A Comprehensive View of the U.S. Health Care Safety Net

Executive Summary

In a recent report, the Institute of Medicine defined the health care safety net as "…a patchwork of providers, funding, and programs tenuously held together by the power of demonstrated need, community support, and political acumen."[1] The providers and services that make up the safety net vary from state to state, and from community to community, making it difficult to define and measure. The objective of this paper is to develop an overview of the safety net through a comprehensive literature review, focusing specifically on how the safety net is defined, including its providers, recipients, funding sources, and measures. The paper also provides a discussion of the policy issues surrounding the safety net, as well as recommendations for future research.

Findings

The principal findings of this study provide useful information to policy makers, researchers, as well as community and public health leaders. These findings are as follows:

- The safety net is difficult to define. The safety net is not a uniform system across states and communities. As a result, there are a number of definitions of the safety net, but no standard definition is used consistently.

- Safety net services are typically organized at the community level. The safety net is not a nationally organized system that is similar from state to state. Baxter and Mechanic emphasize that safety net systems are local and are influenced by composition, concentration, financing, and community context.[2]

- There are many providers of safety net services beyond the traditional providers (public hospitals, local health departments, and community health centers). These often less-mentioned safety net providers include private providers, family planning clinics, Indian Health Service departments, school-based health centers, health care centers for the homeless, and rural health providers.

- There are a number of subgroups dependent on the safety that make up the uninsured and underinsured populations. Some of these subgroups include minority and immigrant populations, rural residents, vulnerable populations such as AIDS/HIV patients, and Medicaid populations. Different groups face different barriers in accessing care.

- There are a number of federal, state, and local grants and subsidies upon which safety net providers are dependent. These various funding sources are vital sources of revenue for safety net providers. The level and availability of funding for safety net providers also varies across communities.

- More data are needed in order to effectively monitor the safety net. The majority of data readily available about the safety net represents financial and utilization data from hospitals and federally qualified health centers (FQHCs). The availability of information and data provides an important resource in determining if the health care needs of vulnerable populations are being met.

- There are external forces affecting the viability safety net providers. There are three main factors creating pressure for safety net providers: increase in managed care, decreased financial support, and an increase in the level of demand.

Recommendations

In an effort to strengthen the safety net in its mission to provide health care access to vulnerable populations, the following recommendations are directed towards health services researchers, policy makers, and public health administrators.

- More research is needed on developing specific measures to monitor the safety net, both at the macro and micro levels. There is a need to develop measures to effectively monitor the safety net overtime.

- Additional research is needed on trends in safety net financing mechanisms at the state and local level. The majority of information that currently exits focuses on federal grant programs and subsidies; however, little detail is available regarding local funding sources.

- State, community, and public health leaders should develop standard approaches to assessing how communities are responding to the needs of vulnerable populations. Community and public health leaders have an important role in determining the status of the safety net in their areas, and in developing mechanisms to strengthen and maintain it.

This report provides a comprehensive view regarding the scope of the health care safety net, providing background information to policy makers, health services researchers, and community leaders. The providers making up the health care safety net play an important role in the U.S. health care system, rendering services to the uninsured, underinsured, and other vulnerable populations. The safety net also strengthens the communities in which it is located. Strategies must be developed to strengthen the safety net in order to eliminate the barriers that vulnerable populations experience in obtaining health care services.

A Comprehensive View of the U.S. Health Care Safety Net

Introduction

The United States health care system is organized in a way where the majority of citizens receive access to health care services and coverage through an employer. These private sources of coverage are supplemented with public health plans such as Medicare and Medicaid that provide care to the poor and the elderly. The U.S. health care system differs from other countries that have a universal health care program sponsored by their government.[3] In these countries, health care is viewed as a public good rather than as a privilege. David Mirvis, MD points out that from a philosophical standpoint health care is similar to other public goods such as public safety and defense, and should be regarded as a public good.[4]

However, the U.S. health care system fails to reach a growing number of individuals who are uninsured or experience barriers to receiving needed medical care.[3] Many of these individuals work either part-time or full-time, but are not offered coverage through their employer. As a result, there has been a dependence upon an array of health care providers who make up what is called the health care safety net. The safety net fits into the U.S. health care system as a mechanism for ensuring access to care for individuals who lack health insurance, either private or public, or experience other difficulties in obtaining medical services.

The health care safety net is often referred to as a specific system in place, designed to provide health care to the uninsured and the indigent. However, there is great variation that exists in states and communities regarding the health care safety net. As a result, it is difficult to define what this system is, and how it effectiveness can be measured.

The purpose of this paper is to construct an overview of the safety net by conducting a comprehensive literature review. The results of this literature review can provide researchers and policy makers with a critical analysis of how the safety net is defined, as well as recommendations on how it can be strengthened. This review will focus specifically on how the safety net is defined, including its providers, recipients, funding sources, and measures. The final sections will include issues and gaps identified in the literature, as well as recommendations for future policy and research.

Methods

This literature review consisted of initially searching the MEDLINE database for articles dated within the last five to six years (1995 – 2001), using the keywords: safety net, access to care, uncompensated care, and charity care. Articles, studies, and reports that described the safety net, as well as ways to measure its effectiveness were included in the review. Additional articles were identified from the bibliographies of articles included from the MEDLINE search.

Defining the Health Care Safety Net

The first step to building a comprehensive overview of the health care safety net within the United States is to define what the safety net actually is. Without a strong definition, it is difficult to develop mechanisms to monitor and strengthen the health care safety net. Many definitions exist within the literature describing the safety net (See Table 1). According to a recent report issued by the Institute of Medicine, there does not exist a commonly accepted

definition of the safety net.[1] The health care safety net is a variable entity, one that is not uniform across states, even communities.[1, 2] As a result there are differing ideas of what this safety net really is, such as who the safety net providers are and what populations are served. When the term safety net is used, it can often connote a homogeneous meaning, suggesting that there is a nationally organized system in place that is similar across states. However, there is no national health care safety net, rather it is an entity varying from state to state and more specifically from community to community.[2, 5-7] In their article, Raymond Baxter and Robert Mechanic emphasize the point that safety nets are "local", and are influenced by the composition of the safety net in a particular community, the concentration of services, available funding, and the context of community culture and attitudes toward supporting the safety net.[2]

