.

⁷⁰ See <http://504healthnet.org>: a non-profit organization of 15 community health service provider safety net...

⁷¹ See *T-P* (2009): "Poll backs Charity rehab" – "...voters prefer by a 2-to-1 margin gutting Charity and rebuilding."

Continuity or Rupture? Comparing LSU's pre-storm plans to close Charity Hospital with its disaster capitalized closure following Hurricane Katrina ⁷²

Lovell (2011b) juxtaposes the hallmark of Charity's iconic safety net network with the new challenge arising from the federal government's creation of the Medicaid program, which concentrated the poor and uninsured exclusively to Charity system hospitals:

The uniqueness of Louisiana Charity Hospital system is rooted in the principle that everyone has a right to medical care – certainly anathema to American neoliberalism and hardy individualism, but founded in the 1930s populist doctrine of the Long dynasty that governed Louisiana for decades. However, the arrival in the 1960s of Medicaid, the major program to assist low-income individuals with obtaining health services, intensified a two-tiered system of healthcare (Lovell 2011b).

Though LSU gained administrative control of Charity in 1997, it has not freed it from *dueling* with state administrations against reallocation of much of its self-generated DSH budget. Thus LSU has sought to “(avoid) replicating the ‘old Charity model’ of reliance on State funding” (ADAMS 2007, p. 5.1). Lovell suggests *LSU's planning process was already underway in the months before Hurricane Katrina toward the replacement of Charity Hospital:*

Burdened with hospital accreditation problems and a deteriorating facility, LSU had long envisioned building a new hospital, in part to attract a private patient base and unburden itself of nonpaying patients ... Lack of adequate financing for new facilities stood in the way of that plan. Katrina provided the opportunity to narrow that gap by accessing federal funds to replace the old facility (Lovell 2011b).

Vice President of Communications and External Affairs Charles Zewe clarified that LSU's *new academic medical center model* “turns it more from a charity matrix to a university teaching hospital matrix.” One part of this matrix shift is to replace the pre-storm Charity's 160 on-site outpatient clinics with a network of neighborhood clinics (Moller 2006b). LSU and its new University Medical Center (UMC) announced it will qualify for the Jindal administration's privatized Medicaid HMO clinic network (Maginnis 2011a; Verité 2011, pp. 18-19).

⁷² Regarding the “conceptual tools” of *continuity and rupture* in social change analysis, see Borocz (1997).

Louisiana's Department of Health and Hospitals' (DHH) Coordinated Care Networks (CCN), once known as "Community Care," historically have been arranged to favor individual physician and group practices dispensing fee-for-service care. Their new CCN program, dubbed "Bayou Health," *shifts this payment and delivery model to private managed care organizations*. Medicaid participants must sign-up or be assigned a private Medicaid HMO plan. LSU officials acknowledged their public discomfort with the CCN privatized contract process (Verité 2011, pp. 18-19; Shuler 2011c). LSU public hospitals and clinics will now have to compete for Medicaid patients amongst a group of private insurers, narrowing even further its indigent patient pool. The DHH CCN process also serves to interrupt LSU's process to cultivate its *own physician network to make referrals exclusively to the new LSU UMC*, as LSU already has with its highly-regarded "Shreveport model" out of LSUHSC Shreveport. In effect, the DHH CCN HMO scheme undermines LSU's attempt to transcend its "Charity model" by reinforcing dependency on DHH / Louisiana Medicaid funding, rather than move towards a more diverse payer mix (such as LSU Shreveport) where private insurance and Medicare plays a greater role.⁷³

The new CCN scheme fulfills a long-time ideological goal of Governor Jindal, who favors neoliberal / neoconservative *privatized purchase of services rather than supporting public healthcare delivery and administration* (Shuler 1996b). These private CCN contracts are now "the most lucrative in state government" (Shuler 2011b). The program was passed into law over state legislative objections through an inserted "technical amendment" on an unrelated bill during the final hours of the 2011 Regular Legislative Session. The inserted CCN language, while serving as "fine print" that most legislators simply overlooked, had the profound impact of instituting privatization over the objections of legislators by removing requirements of prior legislative approval and codifying CCN rule making exclusively within DHH (Maginnis 2011b).

⁷³ See Deslatte (2007) and Egler (2007).

After more than five years of planning, winning the FEMA Arbitration and legislative budget scrutiny (and withstanding several lawsuits challenging both Charity's closure and the expropriation of land in Lower Mid-City New Orleans for the combined LSU/VA Medical Center), LSU and the state won final approval from the Louisiana state Joint Legislative Committee on the Budget on September 16, 2011 to begin construction of its Charity Hospital replacement known as the University Medical Center (UMC) (Barrow 2011f; Deslatte 2011).⁷⁴

Despite pledges by local, state and federal officials to consider meaningful public input of alternatives to the abandonment of Charity and the demolition of a federally-designated historic Lower Mid-City neighborhood, LSU's academic medical center plans, along with new Veterans Administration Medical Center plans, have for the most part remained intact since their inception. Indeed, decisions on how the process would unfold were finalized before much of the affected public even knew they were made (Moran 2008).⁷⁵ The state legislature originally demanded Charity's reopening for interim use in the year after Katrina. Yet it has largely afforded Charity's replacement to proceed even as legislators scrutinized the financial details.⁷⁶ New Orleans officials in particular, also initially demanding Charity's reopening, enabled fruition of LSU/VA plans by authorizing the expropriation and destruction of Lower Mid-City.⁷⁷

Though LSU appears to have received its crucial "green light," many uncertainties remain. Ironically, those unknowns, coupled with LSU agreeing to scale back and self-finance parts of their UMC, afforded its ultimate approval since it reinforced perceptions that LSU must move beyond "the old Charity model" to have a viable project (Barrow 2011c). But this outcome underscores that the result will be *far fewer hospital services* than offered by "Mother Charity."

⁷⁴ See *Leblanc et al v. Thomas et al* (2008); *Thurman et al v. Nagin* (2009); *NTHP v. VA and FEMA* (2009).

The author contributed legal research in *Leblanc v. Thomas*; and was a plaintiff in *Thurman v. Nagin*.

⁷⁵ SCR 99 (2006); VA-City MOU (2007); http://www.valsumedcenters.com/index_files/T2meetinginfo.htm.

⁷⁶ HCR 89 (2006); SCR 99 (2006); SCR 76 (2007); Moller (2007a-b, e-f); Barrow (2011e).

⁷⁷ See R-06-143 (2006); M-07-237 (2007); MCS 22944 (2007); Head (email stream) (2008); Egger (2011).

In the months after the storm, LSU spokesperson Marvin McGraw said one thing that was certain: “When we build a new hospital in New Orleans to replace Charity, we would plan to at least return with the services that we had there before” (Moller 2005e). Its 2011 business plan approved by the legislative budget committee however states that LSU’s new UMC *will be less than what Charity provided*. In general, increased numbers of beds available for the new UMC as projected are compared to 275 available before current fiscal year budget cuts *in LSU Interim Hospital*, as opposed to those that were in operation at Charity in 2005 (Verité 2011, pp. 3, 11).

