



Who cares about care? Health care rationalization and the demise of a public hospital after Katrina

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Charity Hospital served the poor and uninsured in one of the US's unhealthiest cities. Though repaired after Katrina, this gigantic New Orleans hospital was permanently shut down to make way for an ambitious recovery plan. Anne M. Lovell explains the mechanisms that are depriving patients of adequate care and demolishing historic neighborhoods.

Analyses of health and disaster usually concern disaster assistance.¹ More recently, they have focused on the ethics of disaster medicine (Leichter-Flack 2011; Fink 2009), in which emergency practices under arduous and uncertain circumstances magnify the bio-political question as to who lives and who dies (Lovell 2011). But this ethical perspective must be applied as well to the period of recovery from disaster, especially when the health infrastructure has suffered and the physical and mental health of survivors is aggravated by the “time-bomb” effect of reactions to trauma and worsening life conditions. In New Orleans after Katrina, these crucial issues crystallized around one of the major controversies of the five-year recovery period: the fate of the public hospital.

From bad to worse: the inequitable recovery agenda

It is a truism that Katrina exposed the face of racialized poverty in the United States. Yet media images of citizens stranded in wheelchairs in flooded water or waving crutches from rooftops also revealed an already-sick and disabled population.² Before the disaster, over one-fourth of the New Orleans population was suffering from one or more chronic diseases of poverty: advanced diabetes, obesity, high blood pressure, cardiovascular disease, HIV and AIDs. The AIDS case rate was 21.2 per 100,000 (versus 14 for the United States) and the diabetes mortality rate 40.8 per 100,000 (versus 25.3 for the United States).³ Infant mortality in New Orleans was 10.3 per 1 000 live births (versus 7 for the United States); among African-American New Orleanians, it had reached 14.5 in 2002.⁴

The hurricane and socially-engineered disaster that flooded New Orleans also damaged or destroyed most of the city's hospitals and clinics, including the public Medical Center of Louisiana at New Orleans (MCLNO), more commonly called Charity Hospital. The second oldest continually

1 The author acknowledges support for this paper from an Agence National de la Recherche grant ANR 07-BLAN-0008-2

2 In Louisiana, 23 % of the population and 28 % of children lived in poverty (versus 17 % and 23 % respectively, in the United States), according to census data analyzed by the Henry J. Kaiser Family Foundation in 2006. www.statehealthfacts.org

3 Diane J. Rowland, Executive Vice President, Henry J. Kaiser Family Foundation and Executive Director, Kaiser Commission on Medicaid and the Uninsured. Testimony before the hearings on “Post Katrina Health Care: Continuing Concerns and Immediate Needs in the New Orleans Region”. Subcommittee on Oversight and Investigations Committee on Energy and Commerce, United States House of Representatives, March 13, 2007. <http://www.kff.org/uninsured/upload/7624.pdf>

4 Association of Maternal and Child Health Programs. *Investigating Troubling Trends: A Report of the AMCHP/CDC State Infant Mortality Collaborative*. September 2007. http://www.amchp.org/publications/PerinatalHealth/Documents/SIMC_Report.pdf. Ethnicity in these measures is

functioning public hospital in the United States, Charity occupied an architecturally significant, 1938 Art Deco building, to which almost 150 outpatient clinics and specialty medicine facilities were connected. Shortly after stranded Charity patients and staff were evacuated in September 2005, General Russell Honoré, commander of the Joint Task Force on Katrina, ordered military units, accompanied by volunteer doctors and nurses and German engineers, to clean, decontaminate and repair enough damaged floors to reopen the hospital for emergency services. Yet Charity administrators persuaded the state's Governor, Kathleen B. Blanco, to order the hospital closed, although state legislature approval is legally required before taking such an action. Numerous witnesses testify that the administrators - the Louisiana State University Health Care Division (hereafter LSU) - shut down electrical and other functions, barred entry to the hospital thereafter and left it to deteriorate before the elements.⁵ Some witnesses claimed LSU allowed, if not perpetuated outright, sabotage of the facility (Brandes Gratz 2011).

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 (Lovell, Bordreuil and Adams 2011). Charity Hospital patients had tended to be African-American and working poor, uninsured or under-insured, but included middle class patients using it regional trauma center, or for treatment of stigmatizing diseases like AIDS, drug abuse or severe mental illness. Furthermore, many New Orleanians feel a strong attachment to the hospital's history, embodied in the claim, popularized in song and other media, of being a "Charity Hospital Baby" (Lovell 2011). LSU's closure of the hospital and lay-offs of over 3000 health employees, many of them African-American, exacerbated the city-wide public health care void. It dovetailed with other processes of inequitable recovery, such as the replacement of public schools with privately-run charter schools; the proposed return of low-lying, mostly poor residential areas to wetland ("green-dotting"); the razing of the historical African-American Lower Ninth Ward neighborhood and four public housing complexes; and biases in recovery assistance against the poor. These sentiments fueled a broad social movement to reopen Charity Hospital, intensified by LSU's announcement in early 2006 of a new academic medical facility to be built on a complex with the future federal Veterans' Administration hospital. By 2007, Re-Open Charity advocates joined preservationists and residents angered that a working class, residential area was to be razed to make way for the VA and as-of-yet incompletely financed LSU-run hospitals, though both could have been situated in other city areas. In fact, the City's Recovery office eventually maneuvered the VA to move to a more densely populated area, doubling the land for both facilities to 67 acres (27 hectares) (Lovell 2012).

