Beyond The Safety Net In Dallas

Structural solutions are needed for the structural problems of the safety net.

by Ron J. Anderson and Paul J. Boumbulian

Parkland Memorial Hospital is one of this nation’s largest, most active institutions making up the health care safety net. It has served the residents of Dallas County (Texas) for more than a hundred years.

Just ten years ago, Parkland was a large, centrally located hospital, which, while recognized for its volume of service, excellence in patient care, and high-quality postgraduate medical training programs, was not known for its amenities or for having a patient-centered environment. Over the course of the past decade, Parkland has transformed itself. It is now an integrated health care system. It has created centers of excellence that make available to the entire community the latest knowledge in such areas as arrhythmia management, cerebral vascular disease, epilepsy, and gastrointestinal treatment. It also has developed its own health maintenance organization (HMO). In addition, it has gone through extensive reengineering. These efforts have produced a decline in the average length-of-stay from seven days in 1986 to fewer than five days in 1995; a reduction in emergency department visits from more than 160,000 visits in 1987 to 122,495 visits in 1995; and a reduction in average “dwell” time in the outpatient clinic, including all diagnostic studies and pharmacy services, from 7.5 hours to 2.5 hours.

Parkland decentralized by developing a nationally recognized primary care delivery system based on a community-oriented primary care (COPC) model, which aims to improve care for both individuals and communities. The COPC network now includes eight community health centers, five school-based clinics, and two mobile clinics. Parkland has learned over the past ten years that to truly improve health, it must address the social and economic determinants of disease such as lifestyle, education, and employment opportunities. This means working with school districts, housing authorities, police and fire departments, churches and synagogues, and employers. These efforts have begun to bear fruit. In 1995 a study was completed that compared COPC patients to non-COPC area residents. COPC patients were two times less likely to be admitted through the emergency department, had shorter hospital stays (3.4 days versus 5.3 days, on average), and had 50 percent lower charges.

Solving Structural Problems

To pay for the decentralized system of community care and its educational and research missions, Parkland has had to diversify its revenue streams and cross-subsidize. Fifteen years ago, 66 percent of Parkland’s funding came from local property taxes. Today only 33 percent of its funds come from that source. This shift was accomplished primarily by means of an increased Medicaid entitlement in Texas and through Medicare and commercial payments for services provided through Parkland’s centers of excellence. As Parkland has worked toward providing relief to local taxpayers while expanding community services and maintaining its missions, it has become more vulnerable in several ways.

■ Maintaining market share. First, even though Parkland prevents many unnecessary

Ron Anderson, a physician, is president and chief executive officer of Parkland Memorial Hospital in Dallas, Texas. Paul Boumbulian is senior vice-president of Parkland.
hospital admissions, it does not “save money,” because beds that would be empty in a closed HMO system are filled at Parkland with unmanaged, uninsured, high-cost patients who fell out of the market basket.

Second, as traditional commercial insurance has dwindled and managed care has reduced the margins on other patients, the Medicaid market (especially uncomplicated obstetrical cases) has become more appealing to other hospitals with excess capacity. Competition for these patients has resulted in a loss of approximately 2,000 deliveries per year at Parkland.

Through the efforts of the medical school faculty, Parkland has a low cesarean-section rate (18 percent), whereas some of the recent entrants into the Medicaid market have rates more than twice as high. Parkland and the medical school also have achieved an infant mortality rate for African Americans that is essentially equal to the rate for whites (nationally it is two and one-half times higher). However, this breakthrough has not been acknowledged by the local market, where other institutions trade on amenities rather than outcomes. Women and their newborns who are served by other institutions are routinely transferred to the Parkland system after Medicaid is discontinued or if complications arise.

Third, Parkland always will be subject to adverse selection by virtue of its mandate: Any patient can enter the system by being sick or injured any day of the year.

The Medicaid situation is poised to become even more distressing. Parkland now has 60 percent of the Medicaid market share in Dallas County. Under the proposed state Medicaid managed care program, Medicaid patients will be distributed among three or four managed care vendors, and although Parkland will inevitably be one of these providers, it would be foolish to assume that it can maintain its current market share. The loss of this revenue will jeopardize the system’s ability to provide educational, research, and mandated services, particularly to persons who lack coverage.