To underscore the previous example, “expansion of inpatient psychiatry services” plans 60 beds, an increase of 22 from Interim LSU Hospital levels. Yet officials acknowledge the beds “rapidly will be filled” with patients (Verité 2011, p. 17). Charity *had* a 128-bed psychiatric Crisis Intervention Unit (BKA 2007) – apart from 84 emergency department beds (Moises 2009).

The proposed UMC also projects an increase in “urgent care clinic” visits (Verité 2011, p. 18). Yet LSU Interim Hospital’s urgent care center, originally open 24 hours a day, has reduced service hours as of July 1, 2011, belying the stated assumptions of the proposed UMC.⁷⁸

Gauging the continuity of pre-storm plans, LSU in this instance has experienced a profound rupture. Medicine clinics and services which once defined Charity Hospital and trained generations of medical professionals have been discontinued. Nor will these services necessarily be a part of the new UMC. LSU-HCSD closed “its inpatient pediatrics program in the face of a diminished population of children” which severely impacted pediatric training across the region (Berggren and Curiel 2006, p. 1551). On August 1, 2010, LSU Interim Hospital also ceased labor and delivery services, closing its neonatal intensive care and nursing care units (McGraw 2010). If this decision stands, a major New Orleans legacy will end – the creation of “Charity babies.”⁷⁹

⁷⁸ MCLNO (2011a-b): Clinic hours’ change substantiated via: <http://www.mclno.org/mclno/menu/>, p. 3.

⁷⁹ Lovell (2011a): “Debating Life After Disaster: Charity Hospital Babies and Bioscientific Futures...”

LSU announced its opening of the UMC will be 2015 – ten years after Hurricane Katrina (Barrow 2011a). There will likely be a change in its management, to the UMC Management Corporation; “a non-profit corporation (which) will retain a CEO.” The “destination programs in identified specialties” have not been identified. The UMC will also have an immediate impact upon the six LSU-HCSD hospitals outside of New Orleans, as “activities that were displaced by Hurricanes Katrina and Rita will be transferred (back) to the new (UMC)” (Verité 2011, p. 3). The result could be more service cuts and hospital closures.⁸⁰

The UMC Business Plan notes that if the federal Patient Protection and Affordable Care Act (PPACA) insurance purchase mandate requirements are overturned, “UMC’s safety net services may be greater than assumed” (Verité 2011, pp. 27-28). Nevertheless, the fiscal impact upon DSH funding, the main source of safety net hospital operating receipts, is projected to be curtailed sharply from current levels after 2014 if the PPACA is fully implemented (Kulkarni, 2011). LSU-run Charity Hospital system facilities already face the loss of DSH funds from DHH reallocation and from the “DSH Audit Rule” that came effective at the close of 2010 – the latter limited the amount of allowable healthcare services that can be federally reimbursed (CMS 2009; Moller 2010a; National Association of Public Hospitals / NAPH 2011; Shuler 2011a).

Business conditions for public and non-profit safety net hospitals, many with aging facilities and out-of-date diagnostic equipment, are driving many to merge with for-profit providers, redesign their healthcare delivery for the consumer marketplace, or face bankruptcy and closure (Landsberg 2004; Harrison and Sexton 2004; Darcé and Pope 2006; Stone 2006). Yet these healthcare marketplace adjustments may also conflict with their charitable missions, *leading to their demise as charity safety net providers* (Landsberg 2004; Stone 2006).

⁸⁰ Baton Rouge’s Earl K. Long is slated to close and merge with Our Lady of the Lake in 2013: (Shuler 2010b). See Maginnis (2010); Hasten (2008) (Huey P. Long/Pineville); and Roberts (2010) (Lallie Kemp/Independence).

Once threatened with the potential loss of a half-billion dollars in DSH funds, DHH officials and Senator Mary Landrieu scrambled successfully to defend Louisiana's adjusted "Federal Medical Assistance Percentage" (FMAP) to reflect the influx of storm relief funds as well as the displacement of thousands of Medicaid recipients to places outside of Louisiana (Shields 2011). Nationally known (derisively) as "the Louisiana Purchase" – Landrieu's 2010 rider was reportedly added in exchange for her support of the PPACA. This political carve out supposedly safeguards LSU Charity hospitals and Louisiana Medicaid until 2014 (Alpert 2011). But this experience yet again urges LSU to move beyond its DSH-reliant "old Charity model."

LSU Health Sciences Center Chancellor Dr. Larry Hollier said that he is "absolutely committed to keeping us away from the charity model" (Moller 2006e). He noted that while Charity for decades "drew young physicians for training and helped keep them in Louisiana to practice" LSU's ability to continue to train seventy percent of physicians that remain in the state must have a "magnet" academic medical center "that is financially sustainable" (Griggs 2010).⁸¹ In this regard, LSU post-Katrina planning is solidly in a continuous line with pre-storm plans to diversify its patient base with a greater concentration of insured, healthier patients.

Hollier said that shifting from "a Charity model" to "an academic medical center model" bypasses the limitations of relying on DSH funding. By attracting more Medicaid patients through the PPACA expansion, Hollier said "more matching federal funds (can) come in because there's not a cap on Medicaid eligibility and matching," unlike DSH funds that are capped. Hollier said this will also expand education opportunities since the subject patient base will become more varied with its expanded payer mix (Hollier Deposition 2009, pp. 71, 94).

⁸¹ For lists of research breakthroughs made while New Orleans' Charity Hospital was in operation, see Yakubik, Brown, Greer and Lee (2011, pp. 4, 11-13) and LSUHSC (2011): <http://lsuhscimportantwork.com/importantfacts>. More UMC superlatives: Moller (2007d): The UMC would mean "a new emphasis on teaching and research"; Barrow (2011b): The new UMC will be "an elite facility that would draw patients from across the Gulf Coast."

While reaffirming LSU's *public* academic medical center status, Hollier elaborated that LSU is "changing the entire way the uninsured receive care." He contrasted the current ten-hospital *state-owned Charity safety net system* with LSU's "*public/private partnership*" model:

The state legislature ... approved a public/private partnership between (LSU/Earl K. Long and Our Lady of the Lake medical centers). The result is a fully funded infrastructure, because 98% of the patients will be insured. This will dramatically reduce our dependence on state health care dollars, and produce a major change in care for the uninsured ... A similar project replicating that public/private enterprise model is underway in New Orleans, where we are building a new academic health center which will serve both uninsured and insured patients ... The private institutions with whom we are partnering have service goals that match well with ours. ... By reducing the hospital funding needs, we can ensure that state dollars are available to be redirected to advance education, infrastructure, and the development of new treatments (Hollier 2010, p. 17).

