THE SAFETY NET
HEALTH CARE SYSTEM

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HEALTH CARE AT THE MARGINS
The Safety-Net Health Care System
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To the patients, families, and staff of the University of Washington and Harborview Medical Centers of Seattle, and Charity Hospital and Hotel Dieu Community Hospital of New Orleans, as well as to the Sisters of St. Joseph of Peace, all of whom taught us everything we know about what it means to be caring professionals in the health care safety-net system.

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The writing of this book comes at a time when, despite almost two decades of attention, health disparities by race/ethnicity and socioeconomic status are continuing to grow. These disparities occur in screening, incidence, treatment, and mortality across a wide variety of diseases and conditions, including cancer, cardiovascular disease, and diabetes. Those at the margins of society, by virtue of living in poverty or otherwise being cut off from the mainstream of society, bear a disproportionate burden of these disparities. We have come to realize their devastating consequences for the personal well-being, work, learning, and interpersonal relationships of individuals, and for the functioning of neighborhoods and communities in which they live.

Although we have become adept at quantifying health disparities, and in some cases have improved the health of individuals, we have made remarkably little progress in reducing disparities at the population level. This at least in part is due to our inattention to the safety-net health care system, the primary health care system for poor, incarcerated, and otherwise stigmatized and marginalized individuals and groups in the United States. Safety-net health care services are poorly understood by the majority of health care professionals and weakly integrated into the larger health care service delivery system. I continue to be surprised by the limited familiarity of my health care colleagues with the safety-net system. Yet, increasing numbers of persons in the United States live in poverty and operate outside the mainstream. Providing professional services to these persons requires a clear understanding of the safety-net health care system. Likewise, ensuring that the services provided are effective requires an understanding of challenges faced by marginalized persons living in all parts of the country, from very rural to very urban.
I am impressed with *The Safety-Net Health Care System: Health Care at the Margins*, because it eloquently addresses an important gap in professional medical training. Gunnar Almgren and Taryn Lindhorst are well versed in health care practice and policy and complement one another in terms of their experience in safety-net hospitals. They are well suited to guide the training of health care professionals, many of whom will at some point in their careers care for the growing population of marginalized persons living in the United States. The topic of safety-net health care is especially timely as the Patient Protection and Affordable Care Act (PPACA) is being implemented, and professions and training institutions are questioning how best to prepare students to provide services under the Act.

This book has the potential to provide much needed guidance for social workers, nurses, physicians, pharmacists, and other professionals who are involved in the provision of care to individuals, families, and communities who receive care through the safety-net health care system. It does so by providing information about the system itself, but also by effectively bringing their lives and the issues that shape those lives, such as poverty, social stratification and stigma, structural and social power, and homelessness, to the forefront in a way that will resonate with students and prepare them to be more effective practitioners.

*Sarah Gehlert, PhD*

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Preface

This book is about professional practice in the safety-net health care system—defined as the clinics, hospitals, and individual health care providers that care for a disproportionate share of the poor, the uninsured, those afflicted by stigmatizing health conditions, and persons otherwise isolated from the mainstream health care system. The two authors who have collaborated on the research and writing of this book bring to bear not only their particular scholarly expertise in health care policy and practice, but more critically their many years of experience as social workers in safety-net hospitals. We intend this book for the nurses, physicians and social workers who anticipate internships and residencies in the hospitals and clinics that include a large proportion of persons who suffer from poverty and a range of other stigmatizing traits and health conditions that are associated with social isolation and exclusion from mainstream health care.

The genesis and orientation for this book originates from two experiences. Many years ago, the first author had a conversation with a medical colleague, a gastroenterologist the author had complimented for his compassionate care of an impoverished woman dying from end-stage alcoholism. In response to the author’s observation that other physicians too often treated patients with the twin stigmas of poverty and addiction with indifference and even contempt, the compassionate gastroenterologist shared his personal theory of why it was that so many of his colleagues harbored deep hostility toward patients that existed at the margins of society:

In my view, one of the unintended consequences of the typical residency program is that doctors are taught to hate the poor, the addicted, and the mentally ill. I mean, here I was, a naïve 24-year-old with little more to offer than a newly minted medical degree, humanitarian instincts and the best of motivations;
plunked down in an urban hospital emergency department flooded with patients living lives I could not understand or in any way relate to...and suffering from problems and health conditions that neither I nor the system could seem to do much about. I hated feeling incompetent and helpless, and eventually I learned to hate the patients that made me feel this way—particularly the poor, [the] addicted, and the mentally ill. Eventually, if I could not find ways to avoid these kinds of patients, I at least learned to keep them at an emotional distance—dehumanize them, if you will. We need to do something different with our residency programs...we are teaching doctors to be indifferent and even to hate, not help.

The second experience was the recent death of the second author’s sister after many years of chronic pain, addiction, and mental illness. Tracy was treated in many safety-net settings over the years. Despite her own strenuous efforts, those of her family and friends, and of the medical and mental health providers who worked with her, she died from her co-occurring conditions. Tracy felt cared for by some of the providers she met on her journey, but just as often, she would describe encounters where she felt discounted or shamed by a health professional.

People such as Tracy are some of the most challenging for health care professionals to help, and we will try to illuminate some of the reasons why in this book. At the same time, as we describe common situations of safety-net patients, we keep in mind that each of the patients the readers of this book may encounter is a Tracy—someone who was once an inquisitive, bright-eyed child full of wonder at the world; someone who often leaves behind family and friends who mourn the person she was and could have been.

This book is one attempt to do something different, not only with medical education but in the education of the other health care professions that are vital to safety-net health care as well. Instead of sidelining or containing discussions of poverty, homelessness, addictions, and chronic mental illness in either undergraduate courses or courses intended for specialists in such areas as addictions and mental health care, we seek to provide students and faculty with a resource book that delves into the nature of safety-net health care and the populations served by clinics and hospitals in the safety-net health care system. We hope that instructors of
foundation practice courses in nursing, medicine, pharmacy, social work, and other health professions will use this text as a resource for classroom and seminar discussions that interrogate the nature of poverty, stigmatizing health conditions, and clinical practice in the context of safety-net health care, including the personal and professional challenges students are likely to confront.

Toward that end, we have organized this book in ten chapters that merge insights from an array of disciplines on the nature of safety-net health care, the populations served by safety-net health care systems, and the challenges clinical practitioners face in these settings. In addition to drawing upon evidence-based practice research in medicine, nursing, and social work, we include in this text decades of research on the communities and populations served by safety-net providers from the disciplines of sociology, anthropology, and social psychology.

The first section of the book focuses on larger social structural issues that affect care in the safety-net system. The first chapter provides historical background on the origins and functions of the safety-net health care system in the United States. This is followed by a chapter that explains current statistics, theories, and controversies in the study of poverty. The next chapter interrogates the social processes that in many ways define the nature of safety-net health care—social stratification and stigma. The fourth chapter addresses the context of power and privilege that is at play between health care professionals and clients in safety-net systems. The fifth through seventh chapters provide an in-depth overview of the populations and communities that depend upon safety-net hospitals and clinics for health care, including the homeless, persons with addictions, and victims of violence and trauma. Chapter eight provides a larger look at processes involved in the creation of "difficulty" in clinical settings, paying special attention to the structural and social power issues at play. The ninth chapter interrogates and deconstructs the nature of a great source of practitioner frustration (and sometimes anger)—patients’ failure to follow-through with treatment interventions that practitioners consider crucial to their health and well-being. The final chapter of the text considers the sources of motivation behind health care practice as a career choice, the emotional consequences of being a safety-net health care provider—and in the end why it is that so many of us are drawn to work that so challenges our personal resilience—and our capacities to rediscover, sustain, and elevate the humanity and dignity of those at the margins of society.
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INTRODUCTION

Poverty and sickness form a vicious partnership.
—Robert Hunter (1907, p. 144)

There must be strong incentives to get people to take a broader, societal view and work with those most in need. Otherwise, why should those with resources ever care about those without them?
—Wayne Lerner, President and CEO of Holy Cross Hospital, Chicago, Illinois (Dialogue, 2009, p. 14)

Imagine you are on a tightrope stretched between two poles. The person in front of you wasn’t given a balancing pole to assist in the transit and fell part way across the rope. It is now your turn to walk out on the line. You received a pole, but now there are wind gusts. Will there be a net to catch you if you fall?

Metaphorically speaking, each person in the United States who is not independently wealthy is walking a tightrope when it comes to his or her health. Even people with insurance may lose their jobs and,
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therefore, their health insurance, or be unable to afford the uncovered costs of health care (e.g., insurance premiums, co-payments, and deductibles). Because of poverty, discrimination, and other factors that will be discussed in this book, some people have fallen from the tightrope into the patchwork system of health care that is known as the U.S. health care safety net. As we shall see in this chapter, no national consensus exists on specific definitions of the safety net. In this book, we take an expansive approach to understanding the health care safety net—it is the system of care that serves a disproportionate share of impoverished and otherwise vulnerable persons. Let’s consider the situation of “John,” a patient encountered by one of the authors who worked within a safety-net hospital whose story illustrates some of the dynamics that cause the fall from the tightrope, and what happens in the “net.”

Case Study: Entry Into the Safety Net

John was 34 years old when he began to have severe pain in his stomach area. He had dropped out of school at 16 and worked as a part-time driver for a local trucking firm. The job did not offer any health insurance benefits, so when the pain he felt in his abdomen became too strong to ignore any longer, he went to a neighborhood health clinic, where he could see a doctor for a small charge. His 1- and 4-year-old sons had received their well-baby checkups at the clinic, so John was familiar with it. John arrived at 7:30 a.m. and was seen at 1 p.m. The nurse called the next day to say that John’s laboratory results were abnormal and referred him for evaluation to the large public hospital located in the downtown core of the city. John knew the reputation of the hospital—it was crowded, run down, and unfriendly. So, it was with some trepidation that he brought his referral paperwork there. He spent 5 hours waiting before he was told that the next available appointment with a health care provider was 5 weeks away.

