Commentary—The History and Contradictions of the Health Care Safety Net

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What is the health-care safety net in the United States, why is it necessary, how did it arise, and what is its future?

In this issue, Jacobson, Dalton, and Berson-Grand (2005) present a picture, within one state, of the current challenges faced by the safety net, which they define as “those organizations and programs, in both the public and private sectors, with a legal obligation or a commitment to provide direct health care services to uninsured and underinsured populations.” The researchers have used qualitative methods to collect and to analyze data from interviews with representatives from a spectrum of safety net organizations. The article conveys a convincing overview of the chronic crisis that such organizations endure. While the study focuses on selected organizations within one state only, those who work in safety net organizations throughout the United States will recognize that problems in Michigan resemble those of many other organizations that try to serve the underserved, especially in poor and minority communities.

On the other hand, readers based outside the United States may become surprised by these troubles of the U.S. safety net. Among economically developed countries, such difficulties arise only in the United States. All other developed countries have enacted national health programs that assure universal entitlement to health-care services. These national health programs do not completely eliminate access barriers. For instance, several countries have not corrected the barriers rooted in geographic isolation of rural communities. Moreover, universal entitlement does not eliminate social class and ethnic/racial disparities in health-care outcomes, which derive more from socioeconomic hierarchies than from inaccessible services (Waitzkin 2001; Bodeheimer and Grumbach 2002; Isaacs and Schroeder 2004; Navarro 2004). The Michigan study, however, will add to the voluminous literature, over at least three quarters of a century, which demonstrates an urgent need for a national health program in the United States (Himmelstein and Woolhandler 2001; Waitzkin 2001; LeBow 2003).

In this context, the future of the safety net becomes clearer. With a national health program, a safety net constructed to serve the more than 40 million people without health insurance and an equivalent number who remain underinsured (including people who write for and read this journal) would become mostly unnecessary. Without a national health program, safety-net organizations throughout the country will continue to struggle with the challenging, chronic problems of survival and responsiveness described in the Michigan study.

Because the Michigan study tries to portray the safety net at a single point in time, the article does not capture the history and structural contradictions that have faced safety-net organizations during the past century. Actually the problems portrayed in this article have existed over a long period of time and have reflected socioeconomic conditions that go beyond the safety net itself. The remainder of this editorial reviews some of this history, as well as the structural contradictions underlying the chronic crisis of the U.S. safety net.

SOCIAL CONTRADICTIONS THAT AFFECT THE SAFETY NET

A series of social contradictions affect the safety net (Waitzkin 2000). Uneven economic development largely determines the availability of services. Geographical areas that face shortages of health workers and facilities tend to be the same areas that are most depressed economically. Monopoly capital in the health sector leads to a concentration of financial resources in a small number of medical centers and corporations. This concentration means that costly, technologically oriented medicine flourishes but low-income and minority communities lack needed services. Professional education, which emphasizes advanced technology and specialization, reinforces the effect of uneven development. After specialized training in medical centers, practitioners often are reluctant to work in areas without nearby hospitals and medical schools. Inequalities in access to services continue to be rooted in patterns of geography, class structure, and racism.

The private–public contradiction also affects the safety net. The private sector is based in private hospitals, private practice, and corporations that provide services (e.g., managed care organizations), manufacture medical products, or control finance capital. As part of the state, the public sector functions through public expenditures and practitioners in public institutions.

The contraction of public hospitals, clinics, and services is the grim underside of private expansion. While private facilities enlarge, often with public subsidies such as tax-exempt status and funding from public trust funds like Medicare and Medicaid, public health-care institutions tend to deteriorate. The decline of public medical facilities goes hand in hand with cutbacks of other public services. Economic instability contributes to the recurrent financial crises of many cities and counties. With these crises, it becomes more difficult to maintain public services of all kinds. Contraction of public medical care is only one manifestation of the general fiscal crisis in the public sector.

PUBLIC HOSPITALS

Public hospitals in the United States have a long history that dates back at least to the eighteenth century. They arose originally in major cities along the East Coast. The motivations of their founding were complex. An important goal was the control of infectious diseases. Tuberculosis, typhus, syphilis, and other infections periodically swept through urban areas. Contagion among the poor threatened the wealthy; infections often spread from poor neighborhoods to wealthier ones, and large-scale epidemics interrupted commerce. One rationale for public hospitals was to provide free or inexpensive medical services to the poor, as a method to prevent the spread of infections.

Humanitarian goals also influenced the founding of public hospitals. Ethical norms in the medical profession called for physicians to devote a specific, though small, proportion of their time to the care of indigent patients. Professional leaders encouraged doctors to offer charitable services within public hospitals and clinics. Patients who used these facilities traditionally provided “teaching material” for medical students and doctors in training. Participation by the poor in medical education was seen as an appropriate exchange for free or inexpensive services. Wealthier clients generally received care from practitioners who had obtained training in charitable institutions. Incentives for the formation of public hospitals, then, included a variety of practical and ethical considerations (Rosenkrantz 1972). By the early 20th century, public hospitals existed in most major U.S. cities or counties.