Legnini and Waldman (1999) investigated tensions within academic medical centers (AMCs) forced to contend with the private healthcare market environment while upholding their once unquestioned mutual provision of medical training *and* safety net healthcare:

AMCs play another important function in the medical system – as safety net providers. Since the establishment of the first hospitals in this country that served the poor exclusively and also trained physicians, academic medical centers have provided large amounts of free care and have been an important source of access to highly specialized services without regard to ability to pay. AMCs have the largest pool of physician labor available to care for the poor – namely physicians in training (both often located in inner cities...) (p. 1).

Even LSU's private healthcare critics suggest that the key for revitalizing LSU's teaching hospital enterprise is to escape the "stigma" of a "Charity Hospital" (Deslatte 2007).⁸² Yet Dr. George Thibault, a professor at Harvard Medical School, said "local history, local culture and local relationships" impact desired changes. Thibault said LSU's challenge will be: "Can you create that *de novo* if you do not have that 100- or 200- year tradition?" (Egglar 2007).

⁸² For viewpoints on *charity* and its association with the stigma of poverty and need: see Fothergill (2003): "The Stigma of Charity: Gender, Class and Disaster Assistance" and Frey (2005): "Big Charity in New Orleans."

In proposing before Hurricane Katrina the consolidation of Charity with University Hospitals through the construction of an entirely new medical campus, Adams Management consultants heavily predicated their assumptions *on discarding the Charity heritage*. Yet their report reflected both divided sentiments amongst LSU-HCSD and LSUHSC professionals (e.g., divided for / against having the new academic medical center in the midst of LSUHSC between Charity and University hospitals due to their proximity to Charity, with those in favor desiring continuing Charity heritage; those opposed suggesting “the charity stigma may be too strongly a part of this neighborhood”) *but most decidedly in favor* for the Charity Hospital mission and clinical research traditions, especially with Tulane clinicians, *to remain in place as an ethic*.⁸³

Though LSU has largely remain consistent with its plans with regards to the project intent as proposed by their consultants, its post-Katrina size has taken a decidedly *suburban scope and look* (moderate-story buildings of five to six floors versus 16 to 17 floors on a smaller land footprint before the storm. This is in stark contrast with pre-Katrina plans when the preferred option amongst both LSU-HCSD and LSUHSC was the South option. Likewise the needs for community consultation in the pre-storm planning was seen as crucial; whereas post-Katrina, *the effective decisions have already been made before public input was even sought*.

Grimly, the 2005 Adams pre-storm report noted about the possibility of the closure of the Medical Center of Louisiana at New Orleans (MCLNO) combined Charity and University hospitals campus if steps were not taken to supplant the hospitals with a new combined facility:

Other than replacement, the only option would be to ultimately close MCLNO and redistribute medical education and patients throughout the private hospitals in the region. This would have a negative impact on the medical education component due to the absence of sufficient clinical mass at any one site, present access challenges for patients, and shift the uncompensated care burden to private hospitals and physicians (ADAMS 2005, p. 3)

⁸³ See ADAMS (2005, pp. 95-97). Post-storm LSU UMC comparisons made via <http://www.newhospital.org>.

Administratively since Hurricane Katrina LSU has made its decision to do away with even the institutional memory of Charity. Indeed, LSU has been in a process of ‘rebranding.’ In addition to exorcizing all references to “Charity hospitals” LSU has also moved away from “LSU Hospitals,” first in favor of “LSU Health System;” and the latest name: “LSU Health.”⁸⁴ Mapped out as part of a “complete logo hierarchy” in order to ensure “consistency” in LSU Health brand “(presentation, usage, messages)... strengthening the overall impression of quality and professionalism for LSU Health as a whole.” It answers the question: “Why a new identity?”

Regardless of what we know (about our health system), it’s what others know about us that defines our brand. Because a brand is not what we say it is. It’s what those who perceive us say it is. That’s why it is essential for us to seek relevance and to connect with the public... As we update our brand to better reflect who we are and how we are perceived in today’s world, it is imperative that we develop a strong visual identity to underscore our commitment to the future. Our new logo and its various versions, is designed to make a simpler, yet more powerful, statement about who we are – one that is both easy to grasp and relevant ... The new logo serves as the springboard for all of our brand identity efforts, the cornerstone around which we will build a more relevant and more focused message about who we are at LSU Health (LSU Health Graphic Standards 2010, p. 2).

Changing cultural perceptions however are likely to be a tall order. According to national surveys, healthcare consumers prefer “*hospital*,” associating hospitals with better and more comprehensive healthcare than “*medical centers*,” contradicting rebranding efforts by hundreds of hospitals across the nation (Mueller 2011; Jacobson 2011; FierceHealthcare 2011).

While LSU has clearly been attempting “a change in culture,” its institutional response has taken dramatic shifts since Hurricane Katrina; and in response to Governor Jindal’s DHH wholesale privatization of Louisiana Medicaid. Particularly with regards to LSU / Charity’s predominately African American patient base “a change in culture” has taken on a decided tone, one that may yet result *in a rupture that could be greater than the closure of Charity itself.*

⁸⁴ See <http://www.lsuhsospitals.org/Media-Relations/Newsletter.htm> newsletters and releases (2008, 2010-2011).

As previously noted in this case study, Charity Hospital during both Jim Crow segregation and following the Civil Rights movement has often been the only comprehensive acute facilities in Louisiana to admit African Americans as patients, albeit with varying degrees of actual dignity and personal treatment. And given Charity's history, substantial numbers of poor whites as well as blacks have been Charity system patients.⁸⁵ Both Salvaggio (1992) and especially Roberts and Durant (2010) extensively document the rise of African American health professionals and hospital administrators since the advent of Medicare and Medicaid. Yet indications of a shift based on race would arise soon after Charity's late September 2005 permanent closure. For comparison, the pre-storm Adams Management report noted:

Further, MCLNO will expand the volume of insured patients through focused programmatic development efforts and a marketing strategy centered on building market share of Medicare and Medicaid populations within the African American community in the core market [of Uptown and Mid-City New Orleans] and New Orleans East (ADAMS 2005, p. 2)

Likewise as noted by McDonald (2002) and reaffirmed in the 2005 Adams report and other venues, LSU Shreveport became the professed model before Hurricane Katrina of culture change away from New Orleans "two-tier system" of predominately African American poor and uninsured going to Charity Hospital and predominately white with health insurance receiving care from non-state private and parish hospital district facilities. Beyond the profound rupture caused by Charity Hospital's post-Katrina closing, LSU leadership lodged their contention for abandoning Charity Hospital and charity care in racial-code class terms:

I have a deep feeling that a lot of this is just a way of putting the least enfranchised people in a dilapidated, damaged, obsolete structure that will allow the upper-class citizens of New Orleans not to be bothered by the likes of them. Not in my backyard. Going into Charity Hospital is inappropriate, even temporarily, by any reasonable standards. (LSU Chief Medical Officer Dr. Michael Butler quoted by Webster 2007).

