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The Status Of Local Health Care Safety Nets


by Raymond J. Baxter and Robert E. Mechanic

PROLOGUE: As the United States and other nations have embraced market incentives, questions have emerged regarding the sustainability of health and welfare safety nets both here and abroad. Indeed, the recent election of Lionel Jospin as prime minister in France served as a startling referendum by its citizens to its politicians to take more care in preserving that nation’s safety net and to move more slowly toward privatization. The United States, which has a much more market-driven system than its European counterparts, faces perhaps an even more complex task in preserving its safety net. Other industrialized nations coordinate their safety-net efforts at the national level, while the American version is really a compilation of safety nets that vary tremendously across communities.

Raymond Baxter and Robert Mechanic of The Lewin Group, a Fairfax, Virginia–based health care consulting firm, present here a snapshot of health care safety nets across the United States. Baxter, as senior vice-president at The Lewin Group, heads the firm’s national public policy practice; he also heads the community monitoring initiative of the Center for Studying Health System Change, which is funded by The Robert Wood Johnson Foundation to track health care in sixty U.S. communities. Baxter has more than twenty years of public health experience, including serving as director of public health for San Francisco and as president of the New York City Health and Hospitals Corporation. He holds a doctorate in public and international affairs from Princeton University. Mechanic is a senior manager at Lewin, where he assists health care providers, government agencies, and community groups with financing, reimbursement, and organizational issues. Recently he published a paper on the impact of managed care on clinical research in Health Affairs (Fall 1996). He holds a master of business administration degree in finance from the University of Pennsylvania.
ABSTRACT: This paper examines variations in the composition, concentration, financing, and community context of local health care "safety nets" and the market pressures that they face. It also reviews financing mechanisms that support these systems and strategies being undertaken to retain publicly insured patients. As safety-net providers compete more aggressively, the availability of the public health, behavioral health, and social services they provide may be affected. Communities may have to consider more explicit investments in these "public goods" if competitive markets remove existing cross-subsidies.

There is a long-standing notion in the United States, dating back to the nineteenth century, that we should maintain a health care safety net for persons who are uninsured, difficult to serve, discriminated against, or who cannot get care elsewhere. In recent years, however, the desirability of having a health care safety net has been questioned by some, including both advocates of universal health insurance and partisans of a "market" approach to health care. Discussion has turned from the important gap-filling role of safety-net providers to debate over whether they can "compete" or should receive help to "level the playing field."

In the absence of major federal or state actions to broaden health insurance coverage, there has been growing concern that the emergence of a competitive, price-driven health care market will prove detrimental to the viability of the safety net and the populations it serves. This is a difficult issue to address because of the complex and ambiguous nature of the safety net and its wide variation across communities. Furthermore, the lack of consistent data limits systematic evaluation of the impact of changes in public financing, market competition, and organizational structure on the stability and effectiveness of the safety net.

In light of these problems, researchers are beginning to examine the impact of health system change through qualitative studies of communities that vary in their political, demographic, and market conditions. Our own work over the past eighteen months has taken us into twenty-three communities where the role and future of the safety net were part of the focus of our research and consulting. Drawing on these experiences, we have attempted to update earlier assessments of the safety net and to identify indicators that help evaluate more systematically how it is being affected by health system change. This "work in progress" addresses four principal questions: (1) What is the safety net, and how does it differ across communities? (2) How do pressures from a changing health care environment affect the safety net in different settings? (3) Is the safety net in crisis? (4) What is needed to stabilize the safety net? We conclude with a discussion of the types of data that could increase our ability to track and understand safety-net developments.
What Is The Safety Net?

The term health care safety net describes an extremely broad range of providers, services, and populations. The composition of the safety net and the concentration of responsibility for care of the poor vary greatly across communities. The relative contribution of different sources of financing is also quite different across settings. The mix of safety-net services—both personal health and public health—varies considerably, as do the local community environments in which these safety nets operate. It is important to understand these variations because the composition, concentration, financing, and community context all affect evaluation of the questions “Is the safety net in crisis?” and “What should be done?”