The day of his first appointment, John stood in line with 20 other people waiting to check in with the clerk. Plastic chairs were arranged in rows in front of the check-in desk, and the single window in the room had security bars across it. After 4 hours, John was escorted to a curtained alcove. The small space was separated by a thin drape from the next area, where another patient was being seen. John could hear bits of the conversations happening around him. A nurse practitioner arrived and told him she would be seeing him that day. John had lost over 20 Pounds because it hurt when he ate. He had also noticed what felt like a lump under his collarbone. John’s provider told him he needed
a CT scan and extensive laboratory tests of his blood. She asked if he had any insurance, because if he did, he could go to the hospital across the street, and receive the tests within a day. Without insurance, John discovered he would have to wait a week before he could receive the CT scan. The hospital had only one machine and there were higher priority clients. The nurse practitioner gave him a prescription for a mild pain reliever, but because John had not been able to work as much recently, he didn’t have the money to obtain the medicine.

Once he received the CT scan, things began happening quickly. John was diagnosed with a rare and progressive form of cancer that was causing tumors to develop throughout his body, some the size of baseballs. He was immediately referred to the oncology clinic, whose next available appointment with a physician was 10 days away. John came to this appointment with his wife Keisha and their two young children. Keisha cared for their sons at home while John worked; the family couldn’t afford child care. The family of four made the 20-mile trip to the hospital on three buses, a trip that took 2 hours.

The doctor recommended an aggressive treatment plan of chemotherapy and localized radiation to reduce the size of the tumors and make John more comfortable. The radiation treatments would require daily trips to the hospital for 2 weeks. John was told to expect that the treatments would make him too sick to work for the time being. Although he didn’t have insurance, the hospital would provide his chemotherapy and radiation as “charity care,” and not charge the family the thousands of dollars John’s care would cost. The doctor suggested that the family speak with a social worker to see if they were eligible for other resources in the community. The social worker talked with John and Keisha about their understanding of what was happening, their concerns, and their needs. She referred John to both the local welfare office and the Social Security administration to apply for disability payments, food, and medical assistance. She also suggested resources in the community such as food banks and support groups for people with cancer and their loved ones.

Every morning that he arrived for radiation, John sat on an uncomfortable plastic chair in a room crowded with other people, and waited, sometimes several hours, to be called. There was no art on the walls; rather, the brown and white tiling was covered with photocopied papers telling patients to present their medical card, or to report experiences of unfair treatment to the nursing supervisor. The radiation clinic was near the street in a windowless room, and as he sat, he observed the uniformed security guards stationed at the entrance.
They carried guns and sometimes seemed to be arresting people who were yelling.

Despite the doctor’s best efforts, the treatments didn’t arrest the cancer and John became increasingly weaker. Within 5 months, he went from weighing 180 Pounds to 120 Pounds. His doctor suggested nutrition supplements, but John couldn’t afford these because he and Keisha were relying on food stamps to feed the entire family. It was getting harder to travel to the clinic on multiple buses, his only consistent source of transportation.

Nine months after his diagnosis, he was referred to a local hospice program operated through a Catholic community hospital. John still had no insurance, so the program accepted him as a free-care patient because the hospital had a religious mission to serve the indigent. John’s wife became his primary caregiver at home, providing his medication, helping him to get to the bathroom, arranging visits with various personnel, all while also mothering their two young sons. John was approved for Social Security disability income, but his rent was over half of what he received. His Social Security amount was a few dollars too high to allow him to be qualified for Medicaid, the indigent health insurance. The family received food stamps, and extra help from the Women, Infants, and Children nutrition program; their extended family members provided extra cash when they had it available.

The hospice nurse suggested that a hospital bed would make John more comfortable. John had no money to rent a bed, so the hospice social worker found an old hand-crank bed that could be donated to the family. John needed time-released morphine to ease the pain from the now numerous and ever-growing cancer tumors in his body. The amount of pain medicine he needed was substantial and cost more than $200 each month. Without insurance to cover the cost, the couple asked their extended family members for help. Sometimes they were only able to purchase a portion of the medicine John needed. John died at home, almost a year to the day after his initial diagnosis of cancer. His wife was unable to afford a funeral and burial, so John’s remains were interred in the city’s “potter’s field,” a cemetery for poor people.

John’s story illustrates dynamics typical of those experienced by people without health insurance who must depend upon the health care safety net—he was one of the estimated 46.3 million Americans (U.S. Census, 2009) who did not have access to health insurance, in his case because of his part-time employment and his meager (but still too high) amount of Social Security. If John had lived for 30 months, he would have become eligible for Medicare health insurance from the
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U.S. Social Security Administration as a person with a long-term disability, but he did not survive long enough. John was part of the working poor when he was healthy, but his illness forced his family into outright poverty. He turned to both the system of local health clinics and some of the hundreds of hospitals that provide specialty care to the indigent for his treatment. At the end of his life, a community hospital hospice provided his care without charge, because of its religious mission of service.

Professionals Need Specialized Knowledge to Work Effectively in Safety-Net Settings

Unlike every other major industrial democracy in the world, the United States lacks a coordinated national health program that covers all citizens. In 2006, 22,000 people died in the United States because they did not have access to health insurance (Redlener & Grant, 2009). Instead of viewing adequate health care as a right that is embedded in the social contract between a nation and its people, the United States’ social, health, and economic policies treat health care as a privilege available only to those with certain forms of employment and levels of income. The safety-net system exists because there is no comprehensive commitment to the health of all in this country. As such, the existence of the health care safety-net system is both an indicator of underlying structural inequalities that beset the nation and an antidote for the worst of these inequities through the access to the health services it provides.

This book grows out of the professional work experiences both authors have had as service providers within the health care safety-net system and our personal commitment to preparing practitioners to be competent and caring resources within these settings. Working in these institutions poses serious challenges for health care professionals. Often, the physical structures of safety-net hospitals are antiquated, and limited funding is available for their upkeep. The clientele of these systems includes some of the most vulnerable and difficult-to-care-for patients within health practice. Their care is compromised by inadequate institutional funding and by the clients’ own inability to pay for needed aspects of their care. Within this context, we have observed (and experienced ourselves) feelings of discouragement and despair in this work. For some practitioners, the difficulties attendant to working in the health care safety-net system can manifest in disdain for and frustration with clients. We believe that the antidote to these
pessimistic feelings is a deeper understanding of the historical and structural issues of the health care safety-net system, and an understanding of the special needs and skills required to work effectively with our clientele.

Institutions within the health care safety net differ from typical middle-class medical settings because of their commitment to serving the poor. With that commitment come challenges that arise because of the poverty facing the clientele of these systems, and the funding instability that characterizes all services that focus primarily on the indigent in the United States. Practitioners who work within health care safety-net organizations need to understand their special history, setting, and context.

Our aim in this book is to encourage and strengthen the commitment of all health care professionals to the safety-net system and to the people within them most directly affected by poverty. This book is designed to give an overview of both the organizational characteristics of the safety-net system and some of the social problems such as homelessness, substance abuse, and violence that are disproportionately represented among the people seeking services in these institutions. In this chapter, we will explore some of the history that has led to the current configuration of the U.S. health care safety-net system, examine conflicting definitions of what constitutes the safety net, describe the chief components of this system and the problems it addresses, and end with a discussion of the challenges currently facing the safety net.

**BRIEF HISTORY OF HEALTH CARE FOR THE MARGINALIZED IN THE UNITED STATES**

Western health and medical care have a rich history that is centuries long (see, e.g., Thompson & Goldin, 1975), but for the purposes of understanding the contemporary safety net we will concentrate on four key time periods that have dramatically shaped the U.S. health care system: the period of industrialization that characterized the latter half of the 1800s and resultant shifts in care at the turn of the century, the governmental response to the Great Depression of the 1930s, the new health programs of the Great Society initiatives of the Johnson presidency, and the most recent decades that can be characterized by health care inflation, ever-increasing numbers of uninsured Americans, and repeated efforts at health care reform.
Chapter 1 Origins and Definitions of the Safety-Net Health Care System

Institution Building in the Late 1800s

People in the latter half of the 19th century experienced massive dislocation as the United States transitioned from a primarily rural, farm-based economy to a system dominated by industrialization, the growth of factories, and wage earning. This shift was associated with rapid urbanization, high rates of internal migration and immigration, White retrenchment after the Civil War, the final defeat of indigenous nations for possession of land and natural resources, uprooting of families, and outbreaks of disease. These various forces strained the capacity of families and individual providers of health services to meet the growing demand for care of the injured, ill, disabled, and aged. As a result, compassionate institutional care that could address the needs of those without other resources became the primary focus of reformers. One well-known example of these efforts was the work of Dorothea Dix, a crusader for the humane care of the mentally ill and an advocate for the creation of state “insane asylums,” as these institutions were called in this time period. Another example was the development of public hospitals whose major purpose was controlling infectious diseases such as tuberculosis, typhus, and syphilis. Public hospitals had a charitable mission of service to the poor, but were also strategic efforts on the part of the wealthy to protect themselves from diseases associated with poverty. By financing health care for the poor, the wealthy sought to contain illness outbreaks and to provide care during large-scale epidemics that threatened commercial interests (Waitzkin, 2005).

