Trauma Surgery & Acute Care Open

Population need versus trauma center financial sustainability: striking the right balance

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To cite: Staudenmayer K. Population need versus trauma center financial sustainability: striking the right balance. *Trauma Surg Acute Care Open* 2024;**9**:e001540. doi:10.1136/tsaco-2024-001540

Ensuring that a statewide trauma system provides timely access to trauma care is challenging. It is made more complicated by the need to manage a balancing act. On one side is having enough trauma centers to meet population need. On the other, the risk of over-designating trauma centers. Over-designation can lead to narrowing trauma center margins as paying patients are parsed between centers. And there is evidence that most new centers are being added near existing ones, which may explain why adding center has not significantly impacted trauma-related mortality.[1 2]

The above article "Changes in Payer Mix of New and Established Trauma Centers: the New Trauma Center Money Grab?" asserts that Pennsylvania suffers from the case of over-designation.[3] In 2004, the state passed the Pennsylvania Trauma System Stabilization Act, providing funding to trauma centers. Since 2004, the number of trauma centers increased while the proportion of insured patients at existing trauma centers decreased. The authors interpreted this finding to indicate that existing trauma centers lost paying patients to new centers. This assumption should be interpreted with caution as neither the study design nor the findings support that assertion. In fact, the opposite conclusions can be drawn.

For one, the data do not firmly establish that there was a loss of paying patients at existing centers. While the percentage of commercially insured patients declined over time, the absolute numbers stayed the same. Instead, there was an increase in Medicaid and Medicare patients that diluted the proportion of commercially insured patients. The "loss" of paying patients may therefore be an illusion from changing demographics.

The second challenge is around the assertion that insured patients at new centers came from the population previously served by the existing centers, but this was not established. For one, new centers must have some proximity to existing centers, as it would be unlikely for a new center remote from an existing one to effectively siphon its patients. However, geography was not considered in the current study. Further, the data show that new centers more often served a rural population, arguing they were serving a different geographic market.

Also importantly, patient need was not assessed. The authors found that trauma admissions almost doubled over the study period suggesting there was rising demand and that new trauma centers may have been needed.

It may be true that newer trauma centers have negatively impacted existing centers in Pennsylvania and it may also be true that this knowledge compelled the need for the current study. However, the study design and findings do not support the assertion that harm was done by adding new trauma centers. It also proves that evaluating trauma system effectiveness may be as hard as the act of striking the right balance between meeting population needs and ensuring trauma center sustainability.

Contributors I am the sole author.

Funding The author has not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Commissioned; internally peer reviewed.

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Linked
► http://dx.doi.org/10.1136/tsaco-2024-001417

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