■ Composition. For purposes of this paper, we define the safety net in any given community as the institutions, programs, and professionals devoting substantial resources to serving the uninsured or socially disadvantaged. Although any provider can participate in the safety net, urban public hospitals, community health centers, some inner-city teaching hospitals, and local health departments are generally considered to be the core safety-net institutions. These organizations assuredly provide a great share of services to the poor. They also provide the lion’s share of the data with which some of the questions we pose can be explored. And they have persistently and effectively publicized their safety-net role to government policymakers and others. But in fact, the safety net extends to a much wider array of providers, services, and clientele.

The mix of services, though dominated by hospital inpatient and outpatient care, is another source of variation in local safety nets. There also are substantial differences in the breadth of mental health, chemical dependency, and health-related social services. The service mix in a given community is closely related to that community’s history and expectations. In some, such as San Francisco, Minneapolis, Boston, and New York, a wide array of population-based and personal care services has traditionally been considered essential. In others, such as Phoenix, Syracuse, and Orange County, California, the provision of basic emergency, clinic, and inpatient care seems to be generally viewed as the safety net.

The populations served by safety-net providers range from the uninsured and Medicaid populations to a broader array of vulnerable populations, including persons with acquired immunodeficiency syndrome (AIDS), substance abusers, the frail elderly, low-income children and pregnant women, the homeless, and the mentally ill.

■ Concentration. The concentration of safety-net responsibilities also varies from community to community. In some, such as
Dallas, a sole public hospital is the core of the local safety net. In others, such as Denver, it is a comprehensive public health and hospital system. Elsewhere, as in Boston, networks of community health centers with private and public mission-driven hospitals exist. In a few places, such as New York and Seattle, many formal and informal organizations share responsibility for safety-net functions, although not necessarily in a systematic way.

One indicator of this is the wide-ranging concentration of hospital indigent care, which varies greatly across large metropolitan areas (Exhibit 1). The top decile of hospitals in 1995 providing the most bad debt and charity care accounted for less than 35 percent of that care in Detroit and New York and more than 65 percent in Dallas, Houston, Los Angeles, and San Antonio. The same 10 percent of hospitals accounted for less than 35 percent of the Medicaid payments in New York, Detroit, and San Diego and more than 70 percent in Los Angeles and Dallas.\(^3\)

Emergency department use, which also varies greatly, is another indicator of hospitals’ safety-net role (Exhibit 2).\(^4\) The top 10 percent in 1995 provided a concentration of emergency department visits ranging from less than 20 percent in San Antonio to more than 35 percent in Los Angeles and Houston.

**Financing.** The mix of resources used to support safety-net

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**EXHIBIT 1**

Concentration Of Hospital Indigent Care Among Top 10% Of Hospitals, 1995

<table>
<thead>
<tr>
<th>Percent of indigent care provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
</tr>
<tr>
<td>70</td>
</tr>
<tr>
<td>60</td>
</tr>
<tr>
<td>50</td>
</tr>
<tr>
<td>40</td>
</tr>
<tr>
<td>30</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

- **Chicago**
- **Dallas**
- **Detroit**
- **Houston**
- **Los Angeles**
- **New York**
- **Philadelphia**
- **Phoenix**
- **San Antonio**
- **San Diego**

**SOURCE:** The Lewin Group analysis of 1995 American Hospital Association Annual Survey data.

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activities is by no means uniform, either. Medicaid and, to a lesser extent, Medicare have been the financial backbone of the safety net in recent years. For example, in 1995, 45 percent of inpatient days in large urban public hospitals were attributable to Medicaid patients and 20 percent to Medicare patients; for outpatient visits, the comparable figures were 34 percent Medicaid and 13 percent Medicare. Similarly, approximately 38 percent of patients seen in federally qualified community and migrant health centers were covered by Medicaid and 11 percent by Medicare.