⁸⁵ See Table 2 on p. 106 and Table 3 on p. 107 for Charity Hospital system and New Orleans data by race.

LSU System President John Lombardi wrote to *The Shreveport Times* proposing “the time has come (to modify the newspaper’s) official style regarding hospitals run by LSU.” He said their “Charity’ system references are “anachronistic and simply inaccurate”:

Those who advocate an alternative to the old “charity hospital” model have become fond of the buzz word “health care redesign” even though they don’t know exactly what the term means or how much more redesign will cost. LSU has been quietly “redesigning” health care for many years and improving outcomes while living within its legislatively approved budget. LSU believes that phrases like “charity hospital” and “charity hospital system” is a part of the state’s proud heritage and a testament to the compassion conveyed by the Great Seal of the State of Louisiana, but they no longer describe the modern approach to medical care being pursued by LSU. In fact, no hospital among the 10 LSU public hospitals is legally known as a “charity hospital.” University Hospital in New Orleans that used to be a part of the Medical Center of Louisiana at New Orleans is now legally known as the Interim LSU Public Hospital (Lombardi 2007).⁸⁶

Lombardi also asserted LSU thinks “the term ‘charity hospital’ has become racially charged and is tinged with a pejorative undertone that not only negatively skews public debate over health care reform, but also feeds perceptions that unfairly challenge the quality of medical care delivered by our medical staffs...” (Lombardi, 2007).

Yet LSU officials apparently had no problem subjecting returning patients of any race to tents and other makeshift accommodations. The closure of Charity Hospital, charged historian Dr. Lance Hill, was “the single greatest obstacle to return of the black community...” Hill, executive director of the Southern Institute for Education and Research, called LSU and the state’s decision to close Charity the cause of “barbarous suffering and pain for people” especially in light of the loss of many black middle class jobs with insurance since the storm. Hill also suggested Charity’s post-Katrina closure merited more media exposure, suggesting that “(closing) the *only* hospital for the uninsured” elsewhere would not be tolerated (Hill 2008).

⁸⁶ Actual legal name: HB 1 (2011, p. 242): “Charity Hospital and the Medical Center of Louisiana at New Orleans.”

Lovell (2011b) concurs with Hill and others that “for poor and African American residents who had struggled to return and rebuild broken lives, Charity Hospital’s closure reinforced their sense that the city was being redesigned for white, middle class residents and tourists.” Unlike many scholars, Lovell details the attempt by Charity’s workers and the U.S. military to reopen the hospital in the weeks following Hurricane Katrina – as well as highlighting the “broad social movement to reopen Charity Hospital, intensified by LSU’s announcement” of the planned razing of the predominately African American working class neighborhood of Lower Mid-City for the future complexes replacing Charity and the original VA Medical Center.⁸⁷

Though this author found no evidence of a *pre-planned conspiracy* to capitalize on the Hurricane Katrina disaster, the catastrophe nevertheless provided a clear opportunity to speed up LSU’s pre-storm plans to replace Charity Hospital with a “market-ready” facility. LSU and the state could have acted to reopen the hospital in the weeks after the storm. Indeed not to do so seemed to belie a “*First do no harm*” medical principle for its health system and its patients.⁸⁸ And the closure of Charity Hospital set into motion consequences that invariably have had a disproportionately negative impact on New Orleans’ African American populace and Diaspora.

Skepticism that the new LSU University Medical Center will be different from what “white New Orleanians and Louisianans that view Charity as ‘a black hospital’” runs deep, even as LSU UMC supporters extol it as the next “destination hospital” for everyone, including those with insurance (Barrow 2011d). More disturbingly, by closing Charity Hospital and dispersing its core indigent patient base *before building its new academic medical center*, LSU risked the loss of meeting both its safety net healthcare and graduate medical educational missions.

⁸⁷ The razing of Lower Mid-City is nearly complete. See Vogel (2011): <http://insidethefootprint.blogspot.com/>.

⁸⁸ *Primum Non Nocere*: “Latin for ‘first do no harm.’ A guiding principle for physicians that, whatever the intervention or procedure, the patient’s well-being is the primary consideration.” <http://medical-dictionary.thefreedictionary.com/First+Do+No+Harm.>; See also Krause (1997) and Lakhani (2011).

Findings: New Orleans' Charity Hospital was closed as the result of disaster capitalism to supplant its original mission in favor of LSU's neoliberal academic medical enterprise

Through the rigorous review of multiple sources of literature and data, this case study *finds that New Orleans' Reverend Avery C. Alexander Charity Hospital was closed as the result of disaster capitalism in order to supplant Charity's original safety net mission in favor of Louisiana State University's neoliberal University Medical Center academic medical enterprise.*

The genesis of LSU's closure of Charity Hospital began years before LSU assumed administrative oversight of Charity and its inspired network of public safety net hospitals. Sorely neglected following the 1965 advent of the federal Medicare and Medicaid programs, Charity's previous administrator, the Louisiana Health Care Authority (LHCA), also attempted to abandon the Big Charity Hospital campus and the *Charity* name fifteen years prior to Hurricane Katrina.

Under the LHCA's administration Louisiana's Charity Hospital system became the recipient of special Medicaid disproportionate share hospital (DSH) federal match payments designed to support safety net hospitals that treated a disproportionate share of the uninsured. Had the funds been distributed as they were intended, the Charity public hospital system could have completely modernized and fully integrated with other medical providers statewide to address Louisiana's challenging health indicators long marked by poverty and racial inequality.

Rather than transforming the state hospital system, DSH "Medicaid golden goose egg" funds became an opportunity for outright avarice and corruption. Charity system hospitals were forced to 'donate' DSH-eligible funds to the Louisiana Department of Health and Hospitals (DHH). The resulting federal fund matches created up to three times the cost of Charity Hospital care to benefit not Charity, but private healthcare enterprises, many of them owned and operated by politically-favored allies of the Edwards gubernatorial administration. Charity system hospitals subsequently lost out on a total of approximately two billion dollars.

Even after U.S. Congressional curbs were instituted and Charity Hospital system administration was transferred to LSU, hundreds of millions of DSH dollars meant for Charity hospitals continued to enrich private providers during Governor Foster's administration. Indeed, upon LSU's assumption of Charity hospitals in 1997, Foster had left LSU without operating funds, as \$86 million of Charity DSH-generated funds instead went to balance the state budget.

Despite Louisiana state legislative attempts to afford LSU a greater ability to command its administration of the Charity Hospital system, almost uninterrupted budgetary shortfalls, coupled with continuing deferred facility maintenance issues, led LSU to seek the replacement of Charity's flagship hospital in New Orleans in advance of Hurricane Katrina. Initially LSU tread a wholly different path than its LHCA administrative predecessor. LSU had attempted to build public, state legislative, then gubernatorial support under the Blanco administration to transform the state hospital system on the chassis of the highly-regarded and beloved Charity into a greater integration with LSU's graduate medical education enterprise. Yet its commitment to upholding Charity's safety net mission under Louisiana's tradition of "Open Access" without regard to one's income had already eroded thanks to LSU institutional means-testing of Charity's medically indigent patients a full two years before Hurricane Katrina struck.