Fast forwarding investment plans at the expense of the uninsured

To understand what was at stake for New Orleans citizens in maintaining the old hospital requires a historical perspective and recognition of the wide variation in health and welfare policies within the United States. New Orleans's Charity Hospital belongs to the only system of state-funded general hospitals, which are scattered throughout Louisiana. "Charity" is thus a misnomer: the 10 charity hospitals standing before Katrina depended heavily on state taxes and on an unsustainable federal mechanism for uncompensated, inpatient care, known as Medicaid Disproportionate Share monies, or DSH.⁶ The uniqueness of Louisiana's 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 health care. A federal-state program that differs across the US in eligibility requirements and amount allocated, Medicaid probably contributed to the disproportionate amount of uncompensated and underinsured care at New Orleans's Charity Hospital. For complex reasons, non-paying and under-insured patients in New Orleans concentrated at Charity, whereas in other American cities, such patients are more likely to be seen at both public and private facilities. Furthermore, under

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5 See the Deposition dated February 6 and 16, 2009 and taken from James P. Moises, a Charity emergency physician, in the class action lawsuit, LeBlanc vs Thomas, that former Charity patients brought against LSU for closing the hospital.

6 The federal government has since asked Louisiana to return millions in mis-spent DSH funds.

Louisiana's populist legacy, "charity" hospitals continued to expand in the 1960s, at a time when other states were dismantling their public hospitals.

While LSU's actions after Katrina countered this principle of right to care, they also shed light on the process through which disaster recovery resources can be used to fast-forward plans underway beforehand. At issue is not simply disaster capitalism, because public and quasi-public interests are at play in this example. 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.⁷ The January before Katrina hit, it announced plans to build a new facility. The planning phase was to begin at the end of 2005, with an occupancy-ready facility projected for September 2010.⁸ 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. However, the Federal Emergency Management Agency (FEMA) ruled early on that Charity Hospital's damage did not exceed the required 50 % of the cost of rebuilding and hence did not qualify for disaster replacement funds.

In 2006, the state legislature mandated the non-profit Foundation for a Historical Louisiana (FHL) to organize a feasibility study of the restoration and replacement options for Charity Hospital. After receiving bids, FHL commissioned a leading hospital architecture firm, RMJM Hillier. Its study, released in 2007, found that gutting the old Charity and building a state-of-the-art medical facility within its Art Deco shell could be realized in fewer years and at considerable savings over the construction of a new hospital.⁹

Meanwhile, LSU, the state and FEMA engaged in a prolonged struggle over the damage estimates. After President Obama's election, and under pressure from the Louisiana Congressional delegation to hasten FEMA's Katrina-related decisions, the Agency awarded \$ 475 million to replace Charity, a considerable jump from its initial \$ 23 million damage estimate. Six years after Katrina, LSU has extended suburban-like sprawl within the metropolitan area, by building horizontal parking lots as place-holders, surrounded by empty lots, near a biomedical corridor and projected economic engine for the city. Yet LSU has yet to produce a viable financial plan or explain where it will find the \$ 400 million still needed for construction or the \$ 100 million annual operating costs the state legislature now balks at providing. This, in a period of economic crisis, and with a national health care reform that will no longer assure LSU of either Medicaid patients or a "captive" uncompensated care patient load for which it can draw funding. Meanwhile, LSU now bills Charity's replacement as an elite regional hospital, with public patients a necessary afterthought (Barrow 2011).

The rise of an alternative non-profit clinic network

Meanwhile, old Charity remains shuttered, creating blight in a once thriving downtown medical district; an interim facility provides inadequate services in relation to need; and the RMJM Hillier Report gathers dust and scorn. Yet two other aspects of New Orleans's recovery have paradoxically worked against restoring the public hospital: the rise of more than 100 primary-care health clinics out of largely volunteer efforts; the failure of the recovery planning process to envision Charity Hospital as a public good.