In addition to providing the majority of insured patients for many safety-net providers, Medicaid subsidizes a substantial portion of care for the uninsured. According to the National Association of Public Hospitals and Health Systems (NAPH), the three sources of financing in 1995 for the uninsured in its member hospitals were local subsidies (51 percent), Medicaid disproportionate-share hospital (DSH) payments (40 percent), and Medicare DSH payments (9 percent). Although a similar breakdown is not available for community health centers, 30 percent of their revenue comes from federal grants, and substantial Medicaid cross-subsidies come from mechanisms such as cost-based reimbursement for federally qualified health centers (FQHCs). Other federal sources, such as Medi-
care’s indirect medical education adjustment, have provided substantial revenue for large teaching hospitals with a safety-net role.

Local subsidies have been extremely variable, as have other sources such as state subsidies and grants. But the absolute contribution of indigent care financing sources, and their attendant vulnerability, is not the full story. In addition to differences in the structure of Medicaid and local subsidy mechanisms, the competitiveness of local markets greatly affects the ability to cross-subsidize indigent care and other safety-net functions.

Community context. Health care safety nets are influenced by local attitudes and politics. Many communities have a strong culture of responsibility for serving the poor, as is evident in cities with long histories of supporting safety-net institutions such as New York and Los Angeles. Others are often less willing to devote substantial public resources to health care for the poor. Community culture is also reflected in and influenced by the presence of organized advocacy groups representing disadvantaged populations. The effectiveness of these groups in mobilizing resources to support safety-net activities and in influencing local politics and the media varies greatly. Finally, some communities have been very successful in influencing federal programs and policies to bring funding into local safety-net programs, which reduces the pressure on state and local resources.

The overwhelming evidence is that safety nets are local. There is no one “safety net” that an observer can point to. The interaction of composition, concentration, financing, and community context defines each local safety net. Thus it is difficult to talk about whether “the safety net is in crisis,” since there is little consistency across communities.

To be sure, changes at the national level in Medicare and Medicaid, welfare reform, and health and social service grant funding greatly affect safety nets at the local level. But at least as important are regional and local pressures. Medicaid managed care, for instance, is driven by state policy and regional health care trends; insurance coverage is also a regional economic phenomenon, mediated by state policy. Ultimately, it is local factors, played out in the context of state policies and regional economic trends against the backdrop of federal policy, that determine the nature of local safety nets and their stability or vulnerability.
Are Local Safety Nets In Crisis?

We have attempted to assess the current status of local health care safety nets based on site visits to a range of communities, discussions with experts, and review of available data. It is difficult to make broad generalizations. However, in the course of this research, we have developed a series of questions, which are helpful in assessing community safety nets: (1) What is the level of need for safety-net services? (2) How competitive is the local health care market, and to what degree are private providers competing for patients who traditionally were served by safety-net providers? (3) Do safety-net providers have capabilities that will allow them to compete effectively in the marketplace while maintaining their safety-net mission? (4) To what extent does the community support safety-net providers and services?

Here we present examples from specific communities. We are cautious about drawing strong conclusions about particular communities based on brief site visits and limited data. Nevertheless, as we synthesized observations from twenty-three communities, a number of common themes emerged.

- **Level of need.** A basic measure of need for safety-net services is the number of persons without health insurance. Other important measures include the percentage of the local population in poverty, the prevalence of certain illnesses, and the rate of underinsurance for services such as mental health care. There is wide variation in the uninsurance rate across major metropolitan areas (Exhibit 3). Factors underlying the uninsurance rate include Medicaid eligibility standards, the existence of publicly subsidized insurance programs targeted to low-income persons, local economic conditions, and unique local population characteristics.

Rates of uninsurance tend to be higher where there are heavy concentrations of small businesses and “underground economy” jobs that do not provide health insurance. The need for safety-net services also tends to be high where there are large immigrant populations who are more likely to be uninsured and to need special services such as translation and assistance in gaining access to health and social services. These populations are most concentrated in New York, New Jersey, Florida, Texas, Arizona, California, and Illinois. Recent federal welfare legislation that limits Medicaid and other welfare benefits available to legal immigrants is likely to increase the need for safety-net services in these states.