The decline of public hospitals did not begin until the mid-1960s, with the passage of Medicare and Medicaid legislation. These laws provided publicly financed insurance for indigent patients, who could use their benefits to obtain services from private practitioners and private hospitals in addition to public institutions. Public expenditures for health care increased drastically

after the mid-1960s, and these funds increasingly went to private practitioners and private hospitals. With public insurance, charity medicine in theory was no longer necessary; poor patients could be “mainstreamed” into the private sector. Other motivations for public hospitals also were less keen than previously. With better sanitation and antibiotics, epidemics were not important public health problems. Medical education could take place in private hospitals affiliated with medical schools, where indigent patients now would bring with them their public insurance benefits. In short, by the early 1970s several prior rationales for public hospitals weakened.

The deepening fiscal crisis of cities and counties, coupled with the availability of public insurance, has led to a gradual contraction of public hospitals, clinics, and services. The most common form of contraction involves cutbacks in facilities and services. Outpatient clinics associated with public health departments, for instance, have reduced their hours and staffing. Preventive and outreach programs have been phased out. Regarding inpatient care, many public hospitals have reduced the number of beds available for patients needing hospitalization.

What happened to patients who previously would have used such hospitals and clinics? Clearly, private hospitals do provide services to some indigent patients with Medicare and Medicaid funding. However, there is also evidence that many clients who previously would have obtained care from public hospitals have not received adequate attention in the private sector. Several groups of patients typically cannot afford private fees, do not hold private insurance, and are not eligible for public insurance programs. For instance, many of the “working poor” have incomes that place them slightly above the poverty level and yet disqualify them from Medicaid eligibility. Members of minority groups, especially those who do not speak English, often face difficulties in using private hospitals, which historically have made little effort to hire minority workers or to provide bilingual services. Private hospitals usually are located in wealthier neighborhoods that are distant from urban and rural areas with low-income and minority populations. Geographic inaccessibility hinders the use of these private facilities, even when patients qualify for public funding. Legally, individual doctors and private hospitals may refuse care to patients covered by Medicare and Medicaid; in some areas of the country, practitioners and hospitals either decline to see publicly insured patients or limit such patients to a fixed proportion of total visits. Despite national “anti-dumping” legislation, private hospitals and clinics still try to transfer uninsured patients to the public sector. Many states have reduced their financial contributions to the Medicaid program. Both Medicaid and

Medicare frequently pay less than prevailing professional fees; in these situations, patients often receive bills for the uncovered portion. In short, a series of obstacles hinder patients from utilizing services in the private sector.

Such problems become even more severe when public hospitals actually close. Municipal or county hospitals have closed in New York City, Philadelphia, Detroit, Los Angeles, and several other large cities, as well as smaller cities and rural areas. In some cases, the planned closure of public hospitals has led to protests by community residents that occasionally have prevented the disappearance of these facilities. In other cases, protests have failed. The likelihood of closing public hospitals is directly related to the fiscal crises of cities and counties. Wealthier communities with a stronger tax base tend to keep public hospitals open and sometimes even enlarge them. When cities and counties encounter greater economic difficulties, public hospitals close more frequently (Shonick 1979; Bindman, Keane, and Lurie 1990).

Another change affecting public hospitals involves the privatization of ownership and control. Privatization refers to the purchase of public hospitals by private corporations or the assumption of administrative responsibility by private management firms. Under either arrangement, city or county funding continues to flow into the hospital for health services, but the control of day-to-day operations changes from a public agency to a private entity. A common justification for the conversion to private control is that private management is less bureaucratic and more efficient than public administration. In fact, studies of private management show costs that are equal to or greater than those of public management and negligible improvements in quality (Waitzkin 2000).

After public hospitals are privatized, uninsured patients are supposed to receive services with financial subsidies from city or county governments. Investigations of several counties in California where privatization has occurred show that many fewer uninsured patients used privatized facilities than those who formerly used the hospitals when they were publicly owned and controlled. What happened to these patients is not entirely clear, but available evidence indicates that uninsured patients frequently are unaware that they can obtain care at privatized hospitals which receive county or municipal funding (Bindman, Keane, and Lurie 1990). Public funds available for uninsured patients at privatized hospitals seldom are publicized.