Despite the numerous definitions that do exist within the literature, there are some commonalities. In examining these definitions, on the surface they all centered on the central idea that the health care safety net is a "system" in place designed to provide care to individuals encountering barriers to health care services.[1, 2, 4, 5, 7-12] Safety net providers are often thought of as providers of last resort.[13] Individuals lacking health insurance, or who are covered, but due to other circumstances are unable to access the health care they need, depend on these providers to fill the gaps of the U.S. health care system.[11]

Another similarity is that a number of the definitions indicate the fragmented nature of the safety net, describing it as a "loose patchwork of providers".[1, 5, 7, 10, 11, 14] Peter Cunningham and Peter Kemper explain this "loose patchwork" in the following way:

> *"The health care safety net is less a highly organized, integrated, and well-financed medical care delivery system than a loosely organized patchwork of publicly subsidized hospitals, clinics, local health departments, and other individual clinicians who care for the uninsured on a more ad hoc basis."(Cunningham and Kemper)*

Another interesting finding is that a number of the articles reviewed, defined the safety net as a system of providers who are legally required to provide care to the uninsured, the indigent, and other vulnerable populations.[7, 9, 15] There is a federal, un-funded mandate called the Emergency Medical Treatment and Active Labor Act (EMTALA), which Congress enacted in 1986 as a means for ensuring emergent treatment to individuals who did not have the ability to pay. This particular mandate applies to hospitals that contract with Medicare.[13] There are also provisions that apply to Federally Qualified Health Centers that require providers to take on the mission to provide care to the uninsured and others with limited access to care.

However, in addition to these requirements and legal obligations, there are a number of providers who take upon themselves the mission to provide "charity care" to the uninsured and the indigent. These providers could be non-profit private organizations, individual private providers, or religious organizations. The Institute of Medicine indicated within their report that the committee questioned including only legally mandated providers within their definition of "core" safety net providers. They found that there are many safety net providers that have the mission to care for the uninsured and other vulnerable populations. The following is the definition of safety net providers from the Institute of Medicine's recent report:

***"Safety net providers are defined 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."*

***"Core" safety net providers are defined as**: "These providers have two distinguishing characteristics: (1) by legal mandate or explicitly adopted mission they maintain an 'open door,' offering access to services to patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients."*

Other articles do not differentiate between this legal mandate or self-appointed mission, rather they are general in reference to the providers who render services to those with limited access to care.[2, 4, 5, 10]

As described, there are a number of different views regarding how the safety net is defined. These different definitions represent a gap within the literature on what the safety net is and its purpose, which may be illustrative of the difficulty in defining such a variable system. As described previously, in order to address the emerging issues affecting the safety net, it is important to develop an understanding of what it is. One particular component in defining the scope of the safety net is determining who the safety net providers are.

Providers of the Safety Net

As discussed, the safety net is composed of health care providers and facilities who are either legally obligated or who take upon themselves the mission to provide access to care, regardless of a person's ability to pay. However, this explanation of safety net providers is broad. Who are these providers of charity care? Are they the same across states and local communities?

Upon review of the literature, there were three types of providers most frequently mentioned as safety net providers. These providers include public hospitals, community health centers, and local health departments.[1, 2, 4, 6, 7, 9, 10, 15-18] These providers are considered core safety net providers, in that they provide an increased amount of care to patients who are uninsured and/or low-income.[1, 2, 6] Using a similar format found in the Institute of Medicine's report on the safety net, this paper will discuss these core safety net providers in further detail as described in the literature reviewed.

Public Hospitals

Historically public hospitals have played a major role in providing care to the poor. Prior to the establishment of Medicare and Medicaid, public hospitals acted as the only source of care for low-income individuals. These hospitals were, at that time, referred to as charity hospitals.[16] Today, there are roughly 1,300 public hospitals within the United States located in large urban areas that continue in this mission to provide care to those who with little or no other access to care.[1] These hospitals are under the ownership and operation of states, counties, or cities.[7]

There are a number of characteristics that differentiate public hospitals from other hospitals within the health care system. One of the more significant characteristics is the increased number of self-paying patients at public hospitals compared to private hospitals. [1, 9, 16] According

to an article by Gage and Regenstein, National Association of Public Hospital (NAPH) members provided, on average, 26 percent of inpatient services and 41 percent of outpatient and emergency services to self paying patients in 1997.[8] In their report the Institute of Medicine indicates that self-paying patients at public hospitals are more likely to be poor, uninsured, and have most or all of the cost of care absorbed by the facility. However, self-paying patients at private hospitals include those who may have insurance, but choose to pay for services excluded by their health plan.[1]

Another characteristic of public hospitals is the type of services offered, compared to private hospitals. As mentioned, these hospitals are generally located in urban areas, and provide a number of specialty services such as trauma, emergency psychiatric, burn care, and poison control. These are important services available to the uninsured and indigent, but also provide benefits to the entire community.[7, 8, 19] Public hospitals are often times associated with medical schools in which medical student residents provide a high proportion of charity care.[7]

Funding sources are another distinctive characteristic of public hospitals. Government sources of funding such as Medicare and Medicaid, specifically disproportionate share payments (DSH) are an important source of funding for public hospitals. However, recently there have been decreases in government subsidies that have caused strains on these safety net providers. Some public hospitals have closed, changed governance, or have been acquired by for-profit or not-for-profit hospitals.[1, 7] These changes may be due to the financial stresses these hospitals are facing; however, the articles mentioning these changes [1, 7] do not specifically indicate this. Further discussion will be provided pertaining to financial sources for public hospitals and other safety net providers.

These are only a few of the characteristics that differentiate public hospitals from private hospitals. Public hospitals are an important source of care for the uninsured and low-income individuals, but also provide essential services to the communities in which they reside.

Community Health Centers (CHCs)

Community health centers (CHCs) are another core provider of the health care safety net (See Table 2). CHCs initially began as neighborhood health centers as part of President Johnson's War on Poverty in the 1960s.[6, 20] The mission of the CHC is to provide primary and preventive services to low-income and uninsured individuals who have difficulty accessing and paying for health care.[1, 20]

The Bureau of Primary Health Care (BPHC) administers the federally sponsored community health center program that provides Section 330 grant funds under the Public Health Service Act to health centers that meet certain criteria.[1, 20] These health centers are also referred to as Federally Qualified Health Centers (FQHCs), a program established in 1989, allowing qualified health centers to receive cost-based reimbursement from Medicaid and Medicare.[1, 20] CHCs must meet the following criteria in order to be designated as a FQHC: be located in a medically underserved area or serve a medically underserved population; have nonprofit, tax exempt, or public status; have a board of directors, a majority of whom must be consumers of the center's health services; provide culturally-competent, comprehensive primary care services to all age groups; offer a sliding fee scale and provide services regardless of ability to pay.[1] CHCs not receiving section 330 grant funds can still receive cost-based reimbursement from Medicaid and Medicare through a FQHC look-alike program. FQHC look-alikes must still meet the eligibility requirements of FQHCs.

