Read the original article by Glenn Melnick et al. and related papers by
Bruce Siegel, Arthur Kellermann, C. Duane Dauner, and a response by Melnick et al.

From The Field

Emergency Care In California: Robust Capacity Or Busted Access?

Californians should not expect their emergency care system to work as it should, as long as so many people remain uninsured.

by W. Wesley Fields

ABSTRACT: Licensed emergency department (ED) capacity is a static measure that is inadequate to evaluate a system that the public and policymakers expect to respond dynamically to individual patients in a timely manner. Government mandates on hospital-based providers, undersupply of trained and willing personnel, and private market imperatives all curtail the functional capacity of the emergency care system. Although most Californians still live within a few miles of the closest hospital, many ambulance patients are diverted much further because of ED crowding. Many ambulatory patients are delayed so long in waiting rooms that they return home without ever being seen.

Were licensed emergency department (ED) bed capacity predictive of the industry's ability to meet the needs of Californians for acute care, the analysis of Glenn Melnick and colleagues would be cause for celebration.[1] Unfortunately, static measures are inadequate to evaluate a system that both the public and policymakers expect to respond dynamically to individual patients who need immediate access to a vast array of resources in every corner of the state at any given moment. Multiple trends not addressed by the authors suggest that the system is far from robust and, without resolution of inherent conflicts between regulators, providers, and payers, destined to collapse no later than California's next large-scale demand for "surge capacity" following a natural or man-made disaster.

■ **Crowding factor.** The U.S. General Accounting Office (GAO) provided an analysis in 2003 of ED crowding, a more dynamic measure of functional system capacity.[2] The GAO report affirmed that crowding is a multifactorial problem that reached historic levels in the new millennium, and it found that the single most common variable linked to capacity was the growing problem of "boarding" patients who were already screened and stabilized by emergency staff until inpatient beds were available. When EDs saturate because of patients waiting for beds and nurses to become available on inpatient units, hospitals increasingly close to new ambulance arrivals seeking emergency care, and waiting rooms fill up with patients waiting for a bed—or even a chair—to become available in the ED. In 2001 the GAO found that 25 percent or more of hospitals throughout Southern California were on ambulance diversion more than 10 percent of the time. Since the implementation of mandated nurse staffing ratios in January 2004, despite an

Wesley Fields (wesfields@cep.com) is president of the California Chapter of the American College of Emergency Physicians and a member of the clinical faculty, Department of Emergency Medicine, University of California, Irvine.

DOI 10.1377/hlthaff.W4.143 ©2004 *Project HOPE–The People-to-People Health Foundation, Inc.*

undersupply of trained personnel, crowding and boarding pose a greater threat to the safety of Californians seeking emergency care.[3]

The GAO found that crowding was more likely to occur in metropolitan areas than rural areas. Not surprisingly, crowding was more prevalent in areas with rapid population growth and most severe in areas with lower household income.[4] Melnick and colleagues may be correct in stating that ED beds per capita are stable statewide; a more rigorous analysis of data by metropolitan statistical areas (MSAs) is likely to reveal that hospitals are only adding ED capacity in suburban markets with higher household income where an adequate return on investment is expected. In urban areas the picture is very different. In Los Angeles, where two million residents lack health insurance, federal courts recently blocked the county government's plan to reduce inpatient capacity at the downtown county facility by a mere 100 licensed beds because it posed an unacceptable loss of access to acute hospital care for the medically indigent.[5]

Not a private voluntary market. Melnick and colleagues based their analysis on the assumption that the system can be understood as a private voluntary market. That is only true for the small fraction of California hospitals that operate on a for-profit basis. The recent announcement that Tenet, the largest for-profit hospital corporation in the state, will sell or close nineteen facilities—eighteen in Los Angeles and Orange Counties—is frank evidence that acute hospital services in California are a failing marketplace.[6] For the vast majority of hospitals that continue to operate on a nonprofit basis, ED operation is not voluntary but a requirement of tax-exempt status. Whether an open door to their own community helps or hurts the financial viability of hospitals depends a great deal on the demographics of their own service area. The hospital and real estate industries have three things in common: location, location, and location.

"The recent announcement that Tenet will sell or close nineteen facilities is frank evidence that acute hospital services in California are a failing marketplace."