- **Market environment.** One of the most important market trends is increasing competition for publicly insured patients. Safety-net providers are concerned that competitors will “cherry
pick” profitable patients while leaving the uninsured in traditional safety-net settings. Competition is influenced by marketwide provider capacity relative to demand for services. Medicaid managed care adds another dimension by changing the basis of competition from service delivery to coverage. Medicaid patients’ access to safety-net providers may be curtailed unless they are enrolled in managed care plans that include these providers in their networks. The competitive dynamics are also influenced by the degree to which private providers are willing to support the safety-net system. Exhibit 3 presents some indicators of changing local market environments.

In some markets, Medicaid patients are being aggressively courted by private hospitals and clinics for “profitable” services such as maternity services. In Los Angeles, for example, billboards placed near the county’s public hospitals attempt to lure Medicaid recipients into private hospitals for maternity care. Unfortunately, there are numerous anecdotes but no systematic studies of how many Medicaid recipients have left safety-net providers, for which services, and under what market conditions.

The loss of publicly insured patients threatens the patient volume and revenues of safety-net providers, as well as the availability of special subsidies for indigent care. In Los Angeles, shifting patterns of care have reduced the Medicaid disproportionate-share funding going to the Los Angeles County hospital system from $387 million in 1991–1992 to $253 million in 1994–1995, while the amount going to private Los Angeles County hospitals increased from $98 million to $339 million.

### Exhibit 3

**Selected Local Market Characteristics Affecting The Safety Net, 1995**

<table>
<thead>
<tr>
<th>Market</th>
<th>Percent uninsured</th>
<th>Inpatient days per 1,000</th>
<th>Hospital beds per 1,000</th>
<th>HMO penetration</th>
<th>Medicaid HMO penetration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>10.4%</td>
<td>886</td>
<td>3.5</td>
<td>42.1%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Dallas</td>
<td>22.1</td>
<td>554</td>
<td>2.8</td>
<td>16.6</td>
<td>0.0</td>
</tr>
<tr>
<td>Memphis</td>
<td>14.1</td>
<td>950</td>
<td>3.7</td>
<td>22.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Phoenix</td>
<td>15.6</td>
<td>543</td>
<td>2.6</td>
<td>26.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Indianapolis</td>
<td>10.8</td>
<td>893</td>
<td>3.7</td>
<td>13.3</td>
<td>3.0</td>
</tr>
<tr>
<td>Cleveland</td>
<td>12.1</td>
<td>895</td>
<td>4.0</td>
<td>20.9</td>
<td>53.0</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>19.8</td>
<td>594</td>
<td>2.8</td>
<td>39.2</td>
<td>23.3</td>
</tr>
<tr>
<td>New York</td>
<td>14.2</td>
<td>1,340</td>
<td>4.5</td>
<td>23.0</td>
<td>13.9</td>
</tr>
<tr>
<td>U.S. average</td>
<td>14.5</td>
<td>760</td>
<td>3.3</td>
<td>20.1</td>
<td>—</td>
</tr>
</tbody>
</table>

**Sources:** Lewin Group estimates based on data from the Current Population Survey, American Hospital Association Annual Survey, and InterStudy.

**Notes:** Inpatient days include service provided to out-of-area residents in community hospitals only, including long-term care units. Calculations assume 1 percent population growth between 1994 and 1995. HMO is health maintenance organization. 

*Not available.*

■ Marketwide provider capacity. Excess capacity—measured by high numbers of hospital beds per thousand population, low hospital occupancy, and high physician-to-population ratios—tends to create more aggressive local market competition. Providers that were not interested in Medicaid patients when their waiting rooms were full find them increasingly attractive as patient volume declines. Hospitals with declining occupancy may find that, at the margin, Medicaid patients are profitable, even at rates substantially below average costs.

Markets with excess capacity and low health maintenance organization (HMO) penetration are more susceptible to wrenching future changes than are those that have already experienced substantial restructuring. For example, if inpatient utilization in New York City dropped overnight to the rates observed in Los Angeles, hospital occupancy would fall from its 1995 level of 81 percent to about 36 percent.