In the latter half of the 1800s, the wealthy who were ill or in need of care received that help in their own homes, but the poor who had no family resources were sent to institutions alternatively called poorhouses or almshouses. Poorhouses became the residence for the indigent, including orphaned children, unemployed men, the mentally ill, the frail elderly, and the disabled or ill. Poorhouses were financed by taxing local residents (much like the financing of contemporary “county” hospitals). In fact, one of the most famous public hospitals in the country, Cook County Hospital in Chicago, began as a poorhouse that provided medical services (History of Cook County Hospital, n.d.). The emphasis of these institutions was to provide essential, no-frills care so that people would view living in the poorhouse as an option of last resort. The idea that services for the poor should be spare with an eye toward discouraging “dependence” is a frequent theme in social welfare policy (Trattner, 1984).
Although much has been written about the poorhouse as a social phenomenon, few historians have delved into the day-to-day lives of the people who lived in these establishments. Wagner (2008) has provided an in-depth portrait of one of the largest poorhouses operating in the United States in the late 1800s. Located outside of Lowell, Massachusetts, Tewksbury opened in 1854 and came to house over 3,000 people a year. Anne Sullivan, Helen Keller’s teacher, lived with her brother at Tewksbury from 1876 to 1880, after her mother died and her father was no longer able to care for the children. Sullivan told a biographer that the ward where she slept was “filled with old women, grotesque, misshapen, diseased and dying” (Wagner, 2008, p. 176). Being sent to the poorhouse filled people with dread. Jane Addams, noted 19th-century social reformer, sociologist, social worker, and Nobel Peace Prize winner, described a woman she met as she established Hull House, one of the first U.S. settlement houses (akin to today’s neighborhood community centers) in Chicago. She remarked that, “the old woman . . . [looked] on with that gripping fear of the poorhouse in her eyes, she was a living embodiment of that dread which is so heart-breaking” (Addams, 1999, p. 106). Addams’s experiences led her to include health services at Hull House, creating the prototypes for the community health clinics that would develop after the 1960s (Waitzkin, 2005).

No system of “long-term care” existed, so the poorhouse came to serve this function as families, increasingly mobile and pulled apart by the industrial revolution, were no longer able to care for their members. One-quarter of the residents of Tewksbury died within 3 years of arrival at the poorhouse (Wagner, 2008). As new institutions for orphans, the blind, and the deaf were created, people with these problems were moved from the poorhouses. As a result, a disproportionate percentage of poorhouse services came to be devoted to the care of the elderly, mostly elderly men without children (Katz, 1986). Additionally, most people with serious mental illness were cared for in poorhouses, particularly in rural areas, despite efforts by Dix and others to create separate institutions for the mentally ill (Katz, 1986). Poorhouses continued to exist in some locations until the 1960s, with many transitioning into long-term care facilities for the elderly and disabled during the 20th century.

By the turn of the 20th century, scientific breakthroughs in germ theory and surgical and medical treatments sparked a deepening interest in the provision of acute care, a medical model focused on diagnosis, intervention, and recovery or cure. In the 50 years from 1880 to
1930, the country’s population doubled, but the number of acute care hospitals increased by over 2,500% (Risse, 1999). Acute care models contrasted sharply with the model of care delivered in the poorhouse, namely basic custodial services for people with chronic, incurable conditions. Acute care was driven by what would become one of the most important groups in the health policy debates of the coming century, the American Medical Association (AMA). By 1900, the AMA had solidified its standing as the main group representing medical doctors and the chief authority for the health of the nation.

The Great Depression and Missed Opportunities

The stock market crash of 1929 signaled the beginning of a decade-long period of severe economic deprivation in the United States and worldwide. One-quarter of the American population was unemployed (compared to about 10% unemployment during the recession of 2008–2010). A record number of homes and farms were foreclosed resulting in large numbers of homeless persons living in makeshift “towns” called Hoovervilles, in mocking deference to a president who many saw as ineffective and unconcerned with the needs of ordinary people.

Franklin Delano Roosevelt, a reformist governor from New York, was elected to the presidency in 1932. He promised a “New Deal” for the American people, one in which the federal government would adopt new roles and commitments in the provision of social and economic aid. Roosevelt’s administration created a number of new employment programs including the Civilian Conservation Corps, the Works Progress Administration (WPA), and the Public Works Administration (PWA). These latter two programs were particularly important to the health infrastructure of the country, constructing buildings that are still in use today. In addition to public health projects such as sewer systems and water treatment plants, the WPA built 226 new hospitals and renovated an additional 2,324, and the PWA built 493 general hospitals and institutions, 205 insane asylums, and 146 specialty hospitals (Leighninger, 2007).

Although the WPA and PWA were dismantled during World War II, Roosevelt’s most lasting contribution came with the passage of the Social Security Act. This legislation provided the first federal guarantee of a minimum standard of income for people who had worked and were retired or disabled. According to the Roosevelt Administration’s Committee on Economic Security, poverty among the elderly prior to...
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the passage of the Social Security Act exceeded 50% during the Great Depression.\(^1\) This rate has steadily decreased over the decades so that now 9.7% of the elderly have incomes under the poverty level (U.S. Census Bureau, 2009). Social Security also provided financial assistance to survivors of deceased workers, the unemployed, and mothers and children in poverty through the Aid to Dependent Children program (which later became known as “welfare”).

Conspicuously absent from the assistance provided through the Social Security Act is the inclusion of a comprehensive program to address health treatment. Throughout the drafting of the Social Security legislation, reformers made efforts to have national health insurance included. These efforts were frustrated in three primary ways. First, the AMA and state medical societies were deeply opposed to any efforts to create a national health insurance program, fearing a loss of their autonomy and the imposition of group practice models over the solo practices operated by physicians at the time (Starr, 1982). Second, President Roosevelt did not strongly favor national health care when compared to his adamant support for unemployment and old age assistance (Kooijman, 1999). Third, the Social Security Act was carefully constructed to maintain the racial status quo, particularly in Southern states (Lieberman, 1998). For example, domestic workers and agricultural laborers (disproportionately African American during this time period) were excluded from coverage under Social Security, a compromise with Southern legislators who feared increased economic independence of African Americans. If national health insurance was adopted, as was advocated by the National Association for the Advancement of Colored People and the National Medical Association (the leading African American physician organization created because of segregation and discrimination within the AMA), this would potentially tear apart the fragile coalition of Northern and Southern White representatives and senators needed to pass Social Security. As a result, policy planners within the Roosevelt Administration, and the president himself, came to believe that including any kind of national health plan would lead to the ultimate defeat of the entire Social Security effort.

\(^1\) At the time that the Social Security Act of 1935 was passed, there were no precise estimates of poverty among persons aged 65 and older or even an official measure of poverty. Based on data from disparate sources such as state surveys and census counts of almshouse residents, the Roosevelt Administration’s Committee on Economic Security estimated that at least one-half of the population of persons over age 65 lived in a state of economic dependence on others. For a critique of this 50% figure, see Gratton (1996) “The Poverty of Impoverishment Theory: The Economic Well-Being of the Elderly, 1890–1950.” *Journal of Economic History* 56(1): 39–61.
Roosevelt assured disappointed supporters that national health insurance would be included in the next round of Social Security reforms, but, unfortunately, his optimism about the eventual creation of a national health care plan was ill-founded.

Although Social Security did not include a national health component, there were modest health efforts included in the legislation. The law funded state-based public health systems, vocational rehabilitation for people with disabilities, and maternal and child health efforts aimed at reducing infant and child mortality.

The People’s Health: Johnson’s Great Society, Medicare, and Medicaid

In the decades following World War II, other industrial democracies were enacting national health care or national insurance plans that provided a basic level of medical care to all citizens (Quadagno, 2005). Attempts to enact national health care in the United States had failed in the 1930s, and 30 years would pass before substantial reform was on the public policy agenda again. The 1960s opened with the lunch-counter sit-ins in Greensboro, North Carolina, protesting discrimination against African American citizens. Efforts to dismantle racial inequality sparked movements in diverse communities in response to other injustices. By the end of the decade, mass demonstrations against the Vietnam War, the creation of the feminist women’s movement, occupation of land by Native Americans, and the emergence of the gay and lesbian liberation effort had all occurred. A common theme underlying all of these (and other) social justice struggles was the focus on wresting control of social problems from experts, politicians, or other institutional authorities and obtaining power for “the people”—typically referring to the segments of society with the least political voice and power through established political and economic institutions. As an example in the health system, several socially radical and progressive groups initiated their own health care programs, independent of the existing medical establishment. The Black Panther party opened clinics in Chicago, New York, Boston, and other cities; feminist clinics developed resources to place medical decision-making power in the hands of women rather than male doctors; and alternative health approaches flourished in the countercultural movement (Waitzkin, 2005). Many of these programs specifically focused their services on the poor, or provided care without charge as did the Haight Ashbury Free Clinic founded in 1967 (which continues to provide services today).
On the national policy front, efforts began in the Kennedy Administration and flourished under Lyndon Johnson to replace institutional care with accessible community-based services. In 1963, Kennedy signed the Community Mental Health Act, which facilitated the “deinstitutionalization” of persons with severe mental illness. One-hundred years earlier, Dorothea Dix had advocated the creation of insane asylums as a compassionate approach to the treatment and care of persons with serious mental disorders. From their progressive beginnings, these institutions deteriorated into places that were as dreaded as the poorhouses of the previous century. The advent of psychotropic medications and a national shift toward community-based care encouraged the return of persons who had been hospitalized (sometimes for decades) to family homes and neighborhoods. Unfortunately, Kennedy’s vision of a network of community mental health centers to support care was never fully realized, as local governments displaced therapeutic and humanitarian goals with economic ones. Ongoing evaluations suggest that disproportionate numbers of the homeless are people with serious mental illnesses such as schizophrenia, bipolar disorder, or depression with psychotic features (Lamb & Bacharach, 2001).