To summarize, public medical contraction has taken place in many parts of the United States. This trend has been intimately tied to the general economic crisis of local governments, most apparent in communities with more severe financial difficulties. Despite the availability of public insurance under Medicare and Medicaid, private hospitals have tended to dump uninsured or

otherwise undesirable patients into public hospitals. Public hospitals themselves have been weakened by cutbacks in facilities and staffing; frequently, they have closed altogether. Some public hospitals have converted to private ownership and/or control. Although this arrangement presumably provides payment for poor and uninsured patients from city or county funds, such patients often have not understood their eligibility for these services and have not used privatized facilities. Resistance by community residents and public-sector workers in some instances has stopped or delayed cutbacks, closures, and privatization. In many communities, however, the erosion of public-sector medicine has continued, and the detrimental effects of public contraction have become clear.

COMMUNITY HEALTH CENTERS (CHCs)

CHCs have appeared in many parts of the United States. They now exist in rural and urban areas that previously lacked regular and accessible services. These clinics differ in their clienteles, organizational structure, and political orientation. Many of them have created remarkable accomplishments, and most suffer from commonly shared problems.

The private-public contradiction has created an incentive for the formation of CHCs. Private medical centers have expanded while leaving the health-care needs of the poor and minorities largely unmet. Public hospitals, which formerly provided services to these groups, have contracted. While CHCs contribute a partial response to the deficiencies that the private-public contradiction fosters, they remain a fragile and incomplete solution.

The history of CHCs in the United States goes back to the late nineteenth century and in Europe even earlier. In North American cities, they began as an extension of settlement houses. These organizations, usually located in poor and immigrant neighborhoods, offered charitable relief and assistance in housing and employment. Medical programs received financial support from private philanthropy and public health departments. As in the case of public hospitals, an important motivation for the formation of CHCs was the prevention of infectious diseases that could spread to wealthier neighborhoods and interfere with commercial activities. Later, during the first two decades of the twentieth century, CHCs became stronger, reflecting the social reformism of the Progressive Era and an emphasis on uplift of the poor. Medical reformers of this period saw the local clinic as a focus of community life and an institution that, along with other charitable services, would help people overcome the effects of poverty. Some clinics employed community

residents in paraprofessional roles, and some adopted procedures of democratic policy making by residents and clinic workers. Although CHCs formed in many North American cities, they were short-lived. With the Great Depression, funding dwindled, and most clinics that opened during the Progressive Era ceased to exist (Stoeckle and Candib 1969; Hollister, Kramer, and Bellin 1974).

The political turbulence of the late 1960s and early 1970s played a major role in the reemergence of CHCs. The civil rights movement led to a growing recognition that inadequate health care was one of many manifestations of racism in North American society. Several militant organizations started medical programs to serve the needs of minority groups. For instance, the Black Panther Party opened clinics in Chicago, New York, Boston, and other cities. These clinics offered primary care and preventive services. Volunteers usually staffed the clinics; the party organized community-based governing boards to make policy decisions. Services were given free or with nominal charge. While the Black Panther clinics responded to black communities, the Young Lords Party and United Farm Workers Union started health-care programs to serve mainly Latinos. Other CHCs served American Indians, Asians, and other minorities.

Additional political movements during this period generated new clinics and health-care programs. The women's movement in particular revealed gaps and insensitivities in obstetrics and gynecology. Sexism in medicine excluded women from professional training and fostered practices that women perceived as degrading. In both urban and rural areas, feminist organizations began to form health-care agencies to address these problems; women practitioners generally served women clients. Most feminist clinics developed educational programs, so that laypersons could learn diagnostic procedures and treatments. Again, these programs frequently used volunteers, who provided services with no or minimal expense to clients.

The countercultural movement also was an impetus for CHCs. A critique of modern medicine was one component of a more general criticism of technologically oriented culture. From this standpoint, specialization and technology were dehumanizing features of medicine that required resistance. Advocates of the countercultural approach correctly pointed out that alternative healing traditions—including homeopathy, chiropractic, herbal remedies, and non-Western methods like acupuncture and meditation—had been suppressed in the United States, even though their effectiveness had not been evaluated systematically. In several areas, countercultural clinics started to provide alternative forms of healing. These “free clinics” gave services without cost to clients, but the symbolism of free care also extended to freedom from stifling qualities of mainstream medicine.

Minority group organizers, the women's movement, and the counter-cultural movement usually favored voluntary services and self-sufficiency. During the same period, however, a major expansion of government and philanthropic financing for community medicine occurred. Funding policies acknowledged that poverty, racism, and geographic isolation were associated with inaccessible medical care and higher rates of morbidity and mortality. New medical programs often followed urban riots that focused worldwide attention on social class deprivation and racism in the United States. Many health initiatives during the late 1960s and early 1970s led to the creation of CHCs. Local clinics received funds from the Office of Economic Opportunity, the Model Cities programs, the Department of Health, Education, and Welfare, the Department of Housing and Urban Development, revenue-sharing moneys, the National Health Service Corps, and other federal sources. Private philanthropies also made contributions. In large part a response to political unrest, public and philanthropic spