'Social triage':
How patient transfers help rich hospitals stay rich

Dispatcher: 911, what's your emergency?

Caller: America's healthcare system is broken and people are dying! (ambulance siren)

Welcome to **Code WACK!,** where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host, **Brenda Gazzar.** This time on **Code WACK!** What's the story behind the **EMTALA** patient protection law of 1986, which requires hospitals to stabilize or treat patients who are in a health emergency regardless of their insurance status or ability to pay. What has this law done for patients and what does it mean for hospitals? To find out, we spoke to **Dr. David Himmelstein,** a distinguished professor of public health at CUNY's Hunter College and a lecturer in medicine at Harvard Medical School. He also serves as a staff physician at Montefiore Medical Center in the Bronx and is the co-founder of **Physicians for a National Health Program**. This is the first of a two-part series with Dr. Himmelstein.

Q: Welcome to Code WACK!, Dr. Himmelstein. Tell us a little bit about yourself and how you became a Medicare for All supporter.

(01:09):

Himmelstein: I'm a doctor. I grew up in New York and really intended to be a doctor, taking care of poor people and contributing to the care of oppressed communities and found that the healthcare system wouldn't let me. There were so many barriers to the adequate care of people in need that it just became impossible to do my job well under the healthcare system as it is. So I got involved in what would we need to do to fix the healthcare system.

(01:36):

Q: Thank you for that. We're going to talk about hospital financing today, but we'd like to start with your 1984 study "Patient Transfers: Medical Practice as Social Triage." It highlighted how transferring patients from private to public hospital emergency rooms can negatively affect their health and outcomes. Can you briefly tell us about that?

(01:56):

Himmelstein: Well, I was a resident at the public hospital in Oakland, California along with many other residents. We were disgusted at the mistreatment of our patients by private hospitals that were afraid they were going to lose money if they took care of uninsured people. So they routinely shoved patients who were coming to their emergency rooms who didn't have insurance into ambulances to send them to us at the public hospitals and many of them were clearly worse off because of often long ambulance rides when they were gravely ill. So the group of us at the public hospital at that time decided to document what we were seeing on a routine basis and really found that there was, when we looked at it systematically, a lot of harm being done to our patients.

(02:42):

Q: You mentioned that many of them were uninsured. What other demographic did these patients have?

(02:47):

Because lack of insurance is much more common among people of color, many were people of color, so a lot of them were Black people, particularly because Oakland at that time had a very large Black population and not very many Latinx folks and so they were by and large poor people, people of color, uninsured people.

(03:07):

Q: Wow. And so did you find that one of the main reasons that they were being transferred was because they were uninsured?

(03:13):

Himmelstein: Well, occasionally they would say that in the medical record openly, but more often they wouldn't say it openly. But it was pretty obvious they were coming from fully equipped private hospitals that had doctors who were perfectly capable of caring for these patients, but they weren't going to get paid or were afraid they weren't going to get paid and that was the motivation.

(03:34):

Q: Mmm-hmmm and I imagine some of them had Medicaid as well?

(03:37):

Himmelstein: Some had Medicaid but far more were uninsured than had Medicaid because at that point in California, Medicaid wasn't that bad a payer. So they would take care of Medicaid patients more readily than the uninsured.

(03:50):

Q: Oh, got it. Okay. Thank you. Did you come across a specific patient whose story moved you while doing this research or even before you launched the study?

(03:58):

Himmelstein: Well, there were a whole avalanche of patients. I guess really two come to mind. One was a young woman who was hit by a truck and taken to a fully equipped private hospital where they did x-rays and found she had multiple broken bones and a chest x-ray that showed that likely her aorta, the largest artery in the body was damaged. And they shipped her, I think it was about 30 miles across the county to us where we confirmed that in fact she did have a grave injury to that blood vessel and we didn't actually have the capability of performing the surgery she needed because the surgical program, the specialized surgical program that could do that had been closed at our public hospital because it was a lucrative service and the private hospitals basically wanted that and didn't want to leave it to our public hospital. So we very urgently transferred that young woman to a nearby public hospital that could do the surgery that she needed and then it would be paid for at the county's expense.

(05:00):

Oh, wow.