After the failure of President Clinton's national health reform efforts, several states launched initiatives embraced by Democrats and Republicans alike as a "health policy laboratory" concept.¹⁰ Massachusetts provides a well-known example with its innovative, near-universal health insurance plan, that provided one template for the 2010 American national health reform act. After Katrina, New Orleans presented a ripe terrain for modernizing and rationalizing health care provision. President G.W. Bush's health secretary dovetailed on pre-Katrina health reforms and used the disaster's void to promote an experimental private-insurance model of managed care. His effort failed. But the grass-roots movement of primary-health clinics, a continuation of pre-Katrina efforts combined with free clinics, faith-based and other clinics founded in the disaster's aftermath, went on to incorporate new concepts like the "medical home", electronic record-keeping and private-

7 *Op cit.*

8 D.R. Smithburg, "Medical Center of Louisiana at New Orleans" (cited in Roberts and Durant 2010, p. 56).

9 <http://www.fhl.org/fhl/news/presvalerts/charityhospitalsyn.shtm>.

10 Eveline Thévenard pointed this out to me. Personal communication, April 25, 2011.

public provider mix.¹¹ 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.

Fractional recovery and the erasure of health as a public question

This narrative of health care rationalization and modernization undermines advocacy efforts for reopening Charity Hospital. A planned recovery process might have incorporated both primary care clinics and a public hospital as necessary to sustaining a healthy city for all social groups.¹² But – and here is the second paradox of recovery – neither FEMA mechanisms for recovery assistance nor the urban planning mechanisms mobilized after Katrina allow for an overall vision of public, urban and health goods. Each fragments recovery processes: FEMA because its resources are project- rather than citywide- focused; city planning because it reduces the object of interest to the level of districts, neighborhoods or zones. Within the recovery planning context, the issue of the public hospital could at best be anchored to questions of where to place the new facility. The abandoned and blighted medical district, situated within a larger commercial and hotel area, drew no attention from the district’s mostly upscale residents. To these mechanisms, however, should be added the effect of weak leadership on the part of the City Council and of the particular interests nested among LSU, the Veterans’ Administration, and other instances that directly or indirectly hastened the demise of Charity Hospital. Instead, they promoted new hospital facilities, against the recovery’s environmental ethic of a smaller urban footprint at the cost of displacing hundreds of residents who had returned and rebuilt their damaged homes. The refusal of city leaders to take on the question of Charity Hospital made it, in the words of the planning consultant for the Master Plan, an “open wound” in the planning process.¹³

The recovery process has left behind a different kind of “Charity Hospital Baby”, to use the language of the movement to reopen the hospital. But these Charity orphans attest to the necessity of expanding the question of health care inequalities and ethics beyond the immediate period of disaster assistance. Meanwhile, the state legislature and New Orleans City Council are refusing to acquiesce to LSU’s demands for more funds and land take-over until they produce a viable financial plan for the new “Taj Mahal” hospital.

References cited

- Barrow, Bill. 2011. “LSU officials tell skeptical legislators University Medical Center can be elite regional hospital”, *Times-Picayune*, New Orleans, May 2. http://www.nola.com/politics/index.ssf/2011/05/lsu_officials_tell_skeptical_1.html.
- Brandes Gratz, Roberta. 2011. “Why was New Orleans’s Charity Hospital allowed to die ?” *The Nation*, April 27, 2011. <http://www.thenation.com/article/160241/why-was-new-orleans-charity-hospital-allowed-die> FEMA documents.
- Fink, Sheri. 2009. “Strained by Katrina, a hospital faces deadly choices.” *New York Times Magazine*, New York, August 25, 2009. <http://www.nytimes.com/2009/08/30/magazine/30doctors.html>.
- Leichter-Flack, Frédérique. 2011. “Saving or leaving to die. Medical ethics and disaster”, *Books and ideas*, April 29, 2011, <http://www.booksandideas.net/Saving-or-Leaving-to-Die.html>.
- Lovell, Anne M. 2011. “Debating Life after Disaster: Charity Hospital Babies and Bioscientific Futures in Post-Katrina New Orleans”, *Medical Anthropology Quarterly*, 25-2, p. 254-277.
- Lovell, Anne M. (forthcoming 2012). “Reformers, preservationists, patients and planners: Embodied histories and charitable populism in the controversy over a public hospital”, in Sparks

11 For an extended discussion of these models, see the special issue of *Health Affairs*, vol. 20 (5), May 2009.

12 These discourses omit any consideration of the social determinants of health, although the city’s health department addressed them during before and after Katrina.

13 David Dixon, presentation of the New Orleans Master Plan draft to neighborhood leaders, Dryades YMCA, March 21, 2008.

and Huret (eds), *American Sodom to American Phoenix: The Destruction and Rebirth of New Orleans*.

Lovell, A. M., Bordreuil, S. and Adams, V. (in press 2011). "Public Policy and Publics in Post-Katrina New Orleans: How Critical Topics Circulate and Shape Recovery Policy", *Kroeber Anthropological Society*, n° 99.

Roberts, Jonathan and Durant, Thomas J. Jr. 2010. *A History of the Charity Hospitals of Louisiana*, Lewiston, New York: The Edwin Mellen Press.

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