In addition to the requirements mentioned above, federally qualified CHCs are also required by law to provide the following services:

- Basic health services related to family medicine, internal medicine, pediatrics, obstetrics or gynecology;
- Diagnostic laboratory and radiology services;
- Preventive health services, including prenatal and perinatal services, immunizations, pediatric eye, ear and dental screenings, voluntary family planning services, and preventive dental services;
- Emergency medical services;
- Pharmaceutical services as may be appropriate;
- Referral services;
- Patient case management, including counseling, referral and follow-up services; and
- Services that enable patients to use the health center, such as outreach, transportation, and translation services [7]

In addition to federally qualified community health centers, there are also community health centers that provide primary care, but do not receive federal grant funding. Some states also have primary care programs focused on providing better primary care access to the uninsured and the indigent. These primary care programs are made up of federal and non-federal community health centers, and may have their own criteria to qualify as a state sponsored community health center. For example, the state of Washington has a program called the Community Health Services Program, within the Washington State Health Care Authority Division. This particular program has criteria that community health clinics must meet in order to receive state funding. Some of the clinics within this program receive 330 federal grant funds; however, there are a number of clinics that are not federally qualified, but meet the states criteria.[21] The mission of the Community Health Services program is "is to promote access to prevention and illness care for underserved and uninsured low-income populations in Washington State."[22]

Local Health Departments (LHDs)

There are more than 3,000 local health departments (LHDs) nationwide.[1, 9] These LHDs have a unique role within the community to ensure that the health of the population is protected, and to implement the three core functions of public health: assessment, assurance, and policymaking. The main functions associated within LHDs are to provide services related to the prevention of disease, particularly communicable disease, as well as provide access and education to programs such as maternal and child health programs.[7]

In addition to the services provided to the community as a whole, LHDs are considered to be vital safety net providers to indigent populations. Lipson and Naierman provided information from a national survey indicating that 10 percent of LHDs are the exclusive providers for vulnerable populations within their community.[9] In a more recent report, the Institute of Medicine also indicated that local health departments provide direct medical services to those with limited access. Some of these services include: immunizations, well child services, nutrition programs (WIC), and testing and counseling for STDs.[1] LHDs are an important provider for the uninsured, the homeless, and immigrants, as well as populations with unique needs such as those with AIDS, STDs, or drug dependence.[1]

Due to changes in the market place, the amount of direct care provided by LHDs has been declining. The largest of these changes is the increase in Medicaid managed care, which has created competition for LHDs as well as other safety net providers.[1, 9] Lipson and Naierman, indicate that LHDs are at a disadvantage in competing in the marketplace due to how they are organized.[9] The affects of changes in the marketplace including Medicaid managed care, will be discussed further in this paper. It is important to note that it was difficult to find detailed information in the literature pertaining to LHDs, aside from the references cited above. Many of the articles reviewed only stated that LHDs were core providers, but were limited in their discussion concerning their role.

Other Safety Net Providers

Although public hospitals, community health centers and local health departments are considered core safety net providers and are most often mentioned in the literature, there are a number of other providers who make available essential services to vulnerable populations. According to an article by Richard Hegner, the Institute of Medicine received some criticism towards their recent report on the safety net regarding the emphasis on the core providers (public hospitals, community health centers, and local health departments). The article stated that the IOM focused the report mostly on Health Resources and Services Administration (HRSA) funded community health and migrant health centers, and other core safety net providers. The report provides little information on community hospitals, emergency rooms, and little emphasis on private versus public safety net providers.[6]

However, the Institute of Medicine does make note of the variation of core safety net providers across communities. The report indicates that some communities may consider school-based health programs, family planning clinics, and Ryan White AIDS programs as core safety net providers. They may also include teaching hospitals, community hospitals, and ambulatory care clinics. The report acknowledges that the committee chose to focus the project on the core safety net providers due to the variation that occurs within local safety nets.[1]

A number of articles included additional, often less mentioned, safety net providers. These providers include: private not-for-profit hospitals providing uncompensated care, private clinics and organizations providing free or discounted care, individual physicians offices, outpatient departments, Veterans Affairs, Indian Health Service, health care centers for the homeless, rural community hospitals, nursing centers, family planning programs, and religious affiliated institutions.[6-10, 23]

A few of these often less mentioned safety net providers are from the private market. According to some of the articles reviewed, these private safety net providers provide a substantial portion of safety net services.[10, 23, 24] In the book The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured, Stuart Altman and Stuart Guterman refer to some of these private providers, particularly private community hospitals, as "the hidden safety net".[25] Fishman also indicates that private not-for-profit hospitals provide a significant amount of uncompensated care.[23] Private physician offices also provide a substantial amount of uncompensated ambulatory care for the uninsured and for low-income individuals. In fact, a couple of articles indicate that a majority of ambulatory care delivered to the uninsured and Medicaid beneficiaries, is provided by private physicians.[10, 26]

Rural providers also play an important role in providing access to health care to rural residents. Physician resources in rural communities are limited and spread-out across a larger

geographical area. Ormond states that "the health care infrastructure in a rural community is the safety net, and to maintain one is to maintain the other." [18] This is especially true in smaller communities where providers serve all residents whether they are insured, uninsured, or publicly insured.[18] In addition, rural underserved areas may have a rural health clinic (RHCs). RHCs are designed to provide primary care services to rural residents who reside in these underserved communities.

Teaching hospitals are another safety net provider not mentioned as often within the literature. Teaching hospitals often provide a substantial amount of uncompensated care due to the availability of specialty services. Some of the services provided by academic health centers and teaching hospitals include transplants, trauma, and burn care.[19] According to a report by Darrell Gaskin, teaching hospitals were more likely to provide public health and specialty services compared to non-teaching hospitals, with the exception of alcoholism beds, obstetric beds, and births.[19] In addition teaching hospitals may be the only sources of these specialty services in some communities and regions.[1]

Populations Served By The Safety Net

In addition to determining who the safety net providers are, the next step is to determine whom these providers serve. The populations served by the safety net vary across communities as much as the safety net structure itself.[2] There are a number of different groups who are served by the health care safety net. The uninsured and the underinsured are the two groups most often referred to in the literature as recipients. However, there are a number of sub-populations among these groups that should also be addressed in order to gain a better understanding of who utilizes safety net services. This section will examine the uninsured and the underinsured broadly, as well as discuss the subpopulations that make up these two groups.

The Uninsured

The uninsured are the primary recipients of safety net services.[1, 2, 4, 6-9, 11, 27, 28] Prior to 1999, the number of individuals lacking health insurance has either been increasing or has remained unchanged since 1987. In 2000, according to the Census, there was 14.0 percent of the population who were uninsured, versus 14.3 percent the previous year. Although the number of uninsured has decreased recently, there still remains a large number of individuals who may experience difficulty in accessing needed care.[7, 24] According to the Census there are roughly 38.7 million people without health insurance.[29]

One particular gap that exists within the U.S. health care system is that some individuals do not meet the eligibility requirements for public-sponsored health care coverage, such as Medicaid or Medicare, or may have difficulty obtaining employer-sponsored health insurance.[6] Baxter and Mechanic state that Medicaid eligibility is an underlying factor of being uninsured.[2] Problems also exist in enrolling uninsured persons who are eligible for Medicaid.[6, 8] As a result these individuals remain uninsured and are dependent upon the health care safety net.

Why is the safety net an important source of health care services for the uninsured? Vieth states "Although the safety net system is fragmented – and in some cases financially unstable – it plays a critical role in providing primary and preventive health care to millions of people".[7] Within the literature there are a number of factors and characteristics that are

associated with being uninsured and how this can affect access to needed medical care. Some of the problems associated with being uninsured include:

- Problems with access [5, 6, 24]
- Low utilization of health care services [1, 5, 24]
- Delayed or forgone care [1, 5, 6]
- No regular source of care [1, 5, 6]
- Unmet health needs [1, 5, 30]

Geographic location can also be a factor related to accessing care and having no insurance. Using data from the Community Tracking Study (CTS), Cunningham and Kemper indicated that if you are uninsured, where you live may determine how difficult it is to access health care services. According to the data, 31 percent of uninsured persons reported difficulty in accessing care or had postponed getting needed care. Even more apparent at the community level, 40% of uninsured persons did not get needed care in communities such as Lansing and Cleveland, where as less than 20% did not get medical care in Orange County.[31] Some of these differences can be attributed to the variation in community characteristics and the available resources in these communities. [31]

Another issue regarding the uninsured population is the fact that they may not be financially attractive to some providers. Mirvis states "There has never been competition for the uninsured".[4] The Institute of Medicine similarly indicates "In a market-driven environment the uninsured, who do not represent a market force, are excluded."[1] As a result, the uninsured are dependent upon the safety net providers who have a legal mandate to provide services.[4]

The Underinsured

The underinsured are another group that is often mentioned in the literature as requiring safety net resources.[1, 2, 4, 6, 8, 9, 11, 27] However, the term underinsured is very broad. Most authors only mentioned the term "underinsurance" with no other explanation or definition. Hegner acknowledged the ambiguity of underinsurance by stating "far better data are available on the phenomenon of uninsurance than on underinsurance." [6] Barbara A. Ormond et al of the Urban Institute, referred to underinsurance as having limited insurance benefit coverage.[18] Baxter and Mechanic provided the example of underinsurance referring to mental health care as an indicator.[2] Mirvis also included the lack of mental health benefits as an example of underinsurance, and states that if there were a universal health plan, the safety net would still be necessary to provide access to these benefits.[4 18]

Other populations

There are a number of subgroups that make up the uninsured and underinsured populations. It is important to examine these specific populations in order to gain a better understanding of the barriers they experience in accessing health care. Some articles are more specific in identifying sub-populations of the uninsured and underinsured, which include minority and immigrant populations[7, 9, 11, 20, 30, 32], rural residents [4, 6, 7, 9, 11, 18], vulnerable populations such as HIV/AIDS patients who don't have adequate coverage [1, 2], and Medicaid populations.[1, 2, 6]

Minority and Immigrant Populations

Among the uninsured, minority and immigrant populations have disproportionately higher rates of uninsurance.[7, 20, 32] In 1999, 33.4 percent of the uninsured were Hispanic, and 33.4 percent of residents born in another country were uninsured compared to 13.5 percent of the native born population.[7] In another study on community health centers by Davis et al, over two-thirds of the patients seen in these facilities were of a racial or ethnic minority groups.[20] Lipson and Naierman indicate that communities with higher proportions of blacks and Hispanics have higher rates of uninsurance. Lipson and Naierman also point out that communities with higher rates of non-English speaking people will have a great dependence upon safety net providers.[9]

Language barriers account for access problems to health care among communities.[7, 11] When individuals have problems communicating in and understanding English, they may find it difficult to obtain needed health care services.[7, 11] As stated previously, community health centers are expected to provide translation services to non-English speaking patients in order to provide better access to primary and preventive care services.[7]

Rural Residents

Rural residents also face barriers associated with access to care. Rural residents are more likely than urban residents to be uninsured.[6, 11, 18] Employer-sponsored health care coverage is not as common in rural areas due to a high proportion of rural residents being self-employed or part of small firms.[18] Another barrier to health care services for rural residents include transportation, such as distances to providers as well as the lack or limited availability of public transportation.[6, 7]

Health care providers in rural areas are a necessary part of the rural health care infrastructure. By having local physicians present who can provide emergency services as well as primary care, rural residents do not have to travel great distances; however, the number and variety of providers in rural areas are more limited.[4] Ormond states: "Uninsured patients in rural areas turn to the same providers that uninsured patients use in other areas – community health centers, hospital emergency rooms, local health departments, and private providers. In rural areas, however, the number of providers is usually limited".[18] In some rural communities, all of the health care providers within that community are the safety net.[6, 18]

Vulnerable Populations

Vulnerable populations can include the uninsured, as well as the underinsured. The literature reviewed was limited in its discussion regarding additional vulnerable populations. The Institute of Medicine referred to vulnerable populations as "special-needs populations." The report focused on four such populations: children with special needs, people with serious mental illnesses, people living with HIV infection or AIDS, and homeless people. These particular groups have needs or conditions that can impede their access to health care services. The report also states "insurance coverage alone is often inadequate to ensure access for these populations who may require outreach and access to specialists or other support programs to meet their special needs".[1]

An interesting point from the IOM report regarding special-needs populations and Medicaid managed care programs is the recommendation for states to be cautious and evaluative

of these populations needs before implementing a managed care plan designed specifically for them. The report notes: "Special-needs populations in the safety net are vulnerable, first, by virtue of their poverty and, second, by virtue of the chronic illness, disability, or social circumstances that place them at increased risk of falling through the safety net."[1]

Baxter and Mechanic also make note of these additional vulnerable populations stating that persons with acquired immunodeficiency syndrome (AIDS), substance abusers, the frail elderly, low-income children and pregnant women, the homeless, and the mentally ill, are included within these extensive populations served by the safety net.[2]

Financial Aspects Of The Health Care Safety Net

As discussed previously, there are a number of safety net providers who administer care to those with little or no access to health services. The financing of the health care safety net is a core element to the viability of these safety net providers to provide care to vulnerable populations.[1, 5, 11, 12, 15] Cunningham and Kemper state some of the problems that safety net providers are beginning to face, all of which focus on some aspect of financial stability. These problems include: 1) reduced public subsidies for uncompensated care; 2) greater difficulty to shift costs; 3) increased competition for paying patients; and 4) increases in the number of uninsured.[5] There are a number of different federal, state, and local funding sources that providers depend upon to finance care to the uninsured, underinsured, and other vulnerable populations (please refer to Table 3 in Appendix). This section will focus on these various funding sources, as well as some of the issues associated with them.

Medicaid

One of the major sources of funding for the safety net is Medicaid.[1, 2, 4-6, 8, 9] Hegner states "no other funding source approximates Medicaid in importance for the safety net."[6] Vieth also notes that Medicaid is the primary source of funding for safety net providers.[7]

Medicaid funding can be either direct through Medicaid patient care payments, or indirect, through Medicaid disproportionate share hospital payments (DSH).[12] DSH payments are an important source of funding for hospitals to subsidize inpatient care to patients unable to pay for services. According to the National Association of Public Hospitals (NAPH), in 1999 Medicaid DSH payments accounted for 31 percent of the financing for uncompensated care at their member hospitals.[33] Hospitals that provide an overbalanced amount of care to uninsured patients receive these DSH payments, which can vary from state to state and hospital to hospital.[7] For example Lipson and Naierman provided information from a 1994 article[34] indicating the variation that exists among states. DSH payments ranged from $27 per uninsured person in New Mexico and $53 in Indiana to $835 in Massachusetts and $1,046 in Missouri.[9] There has been concern among safety net providers regarding the stability of DSH payments. In 1991 and 1993 changes occurred in federal law to limit the amount of DSH spending.[2, 6, 9] In addition, the Balanced Budget Act of 1997 has also reduced federal spending for DSH payments.[5, 7]

Federally qualified CHCs also depend on Medicaid as an important funding source for safety net services through cost-based reimbursement. Medicaid cost-based reimbursement, allows federally qualified CHCs to be reimbursed 100 percent of reasonable costs for services provided to Medicaid beneficiaries. The cost based reimbursement program is an important

source of funding for CHCs. As a result of this program, the care for Medicaid patients is not subsidized by grant funds, rather grant funds can be used to pay for care provided to the uninsured.[7]

Medicare

Another major source of safety net funding is Medicare. Similar to Medicaid, Medicare funding can be in the form of direct payments for patient care, or from Medicare DSH payments. Hospital who serve a substantial amount of low-income Medicare patients, receive additional funding as Medicare DSH payments.[4] According to Hegner, Medicare DSH payments are not as important to providers as Medicaid DSH payments.[6] NAPH indicates that Medicare DSH payments only accounted for 7 percent of the financing for uncompensated care at their member hospitals in 1999.[33]

Medical education adjustments are another indirect funding source from Medicare. Teaching hospitals often provide a large amount of uncompensated care as a result of the services available.[4, 19] Large teaching hospitals receive medical education payments as a source of revenue to subsidize care to vulnerable populations.[2]

Federal Grant Programs

In addition to Medicare and Medicaid**,** the federal government has a number of different grant programs available to safety net providers. These grant programs are targeted to specific services such as primary care, maternal and child health, family planning, and AIDS/ HIV. As mentioned previously, CHCs who meet the requirements to become federally qualified health centers receive 330 grant funds under the Public Health Service Act.[1, 6] CHCs obtain 30 percent of their revenue from federal grants.[2]

Other federal grant programs include Title V Maternal and Child Health Block grants, Title X Family Planning grants, Ryan White Comprehensive AIDS Resources Emergency (CARE) Act grants, and the Indian Health Service program. These programs were mentioned less in the literature reviewed; however, they are important sources of funding for specific programs.

Title V Maternal and Child Health Block grants provide health services to low-income and uninsured children with special needs as well as women and their families.[7] According to the Institute of Medicine's report Title V grant funds provide services that are often not covered by Medicaid programs.[1] The recipients of these grants usually include state health departments.[7]

Title X family planning program is another source of medical services for low-income or uninsured individuals. Title X funding is allocated to various providers of reproductive health services. According to Vieth, family planning clinics receiving title X funding are often times the entry point into the health care system for low-income individuals.[7]

Ryan White CARE program provides funding to states agencies and organizations providing services to persons diagnosed or living with HIV. Funding is also provided to states for AIDS Drug Assistance Programs providing access to drug therapies for low-income AIDS/HIV patients.[7]

Indian Health Service provides federal support to providers who render health care services to approximately 1.5 million American Indians and Alaskan Natives.[6] Hegner was the only reference that included the Indian Health Service as a safety net support, indicating that these services are available in 34 states, 37 hospitals, 64 health centers, 50 health stations and five school health centers.[6]

Additional Funding Sources

Among the literature reviewed, the authors provided other funding sources for safety net providers, such as private insurance payments, uncompensated care pools, cost-shifting, medical education payments, local tax assessments for public clinics and hospitals, state grants, and state and local subsidies.[1, 2, 5-7, 9, 12]

Many of the articles indicated state and local subsidies as important funding sources to safety net providers, however, the authors did not expound on what these subsidies specifically consisted of.[1, 2, 9] Gage and Regenstein, however, did indicate that state and local subsidies accounted for approximately 52% of the funding for NAPH member hospitals.[8] Lipson and Naierman provide some information related to local subsidies. They note that local tax dollars dedicated to subsidies in some communities are quite large ($180 million to Dade and Broward County public hospitals in Florida), while other communities get very little or no support at all.[9] An explanation for the little detail on state and local subsidies may be due to different subsidies that exist among states and communities. In addition, the articles reviewed, were focused on the safety net in general, versus articles that focus specifically on the financing mechanisms.