■ Medicaid managed care. The growth of Medicaid managed care presents both threats and opportunities for safety-net providers. It is a vehicle for private-sector health plans and providers to access the Medicaid funding stream. It also creates pressures for changes in business practices that are threatening to providers that historically have focused on mission. At the same time, it provides opportunities for safety-net providers to attract new Medicaid patients and to serve them more cost-effectively.

Risk-based Medicaid HMO programs, with strong incentives to treat patients in defined provider networks, can have a much bigger impact (positive or negative) on safety-net provider volume and financial status than primary care case management (PCCM) programs, which impose only limited controls on patient choice or service use. Medicaid HMO enrollees can only use safety-net providers in their plan’s network. Furthermore, Medicaid HMOs generally are not required to make special disproportionate-share or medical education payments to safety-net providers.

Indianapolis is one market where core safety-net providers appear to have maintained a strong Medicaid presence. While all Indiana Medicaid Aid to Families with Dependent Children (AFDC) recipients are enrolled in “managed care,” relatively few are in at-risk HMOs. The first Medicaid HMO in Indianapolis (there are now two) was established by Wishard Hospital (the public hospital) in a joint venture with several other downtown hospitals and affiliated clinics. In contrast, nearly 100 percent of Medicaid recipients in Phoenix are enrolled in capitated health plans through the Arizona Health Care Cost Containment System (AHCCCS). Many of these
plans send few patients to core safety-net providers. In Arizona’s most recent 1994 bid cycle, a number of commercial HMOs entered the market, which previously had been dominated by provider-sponsored plans. This has led to substantial deterioration of Medicaid enrollment in the county-sponsored Maricopa Health Plan.¹¹

Some communities have attempted to facilitate participation of safety-net providers in Medicaid managed care through special consideration for plans that contract with safety-net providers in their bid evaluation criteria.¹² Safety-net providers have also been excluded from restrictions that apply to other plans and providers, such as enrollment caps. West Virginia recently implemented a special capitation rate adjustment for Medicaid HMOs depending on the proportion of services provided by publicly supported providers such as health centers, rural hospitals, and local health departments. Although helpful to some, these mechanisms by themselves are not sufficient to level the competitive playing field.

■ Participation in the safety net. Many non-safety-net providers support safety-net institutions through caring for underserved patients and providing political and technical support for core safety-net providers. This support is consistent with the missions of many providers, even if they do not serve many uninsured patients. Many also support safety-net providers because they do not want direct responsibility for indigent care and the special service capacity required.

The level and breadth of support are affected by local culture and financing mechanisms. For example, in communities such as Dallas, an understanding that the safety net is concentrated in a core institution (Parkland Memorial Hospital) is often accompanied by strong public and private support. In Dallas, this is indicated by the high proportion of Parkland’s operating budget provided by local government sources and by the local provider community’s vocal support for its mission.

In other communities such as New York and Boston, there are expectations that a broader range of providers will serve the uninsured, despite the presence of large, public safety-net institutions. This is reinforced by broad-based charity care programs to pay providers that serve the uninsured. In Massachusetts, however, the charity care pool pays higher rates to hospitals with the highest uncompensated care burdens. As a result, Boston’s two public hospitals received more than 90 percent of the cost of caring for eligible patients in 1995 compared with an average of about 50 percent for hospitals statewide.¹³

■ Safety-net provider capabilities. The future success of safety-net providers is influenced by their operational assets, leadership,
and ability to respond quickly to market change.

Operational assets. Physical plant, staff capabilities, and linkages with other providers are important for safety-net providers to compete effectively. Ownership or strong alliances with outpatient clinics also provide a competitive advantage in attracting Medicaid patients. Contrary to stereotype, many public hospitals and community clinics have attractive physical plants in good locations. For example, through its merger with Boston City Hospital, Boston University Medical Center gained a brand-new hospital building and strong referral relationships with local community health centers.

Leadership. The relative concentration or dispersion of leadership affects the overall strength of the safety net. For example, in Dallas, health care providers, the business community, and elected officials all identify the leadership of Parkland Memorial Hospital as a major factor in its perceived effectiveness. One person, referencing its relatively low per unit costs, referred to Parkland as “good government.” Such perceptions have helped Parkland to obtain support from the county Commissioners’ Court. In contrast, Los Angeles has a wide range of organizations and individuals that participate actively in the safety net, but conflicting agendas and insufficient communication have contributed to a lack of consensus about how to approach many of that city’s health-related problems.

Flexibility. Many safety-net providers face constraints such as Civil Service restrictions on hiring and firing, procurement regulations, and uncertainty about annual budget resources, which limit their ability to respond rapidly to market change. And although today’s health care providers are increasingly consolidating to achieve negotiating power and economies of scale, the presence of large public or academic bureaucracies is intimidating to potential partners. Many public and academic institutions are examining their governance structure and implementing changes to create greater flexibility. One of many examples is Denver Health (formerly Denver Health and Hospital Corporation), which recently restructured as an independent public authority to “permit needed flexibility while maintaining a public structure.”

Community support and stability of financing sources. Support for the safety net can be gauged by community attitudes, the tone of local media reports, the activity and influence of organizations advocating for safety-net populations, and the level of public financial support. One indicator of financial support, the size of the public health care delivery system and level of local funding, varies substantially across communities (Exhibit 4). New York and Los Angeles had the largest public hospital systems in 1995, with budgets two to three times higher on a per resident basis than those of
other large cities. Dallas and Boston had the largest per capita local appropriation for public hospitals. These figures, however, tell only a partial story. Community financial support includes other sources of public funding (for example, charity care pools) and the breadth of local provider participation in the safety net.

The future impact of health system change is affected by the stability of safety-net financing mechanisms. Medicaid DSH payments, which grew from several hundred million dollars in the late 1980s to nearly $19 billion by the early 1990s, provided a major short-term boost to safety-net providers, but retrenchment occurred with passage of federal legislation in 1991 and 1993 to limit the use of this mechanism. In the interim, some local governments reduced local funding commitments, which are now difficult to revive. Redistributive indigent care financing mechanisms, such as free care pools supported by hospital or insurance assessments, have also come under fire in states such as Massachusetts as the private hospital market has become more competitive. Dedicated revenue sources, such as local hospital tax districts, linked to a broad-based measure, such as local property values, provide more stability. However, developing the political consensus to put dedicated mechanisms in place can be difficult.

Assessing the viability of local safety nets. Our general impression from brief examinations of a wide range of communities is that three major elements are needed to sustain strong local safety nets: (1) safety-net providers that are sufficiently competitive and innovative to maintain their traditional base of publicly insured patients; (2) a reasonably stable mix of financing sources; and (3) local markets that are not changing too rapidly for rational restructuring. Many health care executives have noted the need for sufficient time to restructure service capacity, develop information sys-

### EXHIBIT 4
Public Hospital System Beds, Budgets, And Local Subsidies, 1995

<table>
<thead>
<tr>
<th>Market</th>
<th>1994 population</th>
<th>Public system beds</th>
<th>Total revenue (millions)</th>
<th>Local appropriation (millions)</th>
<th>Revenue per resident</th>
<th>Local funding per resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>3,211</td>
<td>452</td>
<td>$323</td>
<td>$129</td>
<td>$101</td>
<td>$40</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>9,150</td>
<td>2,909</td>
<td>1,796</td>
<td>224</td>
<td>196</td>
<td>24</td>
</tr>
<tr>
<td>Phoenix</td>
<td>2,473</td>
<td>474</td>
<td>271</td>
<td>73</td>
<td>110</td>
<td>30</td>
</tr>
<tr>
<td>New York</td>
<td>8,584</td>
<td>7,358</td>
<td>3,006</td>
<td>50</td>
<td>350</td>
<td>6</td>
</tr>
<tr>
<td>Dallas</td>
<td>2,898</td>
<td>901</td>
<td>397</td>
<td>154</td>
<td>137</td>
<td>53</td>
</tr>
<tr>
<td>Memphis</td>
<td>1,056</td>
<td>529</td>
<td>185</td>
<td>25</td>
<td>175</td>
<td>23</td>
</tr>
<tr>
<td>Indianapolis</td>
<td>1,462</td>
<td>328</td>
<td>187</td>
<td>43</td>
<td>128</td>
<td>29</td>
</tr>
<tr>
<td>Cleveland</td>
<td>2,222</td>
<td>1,000</td>
<td>299</td>
<td>12</td>
<td>135</td>
<td>6</td>
</tr>
</tbody>
</table>

**SOURCES:** Lewin Group estimates based on data from the National Association of Public Hospitals and Health Systems, the American Hospital Association, and the U.S. Bureau of the Census.

**NOTES:** Population and bed capacity data are from 1994. Revenue data are from 1995.
tems, and create new linkages among providers. While safety-net providers in slow-moving markets can take advantage of this foresight, there is less time for planning and more opportunity for mistakes for those in the throes of rapid change.

**Competitive Strategies**

In addition to lobbying to maintain public sources of support, many safety-net providers are working intensively to develop more competitive operations. Specific strategies include improving quality and customer service; increasing efficiency; reducing inpatient capacity and refocusing resources on prevention and primary care; measuring and improving performance; building integrated delivery systems; and developing new partnerships.

Despite notable successes, safety-net providers are not perceived as leading the industry in these areas. Safety-net providers face real barriers to change; however, some view their unique characteristics as the basis for new competitive strategies.

- **Unique mission and capacities.** Safety-net providers offer a range of nonmedical services such as assistance in gaining entitlements, language translation, transportation, referrals for housing and employment, and day care. These services rarely generate sufficient revenue to cover their cost and are less likely to be provided by non-safety-net programs. However, as private providers expand into Medicaid managed care, some will be unprepared to manage patients who are ethnically and culturally diverse, have above-average health risks, and require a broad range of medical and social services. In this context, safety-net providers that traditionally have served these populations may prove to be effective competitors and attractive partners.

- **Financing structure.** Management of safety-net programs is complicated by their predominantly public financing and attendant uncertainties about available resources. Heavy reliance on inpatient-focused subsidies such as Medicaid DSH payments also conflicts with the need to develop more effective outpatient and community-based services. Many believe that Medicaid DSH funding formulas should be changed to more effectively target funds to core safety-net institutions. Some states are now exploring the possibility of using Medicaid DSH funds to support primary care services.

Some forward-thinking providers have taken advantage of variable sources of funding as “investment capital.” For example, hospitals in Indianapolis and Dallas have used DSH funding to upgrade physical plants and invest in new information technology. Community health centers in Boston have used charity care pool funding to upgrade facilities, and community health centers in Washington
State have “traded in” cost-based FQHC revenues for more favorable capitation rates in their Medicaid managed care plan.

- **Medical school relationships.** Many safety-net hospitals serve as major teaching sites. Faculty physicians often provide the professional services in these institutions and supervise the residents who deliver a large volume of indigent care. While providing access to state-of-the-art technology, services, and personnel for disadvantaged patients, these relationships also pose difficulties. For example, in most medical schools, educational programs still emphasize subspeciality medical care in inpatient settings. Similarly, many safety-net teaching hospitals have closed medical staffs that do not provide admitting privileges to community physicians who care for their indigent patients outside of the hospital.

However, close links to medical schools provide an opportunity to broaden the appeal of safety-net providers through “centers of excellence.” For example, San Francisco General Hospital is a national leader in clinical care and research on AIDS, as is New York’s Bellevue Hospital for emergency care and reimplantation. Furthermore, reform of graduate medical education is increasingly being linked to safety-net providers, such as community health centers.\(^1\)

- **Links to government and unions.** Safety-net providers that are part of city or county governments or other public entities, including universities, often have constraints in areas such as personnel, procurement, and contracting. Many are also unionized, which has often been blamed for high labor costs and limited management flexibility. However, government and unions are major purchasers of health care services, and safety-net providers can take advantage of these relationships to increase market share. Systems such as the Boston Medical Center make their health plan available to employees at competitive rates. Having employees as customers has a positive influence on service. Finally, public employees and unions can provide important political support. Collaboration with these groups may help safety-net providers to access public investment capital and other assistance needed to become more competitive.