Nonemergency admissions more lucrative. Market forces affect ED capacity very differently than Melnick and colleagues suppose. The GAO concluded that twenty-one of the twenty-two most common medical conditions for which Medicare beneficiaries are admitted on an emergency basis are not accretive for the hospitals providing the care.[7] Meanwhile, office-based specialists are free agents who can choose which hospital to refer most insured patients for elective admission for more lucrative procedures. Struggling hospitals are sorely tempted to balance their books by giving priority to nonemergency admissions that will contribute more per case to the hospital bottom line, while ED patients in need of inpatient beds wait for hours or even days. The authors note that most Californians still live within a few miles of the closest hospital: Given current waiting times in EDs, many urban patients return home without ever being seen.[8]

Impact of managed care. Melnick and colleagues imply that the advent of managed care has had no deleterious effect on the emergency care system. Most stakeholders in the emergency care system would vehemently disagree. Access to emergency services has been protected under federal law (the Emergency Medical Treatment and Active Labor Act, or EMTALA) since 1986; managed care plan members are as well protected as the medically indigent. Providers are allowed to seek payment only after emergency conditions have been stabilized, including costly hospitalizations for life-threatening illnesses and injuries for more than six million Californians without health care coverage. The gap between licensed and functional capacity can be traced to this disconnect between our health insurance and health care delivery systems.

In the same period that Melnick and colleagues studied, the health insurance industry

has shifted to a business model that refutes the obligations of private sponsors for anything more than "market rates" for the costs of services to their own covered populations. Legal counsel for the state's Department of Managed Health Care has opined that providers without managed care contracts are not entitled to collect their usual fees from managed care patients, which include the costs of uncompensated care to the medically indigent, and should be compelled to accept the heavily discounted rates that plans and their delegates pay contracted providers in exchange for large volumes of referrals. Nor can the handful of for-profit health plans that dominate the California private market claim that their members' ED use is inappropriate. ED visits in California stand at twenty-seven per hundred people per year—fully ten visits less per hundred than the U.S. average.[9]

■ **Costs of uncompensated care.** The costs of uncompensated care to Americans without health insurance were recently estimated at $35 billion for 2001.[10] Not surprisingly, 92 percent of all hospitalizations by the uninsured are the result of an ED visit.[11] California's share of this burden on hospital-based providers can be reasonably placed on the order of several billion dollars each year. Nor can these costs be offset by payments from the disproportionate-share hospital (DSH) program that the authors describe, since only services to MediCal (California Medicaid) beneficiaries qualify hospitals for reimbursement.

■ **Equal nonaccess.** Californians should not expect that the emergency care system will operate at the capacity reported by Melnick and colleagues until we decide who should pay the hospital bills of the 20 percent of state residents—most from low-income working households—who are not covered by public or private payers.[12] Ironically, the best hope for a favorable outcome in this debate may hinge on the fact that on any given day in many areas, access to the necessary scope of timely emergency services is as much at risk for the most influential citizens of the Golden State as it is for the medically indigent for whom the ED is the last line of defense.

The views expressed are the author's and not those of the American College of Emergency Physicians (ACEP), the California chapter of ACEP, the University of California, or California Emergency Physicians Medical Group.

NOTES

1. G.A. Melnick et al., "Emergency Department Capacity and Access in California, 1990–2001: An Economic Analysis," *Health Affairs*, 24 March 2004, content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.136 (24 March 2004).
2. U.S. General Accounting Office, *Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities*, Pub. no. GAO-03-460 (Washington: GAO, 14 March 2003).
3. "New Nurse-to-Patient Staffing Ratios Challenge California," *Medical News Report* 13, no. 2 (2004): 1–21.
4. GAO, *Hospital Emergency Departments*.
5. S. Fox, "Court Agrees to Keep Rancho Open," *Los Angeles Times*, 6 February 2004.
6. D. Dauner, "Tenet Healthcare's Decision to Divest Nineteen California Hospitals Symptomatic of Broader Flaws in Health Care System," 30 January 2004, www.calhealth.org/public/press/doc.asp?ID=209 (26 February 2004).
7. GAO, *Hospital Emergency Departments*.
8. Ibid.
9. S. Lambe et al., "Trends in the Use of and Capacity of California's Emergency Departments, 1990–1999," *Annals of Emergency Medicine* 39, no. 4 (2002): 389–396.
10. J. Hadley and J. Holahan, "Covering the Uninsured: How Much Would It Cost?" *Health Affairs*, 4 June 2003, content.healthaffairs.org/cgi/content/abstract/hlthaff.w3.250 (27 February 2004).
11. W.W. Fields, ed., *Defending America's Safety Net* (Dallas: American College of Emergency Physicians Safety Net Task Force, 1999).
12. R.J. Mills and S. Bhandari, *Health Insurance Coverage in the United States: 2002 Current Population Reports*, September 2003, www.census.gov/prod/2003pubs/p60-223.pdf (1 March 2004).