# Cost of Treating Uninsured Jeopardizing Trauma Centers

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**Abstract**

Not many years ago, most of the communities in the United States did not have trauma centers. Badly injured patients were taken to the nearest hospital, which was often unprepared to treat them. Many patients with major trauma bled to death, their lungs filled with fluid or their brains became depressed by expanding blood clots as they waited for care. By the 1970s, trauma centers were organized and came to serve as an essential community resource, accepting severely injured patients by ground or air ambulance. In many cases, these trauma centers are primary teaching hospitals for medical schools, developing the latest life-saving treatments. A recent survey of major trauma centers in Texas, however, has shown what is evident to doctors who practice in them. The system of trauma care is in real jeopardy.

Operating income for public trauma centers comes from three sources: 1) county tax support, 2) revenues for care of insured patients and 3) federal and state payments from the Disproportionate Share Hospital Program, or DSH. The program was designed to compensate hospitals for unreimbursed care they provide. Regrettably, the federal Balanced Budget Act of 1997 reduced funding through DSH.

The median operating loss in the current fiscal year for the five public trauma centers who responded to the survey was $18,664,000, a 54 percent increase in losses from the prior fiscal year, and this was after exhausting financial reserves. DSH funds fell 26 percent from the previous fiscal year, or $26.3 million on average per hospital. The average tax rate for 1999 for the public trauma centers was 20.5 cents per $100 property valuation. Tax rates have increased in the last few years in many Texas counties, but not to a level to offset the progressive rise in uninsured care. Trauma accounted for 11 percent of the uninsured care in these hospitals. Operating income for private, not-for profit hospitals comes from two sources: 1) revenues from care of insured patients and 2) federal and state payments to hospitals through the DSH. County tax funds are not available to these hospitals.

In Texas, not-for-profit hospitals pay no taxes but in return must care for uninsured patients at a level of 5 percent of revenues. The median operating loss of the five hospitals that responded to the survey was $663,273, a 46 percent decrease in operating margin. There was a direct correlation between the amount of uninsured care delivered and each hospital's operating income, with some private, not-for-profit hospitals showing losses equivalent to public hospitals. Uninsured care for these hospitals rose 16 percent in the last two fiscal years.

There are few alternatives for trauma centers unless new sources of funding are identified. Texas leads the nation in the percent of uninsured, 24 percent. Texas provides Medicaid coverage to half the percentage of the population, compared to states with more generous eligibility requirements. It is unlikely in Texas that there will be county property tax increases significantly above 24 cents per $100 property valuation to help the public trauma hospitals. It is unlikely that the lost federal DSH funds will be restored to adequate levels.

The alternative to finding new funding sources is a serious problem with trauma care. A hospital is required by federal law to deliver care to all emergency patients, regardless of their insurance status, but only if it has the capability to do so. Federal law does not require hospitals to organize themselves to provide a high level of emergency medical services. If the losses of public and private trauma centers are unsustainable, some of them could choose to get out of trauma care. Of all areas of medicine, this one carries with it the highest percentage of uninsured care because emergency care is rendered to anyone who needs it, regardless of insurance status. The loss of even one trauma center in a

large city could create a situation resulting in unprepared trauma care and preventable deaths.

Three myths have for years dulled public sensibility to the issue of trauma care and to the inseparable issue of the uninsured. The first myth is that severe injuries, because they are sporadic and unpredictable, are also uncommon. Trauma is the leading cause of death in persons under 34 years of age. Three in 100 babies born will suffer a disability from injuries suffered in traffic accidents.

The second myth is that most of the patients cared for in trauma centers are perpetrators of or are victims of urban violence. Most trauma center patients are involved in motor vehicle accidents, falls and industrial accidents. In Texas in 1998 only 7 percent of all patients cared for in trauma centers sustained gunshot wounds, according to the Texas Department of Health.

The third myth is that the uninsured, who come to trauma centers with the insured, are unproductive members of society and, therefore, should be glad to get whatever services are provided. While there has been recent federal relief for uninsured children, three-quarters of the uninsured nationally are adults. Sixty percent of uninsured adults either work or have a spouse who works.

The problem documented in Texas is probably a national one. Reports from trauma centers in California document the same financial distress reported here. Trauma centers are like police and fire departments, an essential community resource. It would be a mistake to conclude that their erosion will only affect the care delivered to the uninsured. Trauma does not discriminate.

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## References

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