**Outlook For The Future**

There are many possible models of how safety-net systems might evolve in the future. At one end of the continuum, safety-net systems can gear up to compete directly with other providers in the medical services marketplace. To be successful, most will have to enhance their technical capabilities in managed care contracting, clinical practice management, performance monitoring, and information technology. This response, however, may not be fully compatible with their charitable and social missions. Safety-net systems that
“The pace of change affecting the safety net is faster than our ability to monitor the stability of safety-net institutions.”

Adopt this strategy may be motivated to reduce activities such as public health, behavioral health, and social services that do not contribute to their financial stability, which will make them look more like private health care providers. Under this model, other providers might pick up some of the slack for safety-net services (if funding is available); more likely, access to care for the uninsured and underserved will decline.

At the other end of the continuum, safety-net providers may focus on maintaining or expanding their original mission. They will still have to make operational changes to compete effectively. But this approach recognizes that competitive markets will not provide all of the resources necessary to realize the safety-net mission; maintaining a “public goods” role will require a social compact with one’s community. As competition removes cross-subsidies from these systems, communities will have to make more explicit investments to maintain an effective safety net.

Making the second concept work requires changes in the historical competition among safety-net providers for resources, attention, and control. Linkages that make sense from a mission and operational perspective can no longer be inhibited by competitive relationships. In developing new partnerships, safety-net providers also will have to think beyond traditional allies. For example, public and academic hospitals must at least be open to asking, “What can I learn from Columbia/HCA?”

- **Data needs.** The pace of change affecting health care safety nets is faster than our current ability to monitor the stability of safety-net institutions and the welfare of populations that depend on them. Unfortunately, most of the available data, research, and analysis are focused on the hospital setting. As we review the role of public policy in an increasingly competitive health care system, one of the most important public goods is information that will allow more effective tracking of the safety net.

In particular, more comprehensive data are needed about care provided to uninsured patients in non–inpatient settings, including hospital outpatient departments, physicians’ offices, community health centers, and other primary care settings. In addition to supporting research, these data could be used to develop indigent care financing mechanisms with incentives for appropriate primary care. There is also a pressing need for better data on mental health, sub-
stance abuse, and senior and family services provided by community-based organizations.

As researchers try to assess whether local safety nets are “in crisis,” better data are needed about the financial status of safety-net providers, the volume of care they provide, and the relative importance of different financing sources. Better data on patterns of care for Medicaid managed care patients are critical for understanding whether patients are being served effectively and appropriately under these programs and to quantify the extent to which these programs have shifted patient volume away from traditional safety-net providers. Such data, combined with the types of community tracking activities being sponsored by The Robert Wood Johnson Foundation and others, will help community leaders, policymakers, and providers to better understand and shape future changes in the health care safety net.

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NOTES


2. Our work was supported variously by The Robert Wood Johnson Foundation; The Center for Studying Health System Change; the Community Initiatives of the United Auto Workers, General Motors, and Chrysler; Hennepin County, Minnesota; a coalition of county and private providers in San Mateo, California; and the Syracuse Hospital Executive Council. The communities included Syracuse; Boston; New York City; Newark; Cleveland; Philadelphia; Greenville (South Carolina); Miami; Minneapolis; Lansing and Flint (Michigan); Kokomo, Indianapolis, and Anderson (Indiana); Memphis; Little Rock; Dallas; Seattle; San Mateo, Los Angeles, and Orange County (California); and Phoenix.

3. On average, the top 10 percent of hospitals in these ten cities account for 53 percent of the reported cost of bad debt and charity care. They also are larger than average, accounting for 26 percent of total hospital expenses. The concentration of bad debt and charity care as a percentage of expenses varies differently across these ten cities.


7. NAPH, “Characteristics of NAPH Member Hospitals.”

8. Lipson and Naierman, “Effects of Health System Changes on Safety-Net Providers.”
Providers.”
10. Ibid.
12. Lipson and Naierman, “Effects of Health System Changes on Safety-Net Providers.”
17. Examples of this are the Health Professions Education Community Partnerships and Community-Based Public Health Initiatives of the W.K. Kellogg Foundation.