The evidence on which this thesis bases its finding of the use of the disaster capitalism paradigm in Charity Hospital's closure begins with LSU's failure to uphold its responsibilities for hospitals statewide under Louisiana's emergency operations plan in advance and following Hurricane Katrina. LSU did erect and staff what was then the nation's largest field hospital on its flagship LSU academic campus in Baton Rouge.⁸⁹ Nevertheless both of its hospitals in New Orleans as well as all other area hospitals literally fended for themselves to deal with the loss of power and sanitation as well as evacuation from a flood-ravaged New Orleans.

⁸⁹ See LSU-HCSD (2006e, pp. 5-6)

Following the evacuation of Charity's patients, staff and their families five days after the storm, LSU essentially abandoned its two New Orleans hospital campuses. Charity doctors and U.S. military personnel indeed found the hospital's entrance doors wide open. Following an assessment authorized under federal disaster plan guidelines, Charity's workers, medical residents and U.S. military personnel proceeded to ready the facility for reopening.

Virtually uninterrupted for weeks in their attempt to revive this critical disaster medical infrastructure, the U.S. military was blocked by LSU officials in seeking installation of back-up electrical generators to support Charity Hospital's permanent reopening. LSU officials also forced the deactivation of temporary generators which had successfully powered-up key areas of the hospital, including its emergency department; and informed U.S. military personnel that Charity would not be reopening, so their disaster recovery efforts would have to end.

LSU then threatened its workers who were otherwise authorized to restore Charity Hospital operations for future medical use with criminal trespass had they remained on the premises. This ended the attempt to reopen Charity Hospital and ended its use as a centerpiece in the U.S. Army's *Taskforce Katrina's* disaster recovery operation of New Orleans.

The State of Louisiana, through its Department of Health and Hospitals (DHH) and Office of Emergency Preparedness, blocked FEMA grant expenditures to fully repair Charity Hospital. The state returned \$340 million in emergency public assistance – the same amount LSU-HCSD's Chief Administrative Officer said it would cost to repair Charity. LSU's choice to use its emergency FEMA funds on the much smaller University Hospital *led to the loss of healthcare that Charity once provided* because of University Hospital's shortage of clinical space. LSU and the State of Louisiana also opted for the use of tents and other makeshift facilities, even as the still JCAHO-accredited Charity Hospital was left shuttered.

The resulting loss of Medicare, Medicaid and private insurance reimbursement because of LSU's use of makeshift facilities contributed to the mass firing of over 2,600 medical workers and the displacement of hundreds of medical residents, inflaming a public health crisis because of their absence. The closure of Charity Hospital and its 160-pre Katrina LSU clinics resulted in the loss of medical care, such that many New Orleans residents would remain displaced away from the city for a prolonged period of time; and for those who managed to return home, a critical shortage of adult acute hospital beds lasted many months.

The closure of Charity Hospital meant the loss of the only Level One trauma center on the Gulf Coast for more than seven months. This specialized unit also did not return back to the city from suburban Jefferson Parish until more than a year after the storm. Charity's closure, particularly of its 128-bed psychiatric Crisis Intervention Unit (CIU), was said to be "the number one cause for the mental health crisis" afflicting New Orleans having amongst the nation's highest rates of untreated Post Traumatic Stress Disorder (PTSD) and preventable suicide.

Because of Charity Hospital's closure, healthcare access for all patients in the metropolitan area as well as Baton Rouge and statewide was negatively impacted, leading to delayed care and medical complications as a direct result of delayed healthcare. Charity's closure also led to millions of dollars in unanticipated expenditures by the remaining reopened facilities; with them collectively still unable to replace the medical care that Charity once provided.

LSU's closure of Charity Hospital was also found by international and national human rights organizations and bodies as having violated the human rights of internally displaced persons. These same human rights organizations found that the demolition of the Lower Mid-City New Orleans neighborhood, slated for LSU's new University Medical Center, would cause further internal displacement, hardship and human rights violations.

Additional benchmarks of LSU's disaster capitalized closure of Charity Hospital involved the timing of its execution (when the city was virtually emptied of its populace), and the lack of meaningful participation in charting New Orleans' healthcare recovery.

Other parties, including the Bring New Orleans Back Commission (BNOB), the Louisiana Health Care Redesign Collaborative, the Bush administration, as well as several former and current local, state and federal officials also contributed to ensuring Charity's permanent closure. This supplanted Charity's historic safety net mission with the attempted *medical neoliberal transformation* of its physical, financial, institutional and cultural assets to favor private health insurance and corporate medicine. Healthcare became a commodity, rather than an inalienable human right, abridging what should have been free following a disaster.

The closure of Charity Hospital came at a time when New Orleans was effectively emptied and much of its populace was internally displaced, unable to return to the city. Charity's closure disproportionately impacted African Americans through the displacement of its predominately African American patient base, house staff and nursing corps, as well as significant numbers of hospital physicians, administrators and contract medical vendors.

Many healthcare professionals, foundation representatives and medical lobbyists failed to acknowledge the attempted reopening of Charity Hospital by its workers and the U.S. military. Resulting disaster recovery decisions were made in *desired expectation of Charity's continued closure*, with the attempted re-allocation of Charity Hospital's main operating Medicaid DSH funds; first towards the purchase of private insurance vouchers, then toward the development of a private non-profit clinic network. Planners of these healthcare redesign efforts following Charity's closure also knew in advance that most stakeholders, especially patients, were unable to participate in decision-making due to their internal displacement.

Epilogue:

Conflict between LSU and the Jindal administration over LSU-HCSD state budget appropriations recalls how broken our healthcare system is without Charity Hospital

Finding its own Fiscal Year 2011-2012 budget in a mid-year shortfall of \$251 million due to reduced tax revenues, Governor Jindal's administration took \$50 million in federal DSH match dollars generated from the LSU Charity Hospital system and gave the funds to the Department of Health and Hospitals (DHH) (Shuler 2012). As a result, LSU-HCSD ordered \$34 million in budget cuts, with \$15 million of them imposed on New Orleans' LSU Interim Hospital (Barrow 2012a). LSU-HCSD closed its dedicated stroke unit, the chemical detox unit, and nineteen psychiatric beds, including one-fourth of its beds at the former DePaul Hospital and ten of twenty beds in LSU Interim's Mental Health Emergency Room Extension (MHERE). The budget cuts have resulted in total reductions of 225 positions, including the actual layoff of 110 workers at LSU Interim (LSU-HCSD 2012b). Hundreds more health professional layoffs and significant service cuts have occurred at six other LSU-HCSD hospitals in Baton Rouge, Bogalusa, Houma, Independence, Lake Charles and Lafayette (LSU-HCSD 2012a).⁹⁰

This reallocation of LSU-HCSD system DSH funding again recalls earlier diversions where Charity Hospital system funds earned their enhanced federal match, then were shifted to benefit private Medicaid providers. Facing a firestorm of criticism for executing these budget reductions, DHH secretary Bruce Greenstein as well as Governor Jindal blamed LSU for wanting to overspend its appropriated state budget (Barrow 2012b; Wilson 2012). Greenstein in particular charged that LSU's cuts to vital programs were "meant to mobilize communities and supporters" for LSU. Yet billings from non-state hospitals and private Medicaid providers *were on pace to overspend DHH's FY 2011-12 budget by nearly \$500 million* (Barrow 2012d).