Following these trends toward the provision of services at the community level, the Johnson Administration authorized a demonstration project to create neighborhood health centers to serve low-income communities. This project supported the empowerment of service recipients by requiring that 51% of the board of directors of any center be clients of the health program. Centers embraced other radical ideas about health care as demonstrated in this example of an early project in Mississippi:

Malnutrition proved to be one of the most serious health problems . . . when the health center began stocking and prescribing food for the malnourished, some officials objected that its pharmacy was only supposed to carry drugs for the treatment of disease. To which the staff responded, “The last time we looked in the book, the specific therapy for malnutrition was food.” The center also became involved in starting farm cooperatives, public transportation and other local projects. (Starr, 1982, p. 371)

By the mid-1970s, Congress authorized the full development of a national network of community health centers (CHC) that would provide primary care services to the indigent.
Chapter 1  Origins and Definitions of the Safety-Net Health Care System

On the national health insurance front, discussions were underway during the Kennedy administration to introduce a program focused on the elderly. The costs of medical care had soared after World War II, but labor unions and others had negotiated private insurance plans that covered hospitalization for the majority of working Americans. However, the elderly did not have access to any affordable coverage of medical care, despite the fact that almost 20% of those over 65 were hospitalized in any given year (Starr, 1982). Kennedy proposed the creation of Medicare, a form of health insurance modeled on the popular “80/20” plans of the day. This type of insurance usually covered 80% of the allowable charges, and patients paid the remaining 20% of the bill. Policymakers also recognized that the “medically indigent” (including impoverished children and their mothers on welfare programs and younger disabled persons) could not obtain adequate health care. Medicaid, a health insurance program for those with incomes under the poverty line, was the policy solution for this group. Medicaid did not adopt the 80/20 model; rather, it paid the entire cost of allowed care, but its reimbursement rates for medical providers were set at a low level and certain procedures were not covered.

Again, the chief opponent of efforts to create national health insurance through Medicare and Medicaid was the AMA. The physician group fought expansion of public insurance, portraying it as a threat to the doctor–patient relationship, suggesting that the government would intervene to dictate the kinds of care a person would receive (Starr, 1982). To gain the cooperation of the AMA, Congress agreed to finance the costs of the new health insurance programs, but allowed financial intermediaries (chiefly Blue Cross) to administer the program.

Medicare and Medicaid reflect the deep split in the American policy psyche in regard to the creation of a social safety net for all citizens (see Table 1.1 for a summary of the differences between social insurance and “means-tested” programs). By the 1960s, Social Security had established itself as a profoundly popular program. Citizens felt entitled to its benefits as a result of their contributions through payroll deductions. Medicare was similarly viewed as a valued entitlement for those over 65 who had contributed to the nation through their work. Medicaid reflected a different orientation. As a means-tested program—indicating that a person had to have limited income or assets (“means”) to qualify—Medicaid was seen as a form of welfare. Means-tested programs in the United States have typically suffered from a public perception that the people receiving them were undeserving of assistance, that they were living off “honest taxpayers,” and getting something
Part I  Systemic Foundations of Safety-Net Health Care

while doing nothing (Katz, 1986). Eligibility for Medicare was set by the federal government, but qualification for Medicaid was determined by each state, outside of federal mandates to cover children and mothers receiving welfare payments and other groups that were deemed “categorically” eligible (Coll, 1995). As a result, states differed dramatically in their income guidelines and the health care services covered. For example, some states cover dental services and mental health treatment whereas others do not (Kaiser Family Foundation, n.d.). In contrast to Medicare, no uniform national standards for coverage and services were set for Medicaid.

Medicare and Medicaid were clearly successful at providing the poor and aged with access to affordable health care. For example, by the mid-1970s, those on Medicaid visited physicians as often as the nonpoor and had as many surgical procedures as those with higher incomes, in contrast with utilization rates substantially lower than the nonpoor in the years before the programs existed (Starr, 1982). However, these improvements were not without certain costs, particularly for public health care systems. Medicare and Medicaid increasingly channeled public funds to private medical practitioners and nonprofit hospitals, siphoning off resources that were traditionally used to support public safety-net providers (Waitzkin, 2005). A further burden for the safety-net system was the fact that private providers would push patients back to the public system when their Medicaid benefits ended. Because poverty is not a constant event, people covered under Medicaid routinely lost their health insurance if they became employed, were disqualified

<table>
<thead>
<tr>
<th>TABLE 1.1</th>
<th>Social Insurance Versus Means-Tested Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SOCIAL INSURANCE</strong></td>
<td><strong>MEANS-TESTED “WELFARE” PROGRAMS</strong></td>
</tr>
<tr>
<td>• Social Security (retirement and disability programs)</td>
<td>• Supplemental Security Income</td>
</tr>
<tr>
<td>• Medicare</td>
<td>• Temporary Assistance to Needy Families (“welfare”)</td>
</tr>
<tr>
<td>• Universal—anyone who has worked for a certain amount of time is eligible regardless of level of income</td>
<td>• Limited to those with a low enough income and no other resources</td>
</tr>
<tr>
<td>• Considered a social “right”</td>
<td>• Considered a form of dependency</td>
</tr>
<tr>
<td>• Generously funded</td>
<td>• Highly stigmatized</td>
</tr>
<tr>
<td></td>
<td>• Frequent reductions in funding</td>
</tr>
</tbody>
</table>
from a program, or had temporary increases in income. At the same time, the low-income elderly, even with Medicare insurance, were unable to pay growing deductibles or co-payments for care and turned to the safety-net system. Although public hospitals have come to depend on these two public insurances to finance care, they faced declining revenues from traditional funders (the locales they served). With weakening of the rationale for their existence as the epidemics of the previous century were largely held at bay with improvements in public health and immunizations, public hospitals faced more precarious funding situations, as we will explore further later in this chapter.

From Reagan to Obama: Retrenchment, Failed Efforts, and (Limited) Success

Ronald Reagan was elected in 1980 and reelected in 1984 with more electoral votes than any candidate in American history. Riding a tide of increasing resentment against changes instituted under Johnson’s presidency (both in terms of civil rights and War on Poverty programs), his policy was to shrink funding for social programs and “devolve” responsibility for these services to states, while also increasing funding to military and defense projects. Examples of these efforts were the Reagan Administration’s decision to dramatically reduce funding of the community mental health system, while deinstitutionalization, ensured an increasing demand for outpatient services. If the 1960s were about designing systems to empower the poor, the 1980s were focused on preventing what conservative politicians believed were widespread efforts on the part of the poor to take fraudulent advantage of assistance programs. Reagan popularized these ideas in his first campaign for the presidency, frequently relating stories of the “welfare queen”—a pejorative term for poor women whom he believed were defrauding the system by having more children solely to collect more money from public assistance programs.

The largest health crisis of the Reagan presidency was the emergence of the HIV/AIDS epidemic. The first reports suggesting that a new disease was being seen among young gay men were issued by the Centers for Disease Control in 1981. Rare opportunistic infections such as *Pneumocystis carinii* pneumonia and Kaposi’s sarcoma were occurring in men without any apparent reason for immune deficiency. In 1987, the World Health Organization estimated that between 5 and 10 million people were HIV infected worldwide (Chin & Mann, 1989).
Decades later, there are now an estimated 33.4 million people living with HIV, and in 2008 alone, 2 million people died of AIDS related conditions (World Health Organization, 2009).

Stigma associated with the initial emergence of the epidemic within the gay community in the United States, coupled with fear of contagion, led to examples of medical personnel refusing to treat people they suspected of being HIV positive (Shilts, 1987). As a result, many of the community-based services now available in the U.S. were begun and financed by members of the lesbian, gay, bisexual and transgender communities. Early in the epidemic, the average life expectancy of someone with AIDS was less than 6 months; people often died before they could be certified for Social Security and Medicaid benefits. Because of the stigma and financial issues, many people with AIDS (then and now) have received their care through the health care safety-net system. In 1990, Congress passed the Ryan White Comprehensive AIDS Resources Emergency Act to fund medical treatment for people with AIDS. The advent in the late 1990s of new antiretroviral medications that could check the progression of the disease put a further strain on public health care systems as the costs associated with drug treatment for a single month could be several hundred dollars and HIV positive persons needed these medications for the rest of their lives. These pharmaceuticals transformed AIDS from a terminal illness to a chronic one that could last for decades with substantial health care monitoring and treatment expenses. In response to the life-sustaining and expensive nature of these drugs, Congress created the AIDS Drug Assistance Program to provide resources for the purchase of drugs like AZT and, later, protease inhibitors. Even with federal assistance, some states are unable to provide AIDS treatment to everyone who needs it, which in several states has resulted in ongoing waiting lists for persons in need of these life-sustaining medications (Kaiser Family Foundation, 2011).

National efforts at major health care reform would not be undertaken again until the second year of Bill Clinton’s presidency. Clinton made coverage of the uninsured a major policy initiative in his campaign. Soon after taking office, his wife Hillary Rodham Clinton, a respected attorney in her own right, chaired the Task Force on National Health Care Reform, which developed the proposal eventually presented to Congress for debate. The central feature of the Clinton plan to cover the uninsured was the mandate that employers had to provide health insurance coverage to employees. Initially, the AMA was supportive of a reform proposal, as were the professional associations of nurses, social workers, and pharmacists. Once the bill was introduced, the AMA qualified its endorsement stating...
Chapter 1  Origins and Definitions of the Safety-Net Health Care System

that the mandate should only apply to “firms with over 100 employees
and thereby excluding most private doctors, the majority of whom [did]
not cover their own employees” (Starr, 1995, p. 21). As the debate pro-
gressed, the AMA became more opposed, citing its traditional concerns
about national health care, namely that it would interfere with the doctor–
patient relationship and undermine the quality of medical services (Pear,
1993). The Health Insurance Association of America (1997) (now known
as America’s Health Insurance Plans or AHIP) attacked the bill with a fa-
mous series of ads featuring “Harry and Louise” lamenting the proposed
changes and urging people to oppose its passage. In 1994, the legisla-
tion was declared dead. However, the Clinton administration regrouped
in 1997 to pass a smaller health insurance bill that covered low-income
children not eligible for Medicaid, the State Children’s Health Insurance
Program (SCHIP).