Measuring The Safety Net

In order to ensure that the safety net is able to accomplish its mission to care for those who have access barriers, there needs to be a way to measure and track its effectiveness. Monitoring the safety net can also provide information on the stability of safety net providers.[2] In reviewing the literature, it was difficult to find articles and studies that focused on ways to measure the safety net. The lack of safety net measures in the literature is most likely attributable to the fragmented nature and variation that exists across communities.[1, 2]

According to the IOM's report on the safety net, it is difficult to find comparable and adequate data to assess the financial and organizational status of safety net providers.[1] Traditionally much of the data available is from hospitals and other institutionally based providers.[1, 2] The IOM report states that HRSA provides the only nationally based data on community health centers (CHCs). However, this data may not be very reliable prior to 1995 (establishment of uniform data system (UDS)), and only provides information pertaining to federally qualified health centers (FQHCs) which, as already indicated, are just one of many safety net providers. Aside from these limitations, some articles did provide measures that could be used to monitor the safety net. This section will describe some of these safety net measures, as well as include a discussion of recommendations within the literature for more standard activities to monitor the safety net.

Six articles were chosen for this section in examining characteristics of safety net measures; refer to Table 4 for a complete description of these measures. These measures used can be divided into three categories: access to services, utilization of services, and capacity of providers. These categories are consistent with measures described by Long and Marquis.[28]

Access to Care

As shown in Table 4, there are seven variables within the reviewed studies that are associated with access to care. The majority of these variables focus on the ability of an uninsured person to obtain needed care, such as having a usual source of care, whether or not an individual had an ambulatory visit during the past year, and whether an individual had difficulty obtaining care or had unmet health needs.[5, 14, 27]

Population based surveys are often used as an approach in measuring access to care. Whitmore states that population based surveys include a number of access measures such as aspects of primary care, process of care seeking, barriers to care, and unmet health needs. [27] Forrest and Whelan examined primary care visits made to physicians' offices, hospital outpatient departments, and community health centers.[10] Their study focused on finding out the mix of patients who visited these primary care providers, and the services rendered.

Avoidable hospitalizations is another indicator of access to care, and can be obtained from hospital discharge data Whitmore defines avoidable hospitalizations as "a set of conditions that are considered treatable in ambulatory settings and for which hospitalization indicates a lack of access to high-quality primary care." Avoidable hospitalizations are outcome-based and can measure the quality of ambulatory care an individual is receiving, and the level of care management. In contrast, access measures used in population based surveys cannot provide information on the quality of care an individual is receiving and whether or not this care is received in an appropriate setting.[27] Whitmore includes uncompensated care as a measure of access to care. Uncompensated care is generally defined as the sum of bad debt and charity care. This particular measure could be viewed as an inaccurate method for measuring access to health services. Within her article Whitmore provides the following limitations to using uncompensated care: Changes in uncompensated care may not indicate changes in access; uncompensated care may underestimate the amount of free care given if government subsidies and grants are not counted in the total; and uncompensated care may overstate the amount of free care given, since bad debt may not be a result of providing free care to the indigent.[27] In contrast to this view, the IOM safety net report referred to a study by Weissman et al[35] finding that the majority of patients that incurred bad debt versus charity care, were below the poverty level.[1]

Utilization of Services

Two variables in Table 4 are related to the utilization of services. These variables include "state and local health and hospital expenditures as a percentage of total health spending" and "emergency and outpatient department use." Long and Marquis did not go into detail regarding the measure of "state and local health and hospital expenditures" and why this would be considered a safety net measure. It is possible that this could be a measure to determine the amount of public funds used to provide care to individuals who cannot afford to pay for health care.

Long and Marquis indicated that they would have preferred to useonly "pure" measures of capacity in their study, such as the number of public hospital beds; however, they stated that these measures were not always available. They provided the example that if they were to only include counts of the number of hospital and emergency departments, they would not be able to measure the number of patients that could be served. Instead, they used utilization measures,

rather than capacity measures, to make the differences in the number of facilities more standard.[28]

Capacity of Providers

"Capacity of provider" measures include variables focusing on the availability of services to populations with little access to care. As shown in Table 4 these measures include: the number of public hospital beds as a percentage of total hospital beds; the number of uninsured children served by Bureau of Primary Health Care (BPHC) supported health centers; and the number of National Health Service Corps (NHSC) providers in federal grant funded facilities. All of the capacity measures were from the Long and Marquis study. Similar to other measures within this study, Long and Marquis provided limited information on how they are defined as safety net measures.[28]

Additional Measures

In their article "The Status of Local Health Care Safety Nets", Baxter and Mechanic include another dimension to safety net measures that examines the level of need for safety net services. Baxter and Mechanic state four basic indicators of the level of need: 1) the number of persons uninsured; 2) the percent of the local population in poverty; 3) the prevalence of certain illnesses; and 4) the rate of underinsurance, such as lack of mental health services. The article states that the level of need for safety net services varies greatly across major metropolitan areas.[2] Areas with large concentrations of small employers, jobs lacking health insurance coverage, and immigrant populations, are more likely to require safety net services.[2]

What is Needed?

Information on the safety net is important for policy makers and researchers for their role of monitoring the safety net and the stability of safety net providers.[2] The measures referenced above include only some of the variables that could be used to monitor safety net providers and services. However, according to the current literature more information is needed to effectively monitor the safety net.[1, 2, 27]

As mentioned previously, much of the data that is available to monitor the safety net is hospital data. Baxter and Mechanic state that more outpatient setting data is needed, such as hospital outpatient departments, physicians' offices, community health centers, and other primary care locations. This type of data can provide information related to primary care services available to vulnerable populations. Other needed data includes information on the financial status of safety net providers, the amount of care provided, and the importance of varying funding sources. This information can help to determine the stability of the safety net and its providers.[2] In addition, Baxter and Mechanic note that more information is needed related to mental health, substance abuse, and senior and family services.[2]

The Institute of Medicine included recommendations on the need for more information.