⁹⁰ Three hospitals under LSUHSC Shreveport also face budget reductions and the loss DSH match funding; but did not face major cuts in vital programs or employee layoffs (LSU System Board of Supervisors 2012).

The Jindal Administration has moved swiftly to privatize Louisiana Medicaid delivery through its *Bayou Health* scheme. Medicaid recipients are being forced to choose or be directly assigned to five private HMO providers in order to access primary and acute medicine. Enacted in the final hours of the 2010 Louisiana State Legislative Session, Bayou Health is scheduled to reallocate an additional \$2.2 billion of the state's \$6.7 billion in annual Medicaid expenditures to private insurance providers. Critics have charged the program will not save the state money, will disrupt doctor-patient relationships, and was passed into law through a series of last minute obscure state budget amendments that bypassed the full scrutiny of state legislative budget and health and welfare committees (Barrow 2011g; Maginnis 2012). Indeed, state Medicaid overwhelmingly *has become a private enterprise*, as private providers are commanding close to \$5 billion or almost three-quarters of Louisiana's Medicaid program (DHH 2011, p. A1).

Under current cost projections, the only way DHH will be able to balance its corporate Medicaid largess within the current fiscal year is through its continued receipt of enhanced federal DSH funds generated out of currently budgeted LSU public hospitals (DHH 2012). Yet LSU's response has been curiously muted for an entity which critics and supporters alike have long ascribed it "a fourth branch of government" status.⁹¹ Indeed, in response to the Jindal administration lambasts of LSU's poor budget performance, LSU President John Lombardi issued a memo requesting LSU system administrators *not to complain* about the austere dimensions of the state budget. As a result, virtually no one publicly commented to the Jindal administration's recent release of its Fiscal Year 2012-13 state budget (Barrow 2012c). Likewise, aside from non-judgmental responses to DHH's obvious re-appropriation of LSU-HCSD's 2011-12 budget, LSU officials remain tight lipped (Farris 2012, Barrow 2012d).

⁹¹ See http://louisiana.gov/Government/Executive_Branch/#boardsandcommissions. The LSU Board of Supervisors is the largest of Louisiana's more than 500 appointed boards and commissions.

While DHH Secretary Greenstein smarts from public criticism in response to LSU-HCSD's draconian budget cuts, both Greenstein and LSU officials seem all too eager to outsource to private providers vital healthcare functions, and indeed graduate medical education programs that were once the primary domain of the state-run Charity Hospital system. Though Governor Jindal charged that LSU hadn't made significant budget reductions from the beginning of the current fiscal year, LSU's Executive Budget cuts of key hospital and medical school programs leave critics and supporters alike to wonder whether LSU might be more aligned with Jindal's private enterprise-paradise. LSU-HCSD within the 2011-12 Fiscal Year is proceeding to complete the elimination of obstetrics, pediatrics, hyperbarics and hospital dentistry programs. Documents detail that FY 2011-12 expenditure reductions will reduce LSU-HCSD's budget by \$63 million (LSU System 2011, p. 1146). LSU also appears to be on track to meet its 2013 deadline to shutdown its Baton Rouge Charity Hospital, the Earl K. Long Medical Center.

LSU public hospital system workers, patients and the communities in which they are located increasingly are becoming bewildered over how state officials could mete out such damaging budgetary reductions – and how LSU officials have been largely silent in the face of them. Indeed, so many key hospital services are being discontinued that their *raison d'être* is now in question. Most endangered is Louisiana's once acclaimed Charity Hospital network.⁹²

More than one hundred health and public safety professionals along with current and former LSU and Charity Hospital patients demanded the reversal of planned cuts during a special meeting of the New Orleans City Council. Councilmember Susan Guidry posed what she called “the \$64 question ... the elephant in the room kind of thing” which had to send a chill onto LSU:

“How is it that the state is going to be able to run this mega hospital if they can't even run our little Interim Hospital now?” (New Orleans City Council 2012).

⁹² See Rainier (2012); Decker (2012); *American Press* (2012a & b); Houma Today.com (2012a & b).

Questions as to whether LSU still has the ability to uphold its 1997 commitment to provide safety net hospital and clinical healthcare to the poor and uninsured of Louisiana, much less be able to fulfill their graduate medical education transformation with its new University Medical Center project cannot be overstated. For possibly the first time in the state's almost 200 year history, state general funds are proposed *not to be appropriated* to support the historic Charity Hospital system. Instead, true to the model of governance Governor Jindal has long espoused, proposed funding for the LSU Health public hospital system is slated to come from non-state government sources. Indeed, the "means of financing" of the proposed Fiscal Year 2012-13 Louisiana Executive Budget relies heavily on *the sale of state assets*, including the sale of the former New Orleans Adolescent Hospital (NOAH)! And the balance of what would normally be constituted with state general fund appropriations for the LSU/Charity system proposes to utilize unspent budget balances of close to fifty local and state agencies and support funds – including unspent Hurricane Katrina disaster recovery funds under the Gulf Opportunity Zone Act of 2005 that were meant for currently unmet needs in New Orleans.⁹³

To add insult to injury, the collected funds purportedly meant to cover the loss of state general fund allocations for LSU/Charity public hospital operations are being directed not to LSU-HCSD directly, but to a Louisiana Department of Health and Hospitals (DHH)-controlled "Medical Assistance Trust Fund." This aspect alone suggests *that LSU-HCSD again will face a raid on their Fiscal Year 2012-13 budget* as they experienced during the middle of the Fiscal Year 2011-12! Indeed, LSU Vice Chancellor for Health Affairs Dr. Fred Cerise said that LSU is anticipating that DHH *will take about \$50 million in LSU DSH-eligible funds* to gain enhanced millions of federal matching dollars *to benefit DHH's private medical vendor program.*⁹⁴

⁹³ See Louisiana House Fiscal Division (2012); LSU Health (2012); HB 822 Digest (2012).

⁹⁴ See Cerise 2012a and Cerise 2012b; LSU Health (2012).

