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Edward J. Connors

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# The Challenges of Urban Health Care Delivery

Edward J. Connors*

While the world of urban health care delivery appears much more focused, it is still a world of great diversity. Within a single city, health care is delivered by major teaching institutions, public general hospitals, as well as community hospitals. Major teaching institutions not only have the high-technology care so much in demand but also the high costs entailed by such care. Public general hospitals are overburdened with the poor, those with no insurance, either public or private, and those with the lowest socioeconomic status, the drug addicts and the homeless. Community hospitals are in the midst of an identity crisis because the communities they were established to serve have moved away, leaving them with new populations with new needs. Community hospitals run by religious groups are struggling with the dilemma of how to be true to their mission when their financial operating margin has all but dwindled away.

Urban institutions often mirror the diversity of their neighborhoods where the wealthy and poor live side by side, where low-technology outreach programs and nutritional services are as critical, if not more so, as the high-technology and highly regarded trauma units. From city to city, urban hospitals are facing similar yet different situations. New York City hospitals, which have an almost alarming 90% to 95% occupancy rate, are concerned about where they will put people, whereas most other metropolitan areas are closer to the urban hospital national average of about 60% occupancy. The role of public hospitals in the urban health system also varies greatly. New York City has an extensive system of 11 municipal hospitals, Chicago has one county hospital, and Philadelphia has not had any public hospitals since the 1970s when those hospitals were closed. However, despite these differences within and among urban health care delivery systems, all have similar problems: the extremely serious situation of inevitably more closures as well as the crisis in access to health care in some neighborhoods.

The problems of health care in urban areas reflect the problems of America's big cities. When the cities' educational systems, public health systems, tax bases, and federal and state aid are deteriorating, the meaningful question is not why urban hospitals are facing crisis but how these hospitals are managing as well as they are with these problems. Our nation's urban hospitals are dedicated to serving their communities and are doing remarkably well given the challenges they are confronting.

The challenges for urban hospitals nationwide include Medicare shortfalls, inadequate Medicaid payment for inpatient and outpatient care, uninsured or unsponsored patients, societal problems, illnesses such as the acquired immunodeficiency syndrome (AIDS), drugs and their attendant costs in substance abuse treatment, violence, neonatal care, homelessness, psychiatric illness, and often the lack of community-based alternatives to replace the closed governmental mental institutions and to deal with the shortage of nursing home beds. The result, in my opinion, is urban hospitals being stretched to and in some cases beyond their limits. In New York, our nation's largest city, hospitals have asked the state for immediate infusion of $300 million because "large prestigious medical centers and small, proud community hospitals alike are living hand-to-mouth" (1). All hospitals—urban, rural, and specialty—need fair and adequate payment for services rendered if they are to continue to provide those services demanded by the residents of their communities, but this is not what is happening.

The problems of Medicare payment are well known. For each Medicare patient admission in 1989, the average hospital in this country loses eight cents per dollar, and more than 41% of all urban hospital days are paid for by Medicare. Medicaid is a nationwide problem that is manifest at the state level, and while eligibility and payment varies between states, few states have adequate Medicaid programs. According to the National Governor's Association (written communication, May 11, 1989), Medicaid eligibility in those states with the nation's three largest cities ranges from 41% to 83% of the federal poverty line. Horrendous as these figures are, in somewhat smaller urban areas, such as Dallas and Houston, Medicaid coverage is a dismal 22% of the federal poverty line. When Medicaid payments

*President, Mercy Health Services, Farmington Hills, MI.
Address correspondence to Mr. Connors, Mercy Health Services, 34605 Twelve Mile Road, Farmington Hills, MI 48331.

are inadequate, as they almost always are, the effects on urban hospitals can be dramatic.

Public hospital experts agree that it is not unusual for Medicaid to sponsor half of their patients. In Chicago hospitals as a whole, Medicaid accounts for about 20% of revenues, and that is in a state whose Medicaid program repays only 67 cents of every dollar spent on care. A similar situation occurs in Los Angeles, where hospitals are also reimbursed 67 cents for each dollar of care rendered to Medicaid patients.

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Medicaid is not the only problem. Of the 37 million uninsured Americans, two-thirds are working and have families. Usually they have low-income jobs in small firms that cannot afford their health coverage, and while some of their care is supported by local tax bases, more than half is not. Chicago estimates that 80% of uncompensated care is given in private hospitals. Unsponsored care, which is uncompensated care minus tax revenues, has reached $7 billion annually nationwide.

These are not just facts on a balance sheet. They affect people's lives because they affect access to care. In the worst case, hospitals close. In 1988, 38 urban hospitals closed. In Chicago alone over the last five years, 12 hospitals have closed. In southern California over the same time span, 27 hospitals have closed, many in the Los Angeles area. Some were smaller hospitals with low occupancy, and nearby hospitals were able to pick up the care.

While not every hospital must stay open, we need to take steps to help hospitals alleviate excess capacity through conversion and closures and mergers and consolidations. However, some hospitals that closed were essential to the urban health care network, and we must be even more aggressive to assure that needed hospitals remain open.