(05:00):

Himmelstein: I guess another was a gentleman who was taken after an automobile accident to a hospital owned by the Kaiser Health Plan and he was apparently thought to be uninsured. That's what the note said from Kaiser and transferred to us at Highland fairly nearby actually and when he arrived he had bone and brain literally showing through a wound in his head and we found he also had a broken neck. He miraculously was not quadriplegic but underwent emergency surgery to stabilize his head wound and his broken neck. And apparently did okay. It turned out he actually was a Kaiser member, but they hadn't initially found him in their files when he was taken there and when they found out that he was a Kaiser member, they demanded that he be transferred back to Kaiser immediately because they didn't want to pay for his care at the public hospital. So I guess those two cases kind of stick out in my mind.

(05:59):

Oh my gosh, they both sound so extreme. I'm sure these kinds of things happen much more than the general public realizes.

(06:04):

Himmelstein: Well we found quite a number of people who were admitted straight to the operating room or to the ICU so these were many of them very sick people.

(06:13):

Q: Right, right. The woman that was hit by the truck. So she was transferred two different times?

(06:19):

Himmelstein: Yeah, both of these were transferred two different times. Yeah.

(06:22):

Q: Wow. And do you happen to know how the woman who was hit by a truck fared?

(06:25):

Himmelstein: We were told that she did live. I don't know more than that.

(06:28):

Q: Okay. Wow. Really powerful stories. Your study resulted in new legislation to protect emergency room patients who couldn't pay for their care. Is that right?

(06:38):

Himmelstein: Our study and it was done again with a number of colleagues and similar studies from other public hospitals around the country – so the public hospital in Chicago and one of the public hospitals in Tennessee. The doctors there found similar things going on and we later learned that Senator Kennedy's office became aware of these studies and was the motivation for him to propose this law that requires hospitals to stabilize patients before refusing them care. So they can still refuse care, but if you're in a life-threatening condition or in active labor, they have to take care of you.

(07:15):

Q: Wow. Has that happened where they've actually transferred people in the midst of labor?

(07:19):

Himmelstein: Oh I'm sure it did.

(07:21):

Q: Unbelievable. And what is the name of that law?

(07:23):

Himmelstein: It's the Emergency Medical Treatment and Active Labor Act. EMTALA. It's known as E-M-T-A-L-A.

(07:29):

Q: Thank you for that. So let's connect the dots to hospital financing. The EMTALA law has been controversial in part because of the cost to hospitals of caring for the uninsured. What can you tell us about that?

(07:41):

Himmelstein: Well, what it says to a hospital is you actually have to take care of someone if they're in a life-threatening condition, even if you may not be getting paid for it. And some hospitals say, well that's a money loser and it's going to put us in financial straits. And probably they're right for some hospitals there are grave financial problems that they're under and caring for uninsured patients makes things worse. So on the one hand, they want to do something terrible and on the other hand, one can see why they would want to.

(08:12):

Q: Hmmm. Got it. Let's shift forward and look at how hospitals fared during the COVID pandemic. We know as an NPR headline pointed out that hospitals serving the poor struggled during COVID and wealthy hospitals made millions. Why is this?

(08:25):

Himmelstein: Well, the hospitals got huge federal bailouts from the federal government. So they stopped - by and large - doing a lot of the elective care that's most profitable for them. So things like joint replacements and elective surgeries of other kinds and those are the things that are most profitable and the federal government stepped in and said, well, we'll make up the losses for you. We'll give you what turned out to be hundreds of billions of dollars to bail you out. But most of that money went to the hospitals that were losing their lucrative business and it was not the safety net hospitals that were losing most of the lucrative business. They were already not getting a lot of that money making stuff. So less of the federal bailout money went to them and at the same time they were the ones who were most inundated with COVID patients and serving the greatest needs.

(09:20):

Q: Right. did the hospitals that were serving significant numbers of COVID patients, did they get funding for that?

(09:25):

Himmelstein: They got some, but generally not up to what was actually needed to keep them fully solvent.

(09:30):

Q: Oh, okay. Have you heard of any hospitals going bankrupt or having financial issues because of the COVID influx of patients?

(09:38):

Himmelstein: You know, it's hard to separate the COVID influx from other causes of hospital distress, but certainly there are hundreds of hospitals around the country that are in financial distress and much of it worsened during the COVID pandemic. I mean the other thing going on frankly was there was a shortage particularly of nurses and other frontline personnel and to make up for nurses who were out because they had COVID or resigned because they didn't want to take care of patients in that situation. Hospitals turn to what's called registries. So these are companies that sign up nurses and say we'll get you a temporary assignment at a hospital, but at much higher daily pay than the hospitals normally pay their nurses, so many hospitals really suffered financially because in order to take care of patients they had to rent nurses essentially at a much higher price.