Although Clinton pushed through piecemeal expansion of health
coverage, he also signed legislation limiting or removing support to other
indigent groups. For example, Clinton’s efforts to “end welfare as we
know it” resulted in the passage of the Personal Responsibility and Work
Opportunity Act of 1996, which severely limited the availability of public
financial assistance to poor women and children. The act imposed time
limits on the receipt of assistance, so that eligible families could receive
support for not more than 5 years, with some states limiting aid to even
shorter periods. The act increased penalties for noncompliance with work
requirements and other rules, allowing the complete removal of families
from the program. A study of Medicaid usage after welfare reform in one
state indicated that one-quarter of women who were sanctioned off the
program needed Medicaid, but were unable to obtain it (Lindhorst &
Mancoske, 2006). When welfare benefits end, a sizeable minority of recip-
ients who remain income eligible for Medicaid may no longer receive it.

Similarly, Clinton also signed legislation prohibiting assistance
through the Supplemental Security Income (SSI) program of Social
Security for people who were disabled and unable to work as a result
of drug addiction or alcoholism. SSI is the main income support pro-
gram for people with disabilities or the elderly who cannot qualify for
Social Security payments because they have not worked enough. SSI
is another of the means-tested programs; a person cannot qualify for
SSI payments if he or she has other income or resources. In 2009,
7.68 million Americans received SSI payments, 15.5% were children
and 26.4% were over 65 years old (Social Security Administration,
2010). As part of their Contract with America, Republican Congress
members pledged to stop financial support to people with addictions,
although they represented less than 2% of people on SSI (Watkins & Podus, 2000). Evaluation of the effects of the policy suggested that SSI did not contribute to continued substance use (Watkins & Podus, 2000) and that a significant percentage of the people disqualified from services had been previously hospitalized for medical problems or serious mental disorders (Hanrahan, Luchins, Cloniger, & Swartz, 2004). The policy change resulted in over half of these former SSI recipients having no access to health insurance, despite their elevated health needs. The contraction in this program undoubtedly returned these persons to the rolls of safety-net providers.

The largest expansion to occur in any national health program since the passage of Medicare and Medicaid in the 1960s happened when the George W. Bush Administration shepherded a plan through Congress in 2003 creating a prescription drug benefit for recipients of Medicare. When enacted in 1965, Medicare covered hospitalization and physician services, but it did not cover any medications prescribed on an outpatient basis. Pharmaceuticals have played an increasing role in medical treatment, and their costs have risen significantly since the passage of Medicare. During the debate on the prescription drug bill, examples were given of seniors having to choose between paying for medications and food on their limited monthly incomes. The Medicare drug benefit passed by Congress provided coverage of medications (after payment of a premium, deductible, and co-payment) up to $2,400 annually. After a person exceeded this amount of outpatient medication, he or she became responsible for the full cost of the medicine until the beneficiary accumulated approximately $4,000 in out-of-pocket expenses, at which point Medicare again resumed coverage of prescriptions. This gap in coverage was commonly referred to as the “donut hole,” and was created in response to political concerns about the cost of the drug benefit. Within 5 years, nearly three-quarters of Medicare recipients had signed up for the service (Goldstein, 2009).

In addition to Medicare prescription coverage, the Bush Administration also significantly expanded the CHC network. President Bush funded the establishment of 1,200 new health clinics in rural and medically underserved areas. The number of patients served more than doubled, with over 16 million people receiving treatment through the clinic system, the majority of whom are indigent (Sack, 2008).

The most recent chapter in efforts to ensure health care for all in the country has occurred with the passage of the Patient Protection and Affordable Care Act (PPACA) of 2010. The Obama Administration kept the idea of mandating insurance coverage from the Clinton
reform efforts, but instead of requiring employers to cover workers, individuals will be required to purchase their own health insurance coverage or face an annual fine of several hundred dollars (up to 2.5% of an individual’s income) for not doing so. In addition to requiring the purchase of health insurance, the Obama plan also prohibits insurance companies from refusing to cover preexisting conditions, or from dropping coverage of persons who have high-cost conditions. If all Americans purchase insurance as required under the plan, 94% of U.S. citizens and legal residents will have at least minimal health insurance coverage. People with incomes up to four times the federal poverty level who are unable to afford the cost of care will be eligible for governmental subsidies, so they will not have to pay more than 10% of annual income on health insurance. People with incomes up to 133% of the poverty line will be eligible for an expanded Medicaid program. However, the several million immigrants who are in the country without documentation will not be covered under the PPACA. It is unclear at this time whether this health reform will survive legal challenges from states—currently 18 states are contesting the law in court and over half of state legislatures are considering bills that would nullify aspects of PPACA, including the mandate that individuals buy insurance.

Summary

This historical overview is brief, and other important moments in the history of health care for the marginalized are summarized in Table 1.2. Several key themes recur over the years. First, the system of financing and providing health care in the United States is a patchwork that allows substantial portions of people to fall through the cracks within the employer-based health insurance system because of “accidents” of birth, geography, and employment (Meyer, 2004). This pieced-together system reflects structural inequalities (i.e., that poverty disproportionately affects certain groups of people such as children) and ameliorates some of the worst of these disparities by providing access to care within a safety-net context. Second, the country has been ambivalent about ensuring that all citizens have access to basic health resources. On the one hand, over time, certain groups have been made categorically eligible for health assistance (i.e., the elderly through Medicare), and entire systems of care such as the CHC network have been established. On the other hand, substantial portions of the U.S. population fall outside any coverage system, with thousands dying in any given year as a result of their inability to access care (Redlener & Grant, 2009).
### TABLE 1.2
Chronology of Selected Dates in Safety-Net History

<table>
<thead>
<tr>
<th>DATE</th>
<th>EVENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1788</td>
<td>First veterans, hospital opened in Pittsburgh, PA</td>
</tr>
<tr>
<td>1833</td>
<td>Worcester State Insane Asylum Hospital opened, first hospital for the mentally ill</td>
</tr>
<tr>
<td>1841</td>
<td>Dorothea Dix publishes first report on treatment of “insane poor” of Massachusetts, resulting in the expansion of the hospital at Worcester</td>
</tr>
<tr>
<td>1849</td>
<td>Health care for American Indians provided under auspices of Bureau of Indian Affairs (BIA) transferred to newly created Department of the Interior</td>
</tr>
<tr>
<td>1890</td>
<td>State Care Act in NY—first law in which a state assumed the complete care and expense of the “insane poor”</td>
</tr>
<tr>
<td>1903</td>
<td>First study on the prevention and treatment of tuberculosis undertaken by the Charity Organization Society of New York</td>
</tr>
<tr>
<td>1911</td>
<td>First employer-sponsored group disability insurance policy issued</td>
</tr>
<tr>
<td>1921</td>
<td>Congress created health division within BIA</td>
</tr>
<tr>
<td>1921</td>
<td>Sheppard-Towner Act creates first maternal-child clinics to address infant mortality; repealed in 1927</td>
</tr>
<tr>
<td>1929</td>
<td>Baylor University Hospital offers hospitalization insurance, the origins of Blue Cross</td>
</tr>
<tr>
<td>1930</td>
<td>Establishment of Veterans Administration</td>
</tr>
<tr>
<td>1935</td>
<td>Passage of the Social Security Act</td>
</tr>
<tr>
<td>1937</td>
<td>Congress established the National Cancer Institute (the first illness-specific research center in what became known as the National Institutes of Health in 1944)</td>
</tr>
<tr>
<td>1946</td>
<td>Hospital Survey and Construction Act (Hill-Burton Act) provided funding for hospital construction with the requirement that hospitals provide a certain percentage of free care to indigent persons</td>
</tr>
<tr>
<td>1954</td>
<td>Indian Health Services (IHS) created within the U.S. Department of Health and Human Services, removed from the BIA</td>
</tr>
<tr>
<td>1962</td>
<td>Migrant Health Act creates first health clinics for seasonal and migrant farmworkers</td>
</tr>
<tr>
<td>1963</td>
<td>Community Mental Health Act leads to deinstitutionalization of persons with serious mental illness</td>
</tr>
<tr>
<td>1965</td>
<td>Passage of amendments to the Social Security Act creating Medicare and Medicaid</td>
</tr>
<tr>
<td>1972</td>
<td>End Stage Renal Disease program extends Medicare benefits to cover dialysis for persons with kidney failure</td>
</tr>
<tr>
<td>1972</td>
<td>Creation of National Health Service Corps to provide primary care in medically underserved areas</td>
</tr>
</tbody>
</table>

(continued)
Third, despite multiple policy interventions, a substantial number of people have not or cannot be “mainstreamed” into non-safety-net health systems. Programs such as Medicaid and even Medicare do not ensure that low-income persons can afford associated health care costs or remain enrolled in coverage over time, so a proportion of the population continues to require services provided by safety-net organizations. Fourth, the country’s health resources have been devoted to an individual-oriented acute model of care that prioritizes medical intervention over preventive efforts (for instance, payment for expensive cardiac surgeries, but no reimbursement for weight loss interventions or investment in high-quality accessible food in all communities). In summary, these and other structural deficiencies are at the heart of the existence of the health care safety-net system.
FEATURES OF THE HEALTH CARE SAFETY-NET SYSTEM

Given the history of the health care safety-net system as a patchwork of programs, policies, and organizations, it should come as no surprise that there is a lack of consensus on how to determine who is a part of the system. In this section, we compare various definitions of who is a safety-net provider, followed by a listing of some of the major components of our system of care for the indigent. The final sections of this chapter touch on funding challenges of safety-net providers and debates about the quality of care in these systems.

Defining the Health Care Safety Net

No universally accepted definition for the safety net exists. The Institute of Medicine (IOM)—the national advisory body to the federal government on issues related to health and medical care—issued a report in 2000 entitled America's Health Care Safety Net: Intact but Endangered. The IOM definition is a good place to start in characterizing the U.S. safety-net system:

The IOM committee defines safety net providers as those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients. In most communities there is a subset of the safety net that the committee describes as “core safety net providers.” These providers have two distinguishing characteristics: (1) by legal mandate or explicitly adopted mission, they maintain an “open door,” offering patients access to services regardless of their ability to pay; and (2) a substantial portion of their patient mix is uninsured, Medicaid, and other vulnerable patients. (IOM, Lewin, & Altman, 2000, p. 21)

There are two important components to this definition. First, some people are more vulnerable than others based on their inability to pay for essential health care. As we shall see in the chapters on poverty and stigma, all people are not at equal risk for poverty or a lack of health insurance. Some people, because of their age, gender or race, are more likely to encounter these problems. Second, the safety-net system serves a disproportionately higher number of these people.

Table 1.3 further elaborates the idea of “vulnerability” as it is typically understood to apply to populations cared for in safety-net

[Indigenous language description]
systems. As this table shows, people are more likely to need assistance from the health care safety net if they have certain health conditions, experience certain social problems, or belong to certain social groups who are more likely to experience poverty. For example, safety-net hospitals are more likely to devote resources to culturally sensitive care such as the provision of medical interpreters. The safety-net hospital in Hennepin County, Minnesota, employs 42 full-time interpreters who respond to language requests in more than 60 languages (Meyer, 2004). The head of a Boston safety-net hospital noted, “We offer 18 languages onsite 24 hours a day. There’s no other hospital in the state with that much cultural and linguistic competency” (Felland, Lauer, & Cunningham, 2009, pp. 7–8).

### TABLE 1.3

**Vulnerable Populations Disproportionately Served Within Health Care Safety-Net Systems**

<table>
<thead>
<tr>
<th>Category</th>
<th>Vulnerable Populations</th>
</tr>
</thead>
</table>
| **Uninsured and Underinsured** | • Working poor without employer health insurance  
  • Elders unable to afford co-pays and deductibles in private systems  
  • People covered by Medicaid who are not accepted for care by private health providers |
| **Certain Health Conditions** | • Chronically ill  
  • People with communicable diseases (HIV/AIDS, tuberculosis, and sexually transmitted infections)  
  • High-risk mothers and infants (those in need of neonatal intensive care)  
  • People with disabilities  
  • People with serious mental illness |
| **Certain Social Problems** | • Poverty  
  • Homelessness  
  • People addicted to drugs and/or alcohol  
  • Victims of violence and trauma  
  • Prisoners  
  • Victims of disasters |
| **Certain Social Statuses** | • Legal and undocumented immigrants  
  • Low-income people of color, especially American Indians (AI) and Alaska Natives (AN), African Americans, and Latinos  
  • People who speak limited or no English  
  • Migrant workers  
  • Refugees  
  • Veterans |

*NOTE: Adapted from Gage (1998).*
While satisfying as a general idea, the IOM definition is too vague to be of much use when we try to determine who and how many safety-net providers exist. How much is a “substantial portion” of a clientele? Who determines whether a legal mandate or mission exists? The IOM report itself excludes federally sponsored health care systems such as the Veterans Health Administration and the Indian Health Service (IHS) from its definition of the “core” health care safety net, despite the fact (as we will see later) that these systems serve disproportionate numbers of low-income people. Likewise, it does not take into account the growing amount of health care provided within state and federal prison systems (IOM et al., 2000).

As a result of this lack of clarity, others have suggested alternative approaches. These definitions generally focus on one of three methods for classifying a safety-net provider: the proportion of uncompensated care they provide, the number of Medicaid (i.e., low-income or indigent) patients they see, or the type of health care provider they are (i.e., teaching or public). As illustrated in Figure 1.1, a study of hospitals nationwide by McHugh, Kang, and Hasnian-Wynia (2009) determined that only 98 hospitals, or 2% of hospitals in the United States, qualified as safety-net providers under all three definitions; however, several hundred more met at least one of these three criteria.

Safety-net and non-safety-net hospitals clearly differ in the types of services they provide. Table 1.4 compares the two types of hospitals across a range of services including types of intensive care, mental

---

**FIGURE 1.1** Alternative Measures to Define Safety-Net Hospitals

- Provide care to large number of Medicaid patients (612 hospitals)
- High amount of uncompensated care (697 hospitals)
- Teaching/public hospitals (1323 hospitals)
- Meet all 3 definitions (98 hospitals)

**NOTE:** Data in figure are from McHugh et al. (2009).
Chapter 1  Origins and Definitions of the Safety-Net Health Care System

Origins and Definitions of the Safety-Net Health Care System

When these services are offered, they are far more likely to be provided by the safety-net hospital than for-profit or nonprofit community hospitals.

Health care researchers and policymakers have not agreed upon a set definition of what is a part of the health care safety-net system. As we have summarized, what is considered a safety-net provider varies widely among studies. In this text, our interest is in those people who are marginalized from care, meaning that they do not have the wealth or insurance coverage necessary to buy the care they need from “mainstream” medical systems. We define the safety-net health care system as comprising the clinics, hospitals, and individual health care providers that care for a disproportionate share of the poor, the uninsured, those afflicted by stigmatizing health conditions, and persons otherwise isolated from the mainstream health care system.

Components of the Health Care Safety Net

Within the health care safety net are institutions almost exclusively focused on care to the indigent, and others who have a mix of clientele but who serve a disproportionate number of those without insurance. These various institutions are funded primarily through federal or local taxes, including income taxes. As such, even for people who are not patients within these systems, the existence of these institutions is important to all U.S. citizens, as their funding rests on the (fragmented) “social contract” or agreement between citizens and their governing bodies for the kinds of services that will be provided collectively within a society. Table 1.5 provides a broad overview of programs or

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>% OF SAFETY-NET HOSPITALS</th>
<th>% OF NON-SAFETY-NET HOSPITALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal Intensive Care Unit</td>
<td>76.6</td>
<td>26.7</td>
</tr>
<tr>
<td>Trauma Center</td>
<td>74.5</td>
<td>22.9</td>
</tr>
<tr>
<td>Burn Unit</td>
<td>22.8</td>
<td>3.1</td>
</tr>
<tr>
<td>AIDS Services</td>
<td>83.5</td>
<td>49.0</td>
</tr>
<tr>
<td>Psychiatric Emergency Unit</td>
<td>77.9</td>
<td>42.4</td>
</tr>
<tr>
<td>Outpatient Substance Abuse</td>
<td>45.5</td>
<td>28.3</td>
</tr>
</tbody>
</table>

providers who are members of the health care safety-net system, along with estimates of the most recent annual amount of services provided,

### TABLE 1.5
Selected Providers of Safety-Net Health Care Services

<table>
<thead>
<tr>
<th>SERVICE PROVIDER</th>
<th>ESTIMATED AMOUNT OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospitals(^a)</td>
<td>1.8 million hospitalizations</td>
</tr>
<tr>
<td></td>
<td>36 million outpatient visits</td>
</tr>
<tr>
<td></td>
<td>6 million emergency department visits</td>
</tr>
<tr>
<td>Community hospitals(^b)</td>
<td>5,010 hospitals</td>
</tr>
<tr>
<td></td>
<td>35.7 million hospitalizations</td>
</tr>
<tr>
<td></td>
<td>123 million emergency department visits</td>
</tr>
<tr>
<td></td>
<td>624 million outpatient visits</td>
</tr>
<tr>
<td>Teaching hospitals(^c)</td>
<td>1,007 hospitals</td>
</tr>
<tr>
<td>Veteran's Administration(^d)</td>
<td>171 medical centers</td>
</tr>
<tr>
<td></td>
<td>870 clinics</td>
</tr>
<tr>
<td></td>
<td>5.3 million patients served</td>
</tr>
<tr>
<td>IHS(^e)</td>
<td>46 hospitals</td>
</tr>
<tr>
<td></td>
<td>633 ambulatory care centers</td>
</tr>
<tr>
<td></td>
<td>1.9 million AI/AN served</td>
</tr>
<tr>
<td>Prison health care(^f)</td>
<td>1.6 million inmates in 1,821 federal or state facilities</td>
</tr>
<tr>
<td>Bureau of Primary Care (HRSA)(^g)</td>
<td>17.1 million patients (1 in 18 nationally)</td>
</tr>
<tr>
<td>Community Health Centers</td>
<td>1,080 grantees-half of which are located in rural areas</td>
</tr>
<tr>
<td>Migrant Health Centers</td>
<td>7,500+ service sites</td>
</tr>
<tr>
<td>Healthcare for the Homeless</td>
<td></td>
</tr>
<tr>
<td>Public Housing Primary Care</td>
<td></td>
</tr>
<tr>
<td>Public health departments</td>
<td>No information available</td>
</tr>
<tr>
<td>Long-term care facilities(^h)</td>
<td>16,100 nursing homes</td>
</tr>
<tr>
<td></td>
<td>1,492,200 residents</td>
</tr>
<tr>
<td>Others (school-based health clinics, rural practitioners, rural pharmacists, and minority physicians serving inner-city populations)</td>
<td>No information available</td>
</tr>
</tbody>
</table>

\(^a\) From 2008 data from 89 acute care public hospitals (Zaman, Cummings, & Spieler, 2009).
\(^b\) From 2008 data; 5.8% of care is uncompensated (American Hospital Association, 2009).
\(^c\) From 2007 data; 71% of care is uncompensated (Association of American Medical Colleges, 2009).
\(^d\) From Oliver, 2007.
\(^e\) From Oliver, 2007.
\(^f\) From 2002 to 2009 (IHS, n.d.).
\(^g\) As of 2005 (Stephan, 2008).
\(^h\) Health Resources Services Administration (n.d.).
\(^i\) From 2004 data (Centers for Disease Control, n.d.); nearly 46% of nursing home residents are covered by Medicaid (O’Brien, 2005).
where available. We briefly discuss five of these systems of care to illustrate their varying missions and programs.