Underpayment and nonpayment also have brought about a deterioration, perhaps even a collapse, in the nation's trauma system. In Los Angeles, 19 trauma systems and emergency rooms have closed since 1983. Chicago has lost three of its ten trauma centers, and at least three more are threatening to shut down. Maintaining a trauma system is extremely expensive and almost always means heavy financial losses. Medicaid and Medicare grossly underpay for this needed specialized care. A large number of trauma and emergency patients are uninsured, and for many institutions the question becomes how long they can subsidize these losses without threatening their existence or the many other valuable services they provide. Emergency rooms across this country are crowded with patients and are experiencing what some experts call medical gridlock. Ambulances are diverted, intensive care beds are unavailable, patients wait hours for appropriate beds. According to the American College of Emergency Physicians (2), emergency room crowding affects patient care in 41 states and the District of Columbia. New York attributes this problem to overzealous regulators who, by decreasing the number of serviceable beds, left the system unable to cope with pressures from drug-related violence and illnesses from AIDS. Philadelphia reports that their intensive care beds are frequently filled with ventilator-dependent patients who could otherwise be cared for in nursing homes if it weren't for the shortage problem of approximately 4,000 long-term care beds.

In 1989 approximately 90 million people visited hospital emergency rooms. Many were true emergencies, but many led to unscheduled admissions. The emergency room is coping with the problem of being first in line for health care for the poor without personal physicians, for the uninsured, and for the homeless. A Philadelphia study found that those without insurance use the emergency room four times more than those with insurance. The use of the emergency room is obviously directly related to the absence of a workable primary care system, and this situation is worsening due to less public support and more private reluctance to subsidize care for the poor and the uninsured. In his address to the Section for Metropolitan Hospitals at the August 1989 American Hospital Association meeting, James Squires, Editor of *The Chicago Tribune*, indicated that in the last two decades America has grown increasingly uncomfortable with the poor and has become far less interested in spending tax dollars on the needy. In his words, we have become an America that no longer cares.

***We must work together as providers, as leaders in our community, to construct solutions to the problems confronting urban hospitals and urban communities. ...We must recapture an America that does care about the poor.***

In Detroit we have an oversupply of acute inpatient hospitals and hospital beds. We face a difficult challenge regardless of sponsorship to recruit and retain physicians willing to practice in ambulatory settings in neighborhoods where primary care with continuity is needed and essential. The financial capacity of Detroit's private sector, hospitals and private physicians, to continue to absorb losses is currently stretched beyond the breaking point. Detroit's governmental system, city, county, and state combined, is unable or unwilling to plan and coordinate a financing system that will enable the development of a cost-effective, coordinated, and financially solvent health care delivery system.

The current health care system in Detroit is neither coordinated, cost-effective, nor financially stable. Clearly, government units and the private sector must jointly address this reality soon. Detroit has a provider system that tends to isolate, at least financially, the inner city from the financially more attractive suburban operations. Detroit also has an absence of health pol-

icy and strategies with broad understanding and support that can solve our current challenges or even move us toward the direction of solution.

Although urban hospitals have sophisticated services used by paying patients as well as the indigent and have a dominant role in the training of our nation's health professionals, the dilemma for urban health care and urban hospitals continues to be who will accept the responsibility for the poor. Urban hospitals have all too often been the safety net for the poor and the uninsured, and although these hospitals will continue to care for these vulnerable people, other steps must be taken. We must work together as providers, as leaders in our community, to construct solutions to the problems confronting urban hospitals and urban communities. We must assure that the poor continue to have access to high-quality, appropriate health care services. We must assure that our trauma centers remain open, and we must avoid gridlock in our emergency rooms and intensive care beds. We must recapture an America that does care about the poor.

I believe the core of a reform movement within the delivery as well as the financing system in the 1990s must include at least two priorities. First, we must solve the financing challenge. We need three sources of financing: 1) Medicare; 2) private health insurance extended to include all workers and their dependents, which would raise the current number of covered Americans from 170 million to 190 million; and 3) a new federal/state program with adequate financing—which means taxes—to cover those who don't fit in the first two categories. Second, we must have a coordinated, cost-effective delivery system. Coordination will require community-wide health planning with influence, and cost-effectiveness will require managed care on a broad scale and success in developing workable, practical measures of clinically appropriate care as well as the courage to enforce the measures as they are developed. Cost-effective, coordinated care will also require a new and revised delivery system to move us away from the current fragmentation of comprehensive health delivery organizations.

Comprehensive health delivery organizations are capable of assuming responsibility for health promotion, disease prevention, ambulatory-based medical care, acute inpatient care, long-term care, and rehabilitation. These premises of comprehensive health delivery organizations have been set forth recently by the Greater Detroit Area Health Council which drafted the elements of such a changed delivery system, a system able and willing to contract for a comprehensive set of services for a fixed price per year, including all citizens, because all would have personal health coverage, including the aged, the disabled, and the unemployed and their dependents.

The future is unclear and uncertain, but in my view any reform package must include those elements. As Rosemary Stevens (3) wrote in *In Sickness and in Health*: "There is no system or obvious direction for the future. As in the past, the [urban] hospital system is what we make it for good or ill, both a charity and a business, because the quality of American medical care is indeed an index of American civilization."

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