Institute of Medicine, “America’s Health Care Safety Net: Intact but Endangered Chapter 2”

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- America’s safety net is not secure and not uniform across states and communities
- core safety net providers have a critical role in providing care to people who fall outside market
- core safety net providers (e.g., community health centers, public hospitals) provide a small share of care to the poor and uninsured, but share is disproportionate to that provided by other providers
- core safety net providers offer comprehensive medical and enabling (“wrap-around”) services (e.g., interpreters, transportation, outreach, nutrition, social support)
- also offer critical highly specialized services (e.g., trauma care, burn care, neonatal care)
- train large numbers of physicians and other healthcare professionals
- cannot engage in cost shifting, rely on Medicaid, grant funds, charitable contributions, and donations
- Medicaid compensation systems: Federally Qualified Health Centers (FQHCs) and Disproportionate Share Hospitals (DSHs)
- population characteristics: poor, minorities, immigrants, geographically or economically disadvantaged communities, broad range of social, demographic, or poverty-related health problems
- lack of health insurance can be the primary barrier
  - Medicaid provides low levels of provider payments, resulting in limited and skewed provider participation
- often limited coverage of pharmaceuticals, mental health treatment, substance abuse treatment

- other groups at risk include the homeless and people with complex health problems (e.g., mental health, HIV/AIDS)

- minorities are more likely to be uninsured and go to safety net hospitals

- 71 million Americans live in medically underserved areas (MUAs): urban African-Americans and Hispanics + rural whites

- legally designated “essential community providers” or “providers of last resort” + mission-driven providers

- public hospitals:
  - about 1,300 public hospitals
  - goes back to public and nonprofit charity hospitals that provided for the poorest
  - until the 1965 creation of Medicaid and Medicare, public hospitals were the only alternative available to most low-income patients
  - treat many uninsured people and many people on Medicaid
  - little commercial coverage
  - patient population with poorer health status

- community health centers:
  - primary and preventative health services
  - tend to be located in communities with lower incomes, lack of health insurance, and less access to healthcare services
  - some qualify for federal funds, others rely on state and local government subsidies
  - FQHCs: medically underserved area or population, nonprofit/tax-exempt/public, community-based board of directors, culturally-competent, comprehensive primary care services, sliding fee scale, services provided regardless of ability to pay

- local health departments:
  - role under debate and great variation across cities
  - legally required to provide core public health functions but many provide direct care to vulnerable populations

- other providers:
  - community and teaching hospitals
- private practitioners
- school-based health centers
- federally sponsored health services

- core safety net hospitals often seen as less efficient and their contributions are less well-documented, though no real empirical evidence of this

- publicly-owned safety net hospitals might not be competitive because regulations

- unclear whether payment should be cost/volume/performance based to incentivize efficiency

- safety net hospitals are uniquely effective at addressing the special needs of certain vulnerable populations