> *"The committee recommends that concerted efforts be directed to improving this nation's capacity and ability to monitor the changing structure, capacity, and financial stability of the safety net to meet the health care needs of the uninsured and other vulnerable populations."*

The Institute of Medicine acknowledges the fact that no entity within the federal government has the responsibility of monitoring the United States health care safety net. The committee involved with this report recommended that an existing agency, or a newly created unit be assigned the responsibility of being a central body for the health care safety net, specifically with the assignment to create a systematic method to effectively monitor its status. The report states that there is currently no system in place that comprehensively tracks and reports the condition of the safety net on a national level. This newly created function would have the responsibility of monitoring safety net funding programs; monitoring existing data sets, as well as determining where existing data is inadequate; and the identification of failures within safety net systems and providers. Additional responsibilities are outlined in the report.[1]

The availability of information and data provides an important resource in determining if the health care needs of vulnerable populations are being met. Safety net providers have an invaluable role in providing care to populations with limited access to the health care system. By following the recommendations found in the available literature, policy makers and state and local leaders can develop mechanisms to better monitor this needed resource.

Additional Issues

The limitation of data and information is only one of the issues currently affecting the safety net. There are a number of other issues that have emerged from this literature review concerning the health care safety net and its ability to provide care to vulnerable populations. Our current health care system is organized in a way that requires dependence upon safety net providers from individuals lacking insurance, comprehensive insurance, or the ability to pay.[11] As a result there is concern regarding providers ability to cope with changes occurring in the health care market.[1, 9, 11] This section will examine some of these issues specifically looking at the forces affecting safety net providers, whether or not insurance coverage should be expanded, and the issue of how well community health centers are targeting vulnerable populations.

Factors affecting the safety net

There are three main factors most often mentioned within the literature that are attributable to the stress experienced by safety net providers. These factors include 1 increased penetration of managed care; 2 decreased financial support; and 3 an increase in level of demand.[1, 4-6, 8, 9, 11, 15]

Much of the concern that exists among safety net providers regarding the growth of managed care revolves around Medicaid managed care. There has been an increase of "non-traditional" Medicaid providers providing services to beneficiaries. This change in the market has led to increased competition for safety net providers who depend on Medicaid reimbursement.[8, 15] An example of this concern is with maternity services. Gage and Regenstein indicate that between 1990 and 1997, the number of births at National Association of Public Hospitals (NAPH) member hospitals has declined by more than 36 percent (approximately 1,800). This decline is attributable to private hospitals competing for uncomplicated Medicaid deliveries.[16] Norton and Lipson state that the increase of private providers competing for Medicaid beneficiaries is due to the penetration of managed care, as well as the decrease in reimbursement rates.[15]

Lipson and Naierman indicate that Medicaid managed care can either be an advantage or disadvantage to safety net providers, depending on community resources. For example in areas with a low supply of primary care physicians, managed care provides some advantage to safety net providers such as community health centers. However, in areas with a larger supply of primary care providers, managed care produces competition for safety net providers who depend on Medicaid beneficiaries.[9] In addition Lipson and Naierman state that community health centers are in a better position to compete for Medicaid managed care contracts due to their experience with Medicaid patients, as well as the availability of their primary care services.[9]

Decreased availability of Financial support is another factor causing stress among safety net providers. As discussed previously, there are a number of funding sources that safety net providers depend on, although, there is rising concern over their stability. As the number of uninsured increase, safety net providers depend more on grant funding, which can be unpredictable, and targeted to specific programs.[7] The decline of federal subsidies such as the DSH payments for inpatient care, and cost-based reimbursements to FQHCs threatens the pool of support to safety net providers. The IOM also indicates that as a result of managed care, there been a decline in the amount of uncompensated care or charity care provided by private physicians.[1]

Some safety net providers are developing strategies to address concerns related to the instability of financial resources.[2] For example, Baxter and Mechanic note that there is the belief that Medicaid DSH payments should be targeted better to the core safety net providers. They indicate that some states are examining ways in which the DSH payments can be used to finance primary care services.[2]

The increase in the level of demand for safety net services is another factor. Lipson and Naierman state that the primary determinants of demand on the safety net are the number and proportion of uninsured.[9] The Institute of Medicine also indicates that the level of demand is determined by the number of uninsured, as well as Medicaid patients and patients with special needs. The IOM reports that the increase in the number of uninsured is due to declines in employer-sponsored coverage and public coverage, as well as individuals who are uninsured for periods longer than a year.[1] As a result of these factors, safety net providers are seeing an increased number of individuals seeking uncompensated care.[1, 4, 15]

In addition to the increase in the number of uninsured, there is also the potential impact of underinsurance on the health care safety net as employers shift more costs to employees. Experts indicate that this shift in health care costs is the beginning of a trend that will likely increase in the future.[36] A reduction in health plan benefits to save costs could lead to more out-of-pocket expenses for employees, therefore increasing the number of underinsured individuals and the need for safety net services.

Expansion to Health Insurance

As stated above the safety net is impacted by access to health insurance coverage. It was interesting to find differing views on the expansion of health insurance coverage and efforts to strengthen the safety net. Cunningham and Kemper indicate that there is little understanding regarding the effectiveness of increasing subsidies to safety net providers as a way to improve access. These subsidies are directed at the clinicians rather than the uninsured.[5] Instead, they suggest that expanding health insurance coverage to the uninsured would be more effective in improving access to health care.

In contrast, Mirvis makes the point that even if there were a universal health care plan available, the safety net will still be necessary to provide non-covered services. For example mental health care services are often not covered in basic health plans. In addition, Mirvis points out that although there have been incremental steps taken to expand coverage the number of uninsured and underinsured is still increasing.[4] Gage and Regenstein also acknowledge the importance of strengthening the safety net by stating:

> *"This time around, decisionmakers must understand that the debate needs to extend beyond expanding insurance coverage, to include support for current and future initiatives to strengthen and assure broader access to safety –net providers."* [8]

In an article titled "Insuring the uninsured: Time to End the Aura of Invisibility", Kevin Grumbach provides an interesting perspective on the issue of insurance coverage and the safety net, by stating that the safety net is essential in providing services to the uninsured; however, "cannot fully compensate for the lack of universal coverage." Grumbach acknowledges that health insurance provides access to care, but does not ensure adequate access to quality care.[26]

The idea of expanding insurance coverage is important when examining issues of access to care.[26] However, insurance coverage is only one aspect of access to care as shown by Vieth.[7] Access to care also includes factors such as employment, lack of providers, and cultural and language barriers.[7] These factors provide some evidence that just expanding health insurance will not eliminate problems in access to care.