**Safety-Net Hospitals**

When the words “health care safety net” are used, most people think of the network of “county,” “public,” or “charity care” hospitals primarily located in large metropolitan areas. However, small rural community hospitals that are the only source of health care for the poor and uninsured in sparsely populated areas are also a crucial and substantial component of the health care safety net.

In the United States, 10% of hospitals serve between 9% and 50% of the uninsured. The largest public hospital system in the country is the New York City Health and Hospital Corporation (IOM et al., 2000), but people are more likely to be familiar with Bellevue, the oldest public hospital in the New York City system, and in the country. Similar hospitals such as Cook County in Chicago or Charity Hospital in (pre-Hurricane Katrina) New Orleans serve indigent populations in other metropolitan areas. Approximately 1,300 public hospitals exist in the United States, although the majority are now quasi public–private partnerships funded through local tax revenues and insurance-based reimbursement for care (Gage, 1998). Safety-net hospitals care for special needs of the entire population such as traumas from mass casualties associated with gun violence or terrorist attacks and disaster preparedness, as well as the needs of special populations such as the poor (Lewin & Baxter, 2007).

In addition to the public hospitals in the country, not-for-profit, usually religiously affiliated hospitals also are considered safety-net hospitals under the IOM definition since they provide relatively larger levels of uncompensated care or have disproportionate numbers of Medicaid patients. Sectarian hospitals have historical foundations in providing services to members of their own faith communities, but have expanded their missions to serve people within certain geographical locations. For example, the Catholic Health Association (2010) states that there are over 600 Catholic hospitals in the United States and over 60 Catholic health care systems that provide community clinics, long-term care, and advocacy services to persons regardless of religious affiliation.

Finally, every hospital that operates an emergency department (ED), regardless of its typical requirements for payment for care, is a part of the health care safety net as the ED is the only part of the U.S. medical care system—indeed, the entire social welfare system—where “professional
help is mandated by law, with guaranteed availability for all persons, all the time, regardless of the problem” (Gordon, 2001, p. 321). As a result, EDs become locations for both acute and nonemergency medical and social care. For example, many EDs provide sheltering space for homeless persons during emergency weather conditions. Although these departments are designed to assist people with acute needs (i.e., heart attack or trauma victims), many end up providing a variety of nonemergency services. Safety-net hospitals have experimented with approaches that triage and reroute nonacute medical patients to specialized psychiatric emergency care units, on-site primary care clinics, or to social workers for assessment and provision of resources (Gordon, 1999).

**Indian Health Service**

Federally recognized American Indian (AI) and Alaska Native (AN) nations have a unique state-to-state relationship with the U.S. government as sovereign and self-governing entities. The negotiations to end armed conflict against the indigenous peoples of the United States resulted in treaties in which the federal government became responsible for the provision of health care, formalizing this relationship through the Bureau of Indian Affairs (BIA) in 1849. In the 1950s, Congress created the Indian Health Services (IHS) and moved it from the BIA to the U.S. Department of Health and Human Services. IHS is “the only truly national health service for civilians in the United States” (Kunitz, 1996, p. 1466).

According to the IHS, AI/AN people make up approximately 1.2% of the U.S. population and belong to 564 federally recognized tribes in 35 states. However, the number of AI/AN people is believed by many to be much higher because of disputes over trial recognition and enrollment. One-quarter of AI/AN families live below the federal poverty level. As a result of poverty, discrimination, and other difficulties, AIs/ANs have high rates of health disparities (Call et al., 2006). For example, they are more likely to suffer from tuberculosis, diabetes mellitus, and alcoholism, and are also more likely to die as a result of homicide, suicide, motor vehicle accidents, and unintentional injuries (IHS, n.d.).

IHS services are generally provided in reservation-based hospitals or clinics that are accessible to about half of the AI/AN population (Zuckerman et al., 2004). However, most AIs/ANs live in cities (U.S. Census Bureau, 2001) as a result of federal policies of tribal termination and relocation in the mid-part of the 20th century, which resulted in the rapid urbanization of indigenous populations (Evans-Campbell,
Lindhorst, & Huang, 2006). Despite these high rates of urbanization, IHS allocates less than 2% of its funding to urban areas, leaving AIs/ANs in metropolitan areas with little or no access to the health care to which they are entitled by law (U.S. Commission on Civil Rights, 2003).

Recent changes in federal policy have allowed tribes to assume more direct control of health services provided by the IHS within their jurisdictions. This shift in control is accompanied with differing priorities including the need to focus health services on preventive as well as treatment-oriented services, using input from indigenous clients to develop health services, and training AI/AN community members to provide health-related care (Allison, Rivers, & Fottler, 2007).

**Veterans Affairs**

The federal government has established a national network of medical centers, community clinics, and long-term care (nursing homes) for veterans of the Army, Navy, Air Force, and Marines. Veterans who incur serious enough injuries as a result of their service in the armed forces are entitled to comprehensive health care (including hospitalization, rehabilitation, necessary tests, and medications) without charge at a local veterans affairs (VA) hospital or clinic (Hisnanick, 1995). Veterans may also receive care at VA facilities for nonservice-related conditions or for injuries incurred while a service member but that are not as serious. These veterans are charged co-payments for their care, depending on their income level.

VA clients are less likely to have insurance coverage than other veterans. For example, 21% of VA users were uninsured, compared to 9% of veterans overall, whereas almost one-third of VA clients under the age of 65 (i.e., not eligible for Medicare) were uninsured (Klein & Stockford, 2001). People using the VA tend to be “poorer, older, sicker, more likely to have social problems and mental illness” than people in the private sector (Oliver, 2007, p. 23).

**Bureau of Primary Care**

Another federal health program funded by U.S. taxpayers provides primary care services to a number of indigent and vulnerable people through four programs: CHC, Healthcare for the Homeless, Public Housing Primary Care, and Migrant (farmworker) Health Centers. Over 17 million people were seen through one of these programs; 70% of the clientele had incomes below the federal poverty line (Health
Resources Services Administration, n.d.). One in three people in poverty received health care through one of these programs.

With over 700 locations, CHCs are the largest component of this system. CHCs provide a broad spectrum of services to enable participation of low-income clients including case management, health education, nutrition counseling, transportation, translation, and child care. These centers focus on the one in six Americans who live in a medically underserved area—a location (rural or urban) where there are too few primary care providers, high infant mortality, high rates of poverty, or a large elderly population (Lefkowitz & Todd, 1999). The majority of clients of CHCs are poor, uninsured, or receiving Medicaid (Politzer et al., 2001). Millions of clients receive treatment for hypertension, diabetes, alcoholism, drug, or mental health problems through CHCs.

CHCs have played a significant role in reducing poverty and race-related disparities in access to primary care and prevention services. Because of their physical locations in low-income neighborhoods, they are able to become a usual source of care that their patients perceive as user friendly and trustworthy. Unlike any other federally funded health program, CHCs are required to have a Board of Directors composed of at least 51% health center patients, ensuring a voice of the people receiving care in the decision making of the CHC.

Prisons

The United States has the highest prison population rate in the world, 756 per 100,000 persons, even exceeding the imprisonment rate of nations that have a long tradition of authoritarian regimes (Walmsley, 2009). People who are incarcerated are more likely to have health and mental health problems upon entrance to prison; and they are at high risk for acquiring serious communicable diseases because of prison overcrowding, drug use, and sexual behavior or sexual assault. When they are released and they return to their communities, they can transmit these illnesses to others. Researchers have noted that the prison population is growing older (“graying”) as a result of changes in sentencing guidelines; is disproportionately composed of African American and Latino men (“browning”) who are more likely to have been impoverished prior to incarceration; and has women, who are serving time largely for drug related crimes, as its fastest growing sub-population (“feminization”), (Delgado & Humm-Delgado, 2009).
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Each of these groups has special health needs. For example, the graying of the prison population means that an increasing number of inmates are dying in prison from conditions such as cancer and heart disease. As a result, hospice programs are being developed in prisons across the country for the incarcerated who are dying but are ineligible for parole or compassionate release programs (Evans, Herzog, & Tillman, 2002). People living in poverty are less likely to have health insurance, and for many their first contact with any health provider comes in prison (Delgado & Humm-Delgado, 2009). Finally, because the number of women in prison has increased five fold since the late 1970s (Frost, Greene, & Pranis, 2006), local jails and large prison systems have needed to develop health services that are specific to the needs of women—including prenatal and maternal–child health services.

Summary

These five examples demonstrate the patchwork nature of the health care provided in the United States. Some services focus on certain populations, such as Medicare for disabled or older workers, or the VA’s services to veterans of any age. Other systems focus on certain locations such as the county-based safety-net hospital system or CHCs targeted at geographic areas of need. The fragmented nature of this system means that some people live in the wrong place or don’t have the right characteristic to allow them to access health care.

With the shift in the American economy from industrial to service sector employment, more Americans than ever are working part time or are contractual employees who don’t receive benefits such as health insurance. Until the passage of the Obama health reforms, many people were unable to obtain health insurance if they had already been diagnosed with a medical problem (preexisting conditions exclusions). People can “fall” into the health care safety-net system for these reasons and more. Yet, safety-net providers are chronically underfunded and struggle to provide equitable levels of care for their clients; difficulties that are magnified in times of economic downturn and recession.

Challenges to Stable Funding in the Health Care Safety-Net System

Safety-net providers, particularly hospitals, tend to treat sicker patients with complications of poverty, which increases the costs of care (Meyer, 2004). As the economics of care have shifted, non-safety-net providers have scaled back or closed expensive services such as EDs
or psychiatric care, concentrating the burden of these types of care within the health care safety-net system (Lewin & Baxter, 2007). Patients who are indigent are less likely to be able to afford medications that can treat their condition or to have access to high-quality, health-maintaining food and shelter. Patients within the health care safety net often require a variety of services that are not necessary for wealthier clients. Table 1.6 lists some of the services needed within the health care safety-net system, including financial and community resource counseling, social services, interpreters, and security officers. The poorest and most vulnerable in our society require some of the costliest care, but are served within institutions that are more likely to be underfunded and have the most unstable financing—they are in a “chronic [funding] crisis” (Waitzkin, 2005, p. 941).