(10:33):

Q: Wow. That's true. How are safety net and non-safety net hospitals funded differently?

(10:39):

Himmelstein: Well there are a number of funding streams that come to any hospital so the backbones of hospital financing are insurance programs. So Medicare patients account for a very large share of the patients who are at any hospital because the oldest pay people who tend to be the ones most in need of hospital care are mostly covered by Medicare. So Medicare is a big payer for hospital care. Private insurance generally pays the best so hospitals that attract more privately insured patients generally fare the best because a bigger share of their patients are privately insured bringing in the biggest payments. Medicaid often pays less, it depends, varies from state to state, but Medicaid generally pays less than Medicare and certainly less than private insurance.

So hospitals that care for a lot of Medicaid patients are getting paid less per patient than those that care for Medicare and much less per patient than those that care for privately insured. And finally the uninsured and whether hospitals get paid for them or not really depends on local circumstances. So in some cities, there's some government funding that helps defray the costs of care for uninsured patients. In others it's just the hospital that takes the loss and that really just varies from place to place.

(12:09):

Got it.

(12:11):

Himmelstein: So safety net hospitals are really the ones that care for the biggest share of Medicaid and uninsured patients and those are the patients who bring in the least money when hospitals care for them. And as a result those hospitals get less money on average per patient than those that are caring for mainly Medicare and especially privately insured patients. But the other thing is the way our financing system works, two other factors come into play. One is hospitals that have a powerful reputation or that control much of the market in their area when they negotiate with private insurers can get a much higher rate than weaker hospitals or hospitals where there's huge amounts of competition. So just to give you an example, in Boston the biggest system there and the one with probably the best reputation is called Mass General Brigham. It's the merger of Massachusetts General Hospital and the Brigham and Women's Hospital, two well known Harvard hospitals, and they get paid about 20% more from private insurers than the safety net hospitals that have less market power have been able to negotiate. So even from private insurers, places like Cambridge Hospital, the public hospital where I worked for many years get paid something like 20% less than Massachusetts General Hospital does.

(13:36):

Interesting.

(13:36):

Himmelstein: And the other factor besides market power that plays in here is what's the mix of services they're doing. As I said earlier, hospitals get the most profit from doing elaborate surgeries and much less profit from caring for pneumonia or other kinds of routine illnesses and hospitals that do large volumes of that fancy stuff tend to be paid more. So all of those things factor into how much a hospital is getting paid, both by insurance and its payer. And I guess the last factor is for most patients there's some out of pocket costs for co-payments and deductibles that they have to pay and if you have a lot of patients who are poor, you're probably not going to get, be able to collect from those patients for the piece that they themselves would normally be responsible for.

(14:26):

Q: Right. So you may have already answered this question, but I'll ask it. How does the funding source contribute or affect the financial stability of hospitals?

(14:35):

Himmelstein: Well, if you have more privately insured patients, you're likely to be doing better. If you have more uninsured patients, you're almost certain to be doing worse. And if you have more Medicaid patients, you're more likely to be doing worse. And if you're a big powerful hospital that's able to negotiate from a strong position with insurers, you're probably getting paid more. So all of those things, the sources of funding and your market power really contribute.

(15:03):

Q: Mm, right. And how does this affect patients and communities?

(15:07):

Himmelstein: Well the result is that hospitals that care for a lot of uninsured patients or patients covered by Medicaid are on average paid much less for their care than the richer hospitals – the hospitals caring for more privately insured and Medicare patients and what that means is that their buildings are not as nice because they can't afford to upgrade them or build fancy new buildings. They may not be able to afford to upgrade their machinery and may not be able to afford the staffing levels that richer hospitals have. And that sorts pretty closely which hospitals are rich and which are poor with the kind of communities that they take care of. So hospitals that care for poor people, generally are poor hospitals and hospitals that care for rich people are generally rich hospitals. And that also goes along with the race and ethnicity of the patients. So hospitals that care for Black and Latinx patients generally are poorer hospitals and those that care for more White patients and White non-Hispanic patients are generally richer hospitals. So it's a way of saying our payment system structures payment to incorporate racism and oppression of communities.

(16:24):

Thank you Dr. Himmelstein. Tune in next week when Dr. Himmelstein talks about how hospitals will get paid when everybody has Medicare for All.

Do you have a personal story you'd like to share about our wack healthcare system? Contact us through our website at heal-ca.org.

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