**Business versus safety-net ethic.** While Parkland has attempted to improve the health status of its patients and the community, others have been busy trying to refine the “sick care” system—learning how to transform clinical services into commodities and patients to “covered lives.” Risk selection has become far more profitable than true innovation. We are finding that what is a good commodity may not be what is good for the community’s health. It is difficult for the public to understand what is to be gained in preserving safety-net “utility” services such as trauma, burn, and neonatal care and specialized drugs for patients with human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), as few citizens have direct contact with these services. Most healthy people never consider their vulnerability to injury or catastrophic illness, much less that of their community to natural and man-made disasters.

**Building social capital.** The means for addressing the determinants of health reside not in the efficiencies of the market but in what Robert Putnam termed social capital, that is, the bonding that characterizes a strong civil society. Communities with rich networks of nonmarket relationships provide a sense of trust, sharing, and cooperation that increases the efficiency of human relationships. Yet most of the dollars available to affect health status remain in the business of curing.

Some of the public systems that make up the safety net, a few of the not-for-profit institutions, and a very limited number of the for-profit systems have recognized this situation. These foresighted organizations are beginning to establish partnerships with other public or nonprofit institutions to improve health. Current market incentives may lethally harm these institutions and leave inefficient, ineffective, and bureaucratic institutions unharmed. Policymakers should not preserve publicly sponsored health care institutions for the sake of publicly sponsored health care. What should be preserved is a
system of choice by patients. Monolithic palaces of patronage and institutions that treat patients as captives in a disease-oriented sick care system should be reengineered, redirected, and held to high standards of accountability for clinical outcomes, patient satisfaction, and community health status. A civil servant mentality must give way to servant leadership and community partnership.

Summary And Recommendations

The current structural problem, wherein safety-net institutions must operate not only in the marketplace but also under state mandates to provide utility services, must be reconciled through structural change. That means that an all-payer system is required to support medical education and provide for the “stand-ready” costs of services such as trauma, burn, and neonatal intensive care. Reimbursement strategies must acknowledge not only severity of illness but also social severity. The provision of care to large numbers of low-income persons carries a real cost for “wraparound” services that lower barriers to care.

Safety-net institutions should also provide incentives to maintain or create a community health care infrastructure that enhances the health status of the community, particularly in underserved inner-city and rural areas. This could include the development and maintenance of comprehensive primary care networks in underserved communities. Reimbursement methodologies and grant awards should foster collaborative models and not create disruptive competitive behaviors that undermine community partnerships.

Funds need to be made available for outcomes-oriented research. Both safety-net and other providers must be able to show that investments of new dollars or redirected dollars lead to desired results. Safety-net institutions should directly receive direct and indirect payments for medical education and disproportionate-share adjustments for caring for a large volume of low-income persons instead of leaving these payments in the adjusted average per capita cost (AAPCC), which creates a windfall for the managed care organization.

Legislative support also will be required to support safety-net pricing, especially with regard to pharmaceuticals for special populations. We are especially concerned about pharmaceutical support for HIV/AIDS populations because their care is often provided by only a few hospitals in a given area. Pharmaceuticals are part of the safety net but are not always provided at present.

Without these structural changes, we will continue to see the results of failing federal and state policies into the next millennium. Their failure will ultimately come down hard on local governments as unfunded mandates. Communities strapped for revenues to meet challenges of devolution ultimately will be required to reduce services. Unless some fundamental change is made, they will focus only on the “resurrection medicine” of the emergency room and pull back from real innovation and real reform capable of improving the health and productivity of all of our nation’s residents. We do have a structural problem that needs a structural solution, but we also need a change in our hearts to better understand that we cannot leave needed reform of the health care delivery system to the invisible hand of the marketplace.

A version of this paper was presented at The Robert Wood Johnson Foundation/Health Affairs/Alpha Center conference, “What Is Happening to the Safety Net?,” 9–10 January 1997, in Washington, D.C.

NOTES