Most safety-net providers rely on a variety of funding sources in order to see clients, regardless of their ability to pay. Table 1.7 summarizes the multitude of funding sources used by Denver Health, the largest safety-net provider in Colorado, to fund its operations. These sources of funding range from revenue generated by privately or publicly insured clients, to state and county disbursements and private fund-raising. The U.S. government spent a total of $22.8 billion on the health care safety net in 2004—in relative terms, less than 1% of the overall federal expenditures (Kaiser Commission on Medicaid and the Uninsured, 2005).

### TABLE 1.6

**Services More Likely to be Needed by Vulnerable Patients**

- Financial counselors
- Social workers
- Additional security for urban providers
- Translators/interpreters
- Special services for HIV/AIDS patients
- Substance abuse diagnosis and treatment
- Nutrition assessment and counseling
- Transportation services
- Case management
- Mobile services for the homeless and homebound
- Communication services for patients without telephones
- Assistance obtaining housing
- Family violence prevention and intervention services
- Culturally sensitive providers
- Pharmaceutical company medication assistance programs

Adapted from Ginsberg, Gage, Martin, Gerstein, and Acuff (1994).
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### TABLE 1.7
Funding Sources for Denver Health

**Federal**
- Medicaid (Title XIX)
- Medicare (Title XVIII)
- Medicaid Disproportionate Share Hospital (DSH) payments
- Medicare DSH payments
- FQHC payments
- Health Resources and Services Administration Bureau of Primary Health Care Section 330 Grant
- Title V (Maternal and Child Health Services Block Grant)
- Medicaid, Early and Periodic Screening, Diagnosis and Treatment
- Graduate Medical Education
- Indirect Medical Education
- Ryan White Comprehensive AIDS Resources Emergency Act
- Medicaid Major Teaching Hospital

**State**
- State Medicaid programs
- SCHIP
- State medically indigent care programs
- State high-risk insurance program
- State public health programs
- Programs to subsidize care for special populations (i.e., infants and mothers)
- Programs to subsidize care for special needs of all populations (e.g., poison center grant)
- Health Department’s transportation funds (federal block grant)
- Special Supplemental Nutrition Program for Women, Infants and Children
- Immunization Program

**County**
- County indigent care programs
- County contracts for services
- Local public health programs

**Other**
- National and state foundations
- Local contributions
- Self-pay
- Managed care contracts
- Other contracts for services

(continued)
By far, the most important resources for most safety-net provid-
ers are revenues from Medicaid payments and from local governmental
taxing authorities (Lewin & Baxter, 2007). Both of these sources tend to
be highly volatile, rapidly diminishing during times of economic dis-
tress, and increasing at slow rates during more stable times. For ex-
ample, because of economic troubles, the state of Oregon eliminated mental
health and substance abuse coverage for adults receiving Medicaid
(Meyer, 2004). Likewise, the state of Arizona in 2010 suspended pay-
ments for transplants under Medicaid as a result of a budget crisis,
resulting in the deaths of patients no longer able to pay the thousands
of dollars in transplantation expenses (Jones, 2010). Medicaid cutbacks
in funding affect health care safety-net providers more dramatically
than non-safety-net systems, which can continue to spend capital on
facilities, equipment, and technology (Dialogue, 2009).

Systems that receive funding from local governments are faced
with difficult decisions about who should be the beneficiaries of these
limited resources. In Florida, Dade County has a one-half cent sales tax
to generate revenue for Jackson Memorial Hospital, the county safety-
net hospital, but other counties do not have earmarked funds, and their
patients may be seen at Jackson if they require specialty care, mean-
ning that the burden of paying for people outside the area is on people
within the county. Urban safety-net providers become the “care of last
resort” for suburban and rural providers. For example, Harborview
Medical Center in Seattle, Washington, serves patients from across
the state, although their taxing authority is limited to the metropoli-
tan area. As one administrator there noted, “It wasn’t uncommon to
get patients from 100 miles away with a nice letter from their physi-
cian saying the person lost their insurance and they can’t care for the
patient anymore” (Felland et al., 2009, p. 9). Throughout the country, a
debate rages over whether tax dollars should be spent on the provision
of medical care to undocumented workers from other countries.

TABLE 1.7
Funding Sources for Denver Health (Continued)

<table>
<thead>
<tr>
<th>Source of Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indemnity insurance</td>
</tr>
<tr>
<td>No-fault insurance</td>
</tr>
<tr>
<td>Manufacturers’ indigent drug assistance programs</td>
</tr>
<tr>
<td>Proceeds of sales and services</td>
</tr>
</tbody>
</table>

Hospitals outside of the safety-net have traditionally charged privately insured patients more than the cost of their hospital care to cover uncompensated care and costs associated with physician training (Fishman & Bentley, 1997). Financially strong hospitals are in systems that can leverage higher payments from insurers and can use costs from other patients to subsidize uncompensated care (Dialogue, 2009). As a result, a three-tiered system of health care providers exists. In the top tier are non-safety-net providers, next are economically viable health care safety-net providers, and, third, a larger group of smaller, less successful providers (Lewin & Baxter, 2007). As Waitzkin (2005) notes, private facilities often grow by drawing on public subsidies such as tax-exempt status and funding from public trust funds such as Medicare and Medicaid, whereas public institutions tend to deteriorate.

The Quality of Care Within the Health Care Safety-Net System

An implicit assumption exists that non-safety-net providers have higher-quality care. For example, safety-net hospitals (in this case, defined as those with a high proportion of Medicaid patients) scored lower on standardized quality indices (such as compliance with treatment of heart failure or pneumonia), were more likely to incur penalties, and were less likely to receive quality of care bonuses under “pay for performance” systems being created by the Centers for Medicare and Medicaid Services (Werner, Goldman, & Dudley, 2008). Quality appears to depend, however, on the definition used for a safety-net provider. When using McHugh and colleagues’ (2009) definitions of safety-net providers as described in Figure 1.1, those institutions providing high levels of uncompensated care tended to have higher quality measures, whereas certain facility characteristics (such as being a teaching hospital) were associated with lower scores on quality measures. In a study of quality benchmarks at a large safety-net hospital in the West, no disparities in care were found; the quality of care met or exceeded available clinical benchmarks (Eisert, Mehler, & Gabow, 2008).

As noted previously, health care safety-net providers may be more able to create culturally sensitive care because they tend to have a higher number of ethnic minority providers, a history of commitment to the community that engenders trust, programs for language translation, open-door policies, sliding scale fee payments, and geographic location in underserved neighborhoods (Eisert et al., 2008). Within an ethnically diverse safety-net system patient population,
implementation of a multidisciplinary program was associated with increased compliance with medication recommendations among patients; in fact, compliance exceeded the national average (Krantz et al., 2007). Findings such as these indicate that quality of care in some safety-net programs may actually improve outcomes for populations at highest risk for health disparities.

Receiving primary care can help prevent obesity and smoking as well as ensure early intervention for diseases such as cancer, diabetes, or hypertension that lead to high levels of disability and death if left untreated (Starfield, Shi, & Macinko, 2005). Yet, primary care is most likely to be unavailable to people who are uninsured, as we will discuss at length in the chapter on poverty. Many low-income people seek primary care through the network of federally funded CHCs operated by the federal Bureau of Primary Care. A national study of the quality of care provided in these centers concluded that, “the quality of care delivered in CHCs is comparable to that delivered in other settings that provide care for underserved populations and to some national benchmark data from other sources” (Hicks et al., 2006, p. 1718), although the authors did find room for significant improvement in meeting clinical benchmarks. The majority of patients in ambulatory safety-net care are ethnic minorities (Eisert et al., 2008). The care provided in these settings is likely to influence the rate of health care disparities, especially those experienced by people of color who are at the highest risk for lower-quality health overall. Closure or reduction of community-based health care safety-net systems will likely exacerbate these health care disparities.

CONCLUDING COMMENTS—PROTECTING THE HEALTH CARE SAFETY-NET SYSTEM

Enactment of universal health care insurance coverage legislation should increase access to primary care and help improve overall health by providing care to people who have previously been unable to access health services. However, increased insurance coverage alone will not reduce the gap between the “haves” and the “have nots” within the U.S. health care system. A primarily employment-based health insurance system will still exclude some groups from health insurance, such as undocumented immigrant workers and the seriously and persistently mentally ill. Safety-net health care providers will continue to exist in the American system of health care services and will face
ongoing challenges to funding and care provision. As noted sociologist and physician Howard Waitzkin concluded, “Without a national health program, safety net organizations throughout the country will continue to struggle with the challenging, chronic problems of survival and responsiveness” (Waitzkin, 2005, p. 942).

Human societies are a web. Within the health care arena, this means that more generous provision of Medicaid or more employer-based coverage will result in less charity care (Meyer, 2004). As various economic, political, and social changes occur in the next decade, the safety-net health system will continue to provide services in an increasingly complex environment. Protecting the health care safety net will require creative thinking. For instance, more metropolitan areas may benefit from the creation of regional planning forums that consider taxing for services across county boundaries to provide fairer distribution of resources. Likewise, both for-profit and nonprofit health corporations could reinvent their connection to health care’s original mission of quality care for all, while also being required to provide a certain amount of uncompensated care as a public good (Meyer, 2004). In the end, direct support will likely still need to be targeted to the safety-net providers themselves, but could be tied to systems changes that increase the likelihood of providing high-quality care (Hicks et al., 2006). Until a truly universal system of health care provision exists in the United States, safety-net providers will continue to be a key component within the patchwork system of U.S. health care.

REFERENCES


Chapter 1  Origins and Definitions of the Safety-Net Health Care System


Chapter 1 Origins and Definitions of the Safety-Net Health Care System