Community Health Center Use

As mentioned previously, community health centers play an important role in providing primary and preventive services to the uninsured and other populations. However, are these centers able to reach a majority of these vulnerable populations? According to an article by Cunningham, CHCs serve only a small percentage of uninsured individuals (6.5 percent) nationally. Cunningham indicates that location could be an explanation for the low number of uninsured served by CHCs, stating that these facilities are not in every community and many uninsured live outside medically underserved areas where the centers are located.[37]

The availability of primary care services is an important resource for populations with problems accessing care. The uninsured have been shown to be more likely to delay or put off receiving care increasing the likelihood of emergency room use and avoidable hospitalizations.[1, 5, 6] In the areas where CHCs do exist, the percentage of uninsured served is higher (40-45 percent).[20, 37] However, as Cunningham has indicated, there are many uninsured that have income levels above the federal poverty level and live outside the underserved areas targeted by community health centers. In a study by Forrest the Bureau of Primary Health Care (BPHC) estimates that only 1 out of 6 who lack access to primary care receive services from federally funded CHCs. According to the study the majority of the primary care safety net services are provided by hospital outpatient departments, physicians' offices and community clinics.[10]

The policy implications surrounding these findings raise questions regarding the placement of community health centers, and how populations without access to a community health center can obtain primary care services. It is important to note that the articles by Cunningham and Forrest only provide information regarding CHCs covered under Sections 329

and 330 of the Public Health Services Act. There are a number of states that have community health centers that do not receive grant funding from the federal government, and are not considered Federally Qualified Health Centers. Therefore, the percentage of uninsured served nationally by CHCs (federally funded and non-federally funded) could be somewhat higher.

Conclusion

It is evident that the health care safety net is a complex and variable system. Because there is variation in these providers across state and local communities, difficulty can arise in trying to monitor how well the safety net is reaching its target population. This review provides an outline of issues regarding the scope of the health care safety net. The first main point addressed is the fact that the safety net is difficult to define. At this time, there is no standard definition of the safety net system, which is most likely due to the fact that the safety net varies greatly among communities.

A second point discussed is that there are varied providers who participate in the mission of providing health services to vulnerable populations. Although public hospitals, community health centers, and health departments are the core providers, there are also a number of other providers who contribute to the mission of the safety net. These other providers include private providers (such as private hospitals, outpatient departments, and physician offices), teaching hospitals, family planning clinics, Indian Health Service departments, school-based health centers, and health care centers for the homeless. The rural safety net is also unique in that each provider is considered a safety net provider.

Another important finding in this review is the number of subgroups dependent upon safety net providers, which make up the uninsured and underinsured populations. These groups include minority and immigrant populations, rural residents, and other vulnerable populations such as AIDS patients and the homeless. It is important for policy makers and community leaders to be aware of which populations in their area are in need of safety net services, and how the barriers to these services can be removed.

Another important finding is the varied funding sources that safety net providers depend on. Federal, state, and local grant and subsidy programs are vital sources of revenue for providers engaged in the mission of providing the safety net services. However, these financial sources are often unstable and can vary among communities and providers within communities. Also, some communities invest more resources into the safety net, compared to other communities, making it difficult to capture and monitor changes in resources used to finance the safety net.

In addition to developing a comprehensive picture of what the health care safety net is, this review addressed a number of issues. One particular issue is the difficulty of monitoring the effectiveness of the safety net. As indicated, there are little data currently available to monitor certain aspects of the safety net. The majority of data represents financial and utilization data from hospitals and federally qualified health centers. Additional data is needed to determine how successful providers are in reaching out to all vulnerable populations. Another issue is the pressures currently affecting safety net providers. Many of the articles reviewed indicated three main factors that are creating pressure for safety net providers: increases in managed care, decreased financial support, and an increase in the level of demand. Finally, issues identified in the literature on increasing access to care were discussed. This included whether health

insurance coverage should be expanded or not, and the status regarding community health center use.

Recommendations

The purpose of this paper is to provide an overview of the U.S. health care safety net, and to provide information on how the safety net can be strengthened. As a result of this literature review, there are three main recommendations directed to researchers and policy makers.

More research is needed on developing specific measures to monitor the safety net. In reviewing the literature, few articles actually focused on developing measures to effectively monitor the safety net. Although variations exist, there may be certain variables that are consistent across communities, such as provider resources and demands on these resources. It is recommended that further research be conducted to develop aggregate measures of the safety net that can apply to all communities in order to monitor the progress, capacity, and effectiveness of the safety net.

Additional research pertaining to financing mechanisms at the state and local level. According to the articles reviewed, the majority of information regarding funding sources was available on federal grant programs and subsidies; however, little detail was given regarding local funding sources. Since the safety net is by nature more of a local system, it is important to examine what the funding resources are at the state and local level. The research that is recommended will be specific to the communities that are studied, but will provide important information on the resources that safety net providers depend on.

State, community, and public health leaders should examine how their communities are responding to the needs of vulnerable populations, specifically in how they support the local health care safety net. In their article "The Status Of Local Health Care Safety Nets", Raymond Baxter and Robert Mechanic touch on the idea of community support by stating:

> *"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."* [2]

Community and public health leaders have an important role in determining the status of the safety net in their areas, and in developing mechanisms to strengthen and maintain it.

In conclusion, the safety net is a vital resource to individuals who experience barriers in accessing health care. Charles Oberg questions the analogy of a "safety net" as the medium for catching people who fall through the cracks of the U.S. health care system. Oberg states that a net is made up of loosely woven strings in which the smallest of things can fall through. According to Oberg, the safety net is not capturing everyone who is in need of medical care.[38] It is important that efforts are made to strengthen this "safety net."

It is also important to note that the health care safety net is not only beneficial to vulnerable populations, but plays an important role in ensuring the health of the public as a whole. Hegner and Lurie described the public health benefits available as a result of the health care safety net. Hegner indicates that one of the roles of the safety net is to prevent the spread of communicable disease, such as sexually transmitted diseases, measles and influenza. Without safety net providers, there is an increased risk of the general public being exposed to these conditions.[6] Lurie also points out the important services provided by safety net providers such as immunizations, disease prevention, and oral and mental health services. All of these services

contribute in some way to society as a whole. Lurie emphasizes that not every one needs to be a user of the safety net in order to benefit from its purpose.[11]

The health care safety net plays an essential role in our health care system by increasing access to care. Policy makers, researchers, and public health administrators have the responsibility to ensure that resources are available for the safety net to function within our current health care system. As Mirvis states "What is needed is a public commitment to the care of those who, for whatever reason, have fallen off the mainstream tightrope and depend upon the safety net for their very survival." [4] Strategies should be developed to strengthen the safety net in order to eliminate some of the barriers that vulnerable populations experience in obtaining health care services.

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