Drawing from both known medical literature and personal experience, Orleans Parish Criminal Court Judge Arthur Hunter, who presides over New Orleans special mental health court said “everyone suffers from post-traumatic stress disorder, whether their house flooded or not” (Hudson 2009). As confirmed by the public testimony of New Orleans top public safety and medical professionals, *the current state of New Orleans healthcare is precarious* in the wake of recent state budget cuts to the LSU Interim Hospital. Several leaders said that a mental health system that was just emerging from the closure of Charity Hospital following Hurricane Katrina now is threatened with undoing the progress since the storm (New Orleans City Council 2012).

On top of severe Fiscal Year 2011-12 budget cuts to LSU/Charity public hospitals, their impact, along with the projected loss of state general fund support for the coming fiscal year are also anticipated to wallop LSU Health Sciences Center New Orleans graduate medical education and allied health programs. Chancellor Dr. Larry Hollier, in a presentation to the Louisiana House Appropriations Committee March 27, 2012, said the continued drop in state general fund appropriations since 2007 no longer can be mitigated with either federal stimulus funding (due to end with the FY 2011-12 budget year) and rising tuition costs on students – and not suffer the loss of the same students and LSUHSC health clinical access for patients, both levels of which have doubled since Hurricane Katrina. Indeed, unlike its Charity Hospital system counterpart, LSUHSC New Orleans said Hollier is facing from about \$25 million to almost \$37 million in budget cuts for Fiscal Year 2012-13, based on anticipated reductions in state college and university formula funding from the State Board of Regents, and the expected reduction in health services at LSU Interim and other LSU/Charity system hospitals, curtailing needed graduate medical education residency training opportunities for LSUHSC New Orleans students (LSUHSC 2012; Louisiana House Appropriations Committee 2012).

Whatever the level of severity of LSU/Charity public hospital and LSUHSC New Orleans cuts have on local and state healthcare, the manner and timing of their occurrence has created an unprecedented reversal in “Louisiana’s way” of state healthcare and social insurance. Indeed, unless the Louisiana State Legislature fully asserts its constitutional and budget authority, Governor Bobby Jindal will likely make good on his most ideologically neoliberal / neoconservative pledge made when he first became Louisiana’s health secretary sixteen years ago, to slay sacred cows and transform Louisiana’s”focus from being a [public] health care provider to a wise purchaser of [privatized healthcare]” (Shuler 1996b).

Salvaggio’s (1992) characterization that New Orleans’ Charity Hospital during the early and mid-1980s was in its “death rattles,” unfortunately has become far worse today. *Mother Charity then was at least open*. And the former University Hospital, now known as LSU Interim, is but at a quarter of its pre-storm capacity, and is likely to face further drastic service cuts.

Charity’s now-shuttered downtown New Orleans hospital, the emblematic anchor of iconic populist Huey P. Long’s *Share Our Wealth* commitment to the poor and dispossessed has literally become *a shadow* of its former self, even at its austere status of the time of Hurricane Katrina, to gravely portend to New Orleans a profound lack of an intact healthcare safety net.

Charity and its inspired network of Louisiana public hospitals – a holdover remnant of Keynesian New Deal-era policies – have endured through decades of institutional neglect and cannibalization of their assets for private medical interests. They now face perhaps their own *death rattles* – by authorities taking advantage of the epic catastrophe sparked by Hurricane Katrina *through the paradigm of disaster capitalism* – to permanently supplant Charity Hospital’s historic mission in favor of medical neoliberalism.

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Left to right: German engineers pump floodwaters from Charity Hospital’s basement; Charity Hospital’s Emergency Department, September 21, 2005; Charity Hospital’s Emergency Department, June 1, 2009.

Appendix A:

Photographs of attempted reopening of Charity by its workers and the U.S. military

Note: Appendix A provides an internet address to photos taken in 2005 by Charity Hospital doctors, workers and members of the U.S. military both in the immediate aftermath of Hurricane Katrina, during the three weeks following the storm while Charity was being cleaned out by its Emergency Department staff, medical residents, U.S military personnel and other volunteers; as well as some follow-up photos taken in 2006 to certify Charity’s condition. Several of these photos made up “Exhibit C” of the attempted legal intervention by citizens with an interest in the outcome of the FEMA Arbitration; others made up photo booklets distributed to journalists, and state legislators to back workers’ demands to reopen Charity Hospital (Moises 2009b, p. 243).

Save Charity Hospital (dot) com (2011):

<http://www.savecharityhospital.com/content/breaking-news-hospital-appears-clean-after-storm>.

Link to the Foundation for Historical Louisiana / RMJM Hillier’s “Medical Center of Louisiana at New Orleans / Charity Hospital – New Life for a Cultural Icon” film:

<http://www.youtube.com/watch?v=P9RiqkvrIE>.



Left to right: Stairwell to flooded Charity Hospital basement, early September 2005; floodwaters in Charity Hospital basement, undated photo; E-MED tents on floor of Morial Convention Center, fall 2005.

Appendix B:

Photographs taken by LSU of Charity Hospital damage; surviving Hurricane Katrina

Note: Appendix B provides internet addresses to photos taken in 2005 on behalf of LSU Media Relations and Communications, including ones that made up reports prepared by Adams Management (LSU’s lead consultant evaluator of Charity before and after Katrina); and ones posted on LSU System websites outlining both the heroism of its medical personnel and what they termed the “unsalvageable” damage to Charity and University hospitals following the storm. Subsequently University Hospital was reopened in November 2006; while Charity Hospital’s main building remains closed (even as its laundry, workshop, powerhouse and chiller facility also reopened by November 2006.

“LSU Health: Five Years After Katrina and Rita”

<http://www.lsuhschools.org/hurricanes/mcIno.shtml>;

<http://www.lsuhschools.org/hurricanes/ourStory.shtml> (slideshow of photos);

“The Loss of Charity” LSU video: <http://www.youtube.com/watch?v=8v81bNsMjDc>.

Appendix C: The movement to Reopen Charity Hospital and Save Lower Mid-City

Note: In part due to my extensive involvement in the launch of the movement to reopen Charity Hospital, this thesis was not drafted as a social movement analysis; and is only referenced within the context of the stated research propositions of this case study. However, this work would be incomplete without noting the organized groupings of this movement – as on several significant levels it challenged the closure of Charity Hospital and the demolition of the Lower Mid-City neighborhood for the proposed LSU/VA Medical Center. What follows is a chronological listing and brief description of the primary organizational actors in efforts to Reopen Charity Hospital and Save Lower Mid-City:

Doctors for Charity. March 2006-Present. Founded out of the efforts of Charity Hospital doctors, workers and medical residents who had attempted to reopen Charity Hospital within three weeks of Hurricane Katrina, September 2005. <http://www.doctorsforcharity.com/about.html>.

The Committee to Reopen Charity Hospital. Circa Spring 2007-Present. Founded as an offshoot of the Health Committee of the People’s Hurricane Relief Fund and Oversight Committee (circa Fall 2005) – and with remnant activists from the pre-Katrina Advocates for Louisiana Public Healthcare (ALPH). Alternately known as the New Orleans Committee to Reopen Charity. <http://www.charityhospital.net>.

Advocates for Environmental Human Rights (AEHR). Charity Hospital involvement began in 2006 (e.g., brought attention of its closure directly to international human rights organizations and to the United Nations); Provided legal counsel and lawsuit support (e.g., led the attempted intervention of citizens with an interest in the outcome of the FEMA Arbitration, April 2009) as well as community activism. <http://www.ehumanrights.org/ourwork.html>.

Foundation for Historical Louisiana (FHL). Spring 2006-Present. Charity Hospital involvement began following passage of HCR 89 during the 2006 Regular Session of the Louisiana Legislature (naming FHL to coordinate the architectural evaluation of Charity Hospital for possible renovation into a 21st century medical center) Responsible for alerting the national historic preservation community, leading Charity and the Lower Mid-City neighborhood to be nominated on the list of the Eleven most endangered places. <http://www.fhl.org/fhl/news/presvalerts/charityhospitalsyn.shtm>.

ACORN / A Community Voice. Spring 2006-Present. A pre-Katrina ally of Advocates for Louisiana Public Healthcare, ACORN and its successor A Community Voice’s Charity Hospital involvement continues. http://acomunityvoice.com/index.php?p=1_4_About.

Health Law Advocates (HLA). Reopen Charity Hospital movement involvement began in 2007. Provided legal counsel and lawsuit support (e.g., organized and enlisted law firms to file the first lawsuit contesting Charity Hospital’s closure, January 2008). <http://www.healthlawadvocates.org/>; <http://www.hlalouisiana.org/>.

Louisiana Justice Institute (LJI). Reopen Charity Hospital movement involvement began in 2007. Provided legal counsel and lawsuit support (e.g., hosted filing of the first lawsuit contesting Charity Hospital's closure, January 2008) as well as community activism. <http://www.louisianajusticeinstitute.org/programs/health+care>.

C3/Hands Off Iberville. This group of public housing former / current residents and supporters in 2007 helped revive active organizing to reopen Charity Hospital with sponsored forums of 2006 Reopen Charity organizers, leading to the formal designation of the Committee to Reopen Charity Hospital (following the dissolution of the People's Hurricane Relief Fund and Oversight Committee); and remains active in partnership (most recently with the Occupy NOLA). <http://c3handsoffiberville.blogspot.com/>

United Teachers of New Orleans. Charity Hospital involvement began in 2007. Was the first union to formally endorse and continue in solidarity Reopen Charity Hospital efforts. <http://la.aft.org/utno/>.

National Trust for Historic Preservation (NTHP). Circa 2008-Present. The main national organization that has supported through recognition, resources (including staff and funding support) and litigation (e.g., *NTHP vs. VA and FEMA*) the Reopen Charity Hospital / Save Lower Mid-City movement. <http://www.preservationnation.org/travel-and-sites/sites/southern-region/charity-hospital/>; <http://www.preservationnation.org/resources/legal-resources/additional-resources/ldf-updates/2009-5-LDF-Update.pdf>.

Lower Mid-City Residents and Business Owners Affected by the LSU/VA. Circa Spring 2008-2010. <http://www.squanderedheritage.com/2008/06/25/open-letter-to-mayor-nagin-and-city-council/>.

Save Charity Hospital (dot) Com. Circa 2008-Present. Website and campaign launched to escalate reopen Charity Hospital organizing and saving Lower Mid-City from demolition. Created by Eli Ackerman and Jonah Evans with support from the Foundation for Historical Louisiana and Mid-City residents and businesspeople. <http://www.savecharityhospital.com>.

Smart Growth for Louisiana. Charity Hospital involvement began circa 2008 with their push for community participation in the development / expansion of the New Orleans Medical District. <http://www.smartgrowthla.org/>; <http://www.youtube.com/watch?v=cAuw8Ny0eQk>.

Inside the Footprint Blog. September 2009 to September 2011. Founded by Brad Vogel, Fellow of the National Trust for Historic Preservation (NTHP). Nearly-complete chronicle of the struggle to save / demolition of the Lower Mid-City New Orleans neighborhood in advance of the LSU/VA Medical Center. <http://www.insidethefootprint.blogspot.com/>.

New Orleans Bio District Watch. Launched in 2011 as an outgrowth of organizing to save Lower Mid-City; the Mid-City, Gert Town, Zion City and Xavier neighborhoods now face impacts including possible demolition due to the designated Greater New Orleans Biosciences Economic Development District (now known as Bio District New Orleans). <http://nolabiodistrictwatch.wordpress.com>.

And many others. Efforts by Charity's workers to reopen Charity Hospital led the recovery of New Orleans from Hurricane Katrina. Displaced members of the Katrina Diaspora began organizing for the Right to Return to the city. Reopening Charity Hospital was one of the main landmark goals of recovery for those supporting the Right of Return of all pre-Katrina residents. This listing is an incomplete list of efforts in 2009 to broaden the movement: <http://savecharityhospital.com/content/41-organizations-call-governor-and-city-leaders-open-process-decision-making-major-hospitals>.



Photo of K. Brad Ott in front of Charity: Frank Ayami / *New Orleans City Business*

Vita

Kenneth Brad Ott (K. Brad Ott), an Erie, Pennsylvania native, graduated from New Orleans' Warren Easton High School in 1979. A long-time New Orleans progressive community social justice activist, Ott suffered a DVT/Stroke in October 2003 from sitting too long on a trip. Paralysis that occurred was substantially reversed (as well as discovery of a congenital heart defect!) thanks to the quick action of the Rev. Avery C. Alexander Charity Hospital Emergency Department. Ott served as Legislative Chair of Advocates for Louisiana Public Healthcare (ALPH) (2004-2005). He was the appointed Consumer Representative for the Region 1 Health Care Consortium (representing the Louisiana parishes of Jefferson, Orleans, Plaquemines and St. Bernard), as well as co-chairing its "Care for the Uninsured" subcommittee (2004-2008). Ott was also the co-founder of the Committee to Reopen Charity Hospital; and served as its co-chair (2007-2010). Returning to the University of New Orleans (UNO) under a partial Louisiana Rehabilitation Services grant, Ott completed his Bachelor of Arts in Sociology in 2007. Ott was a Student Research Assistant (2006-2010) for the UNO Center for Hazards Assessment, Response and Technology (CHART), an applied research center supporting Louisiana communities' resilience and recovery from disasters under the Participatory Action Research (PAR) paradigm. Ott remained at CHART as a scholar-in-residence throughout 2011 and 2012 to complete this Master of Arts thesis. Contact Ott at kott@uno.edu; bradott@bellsouth.net or P.O. Box 71221, New Orleans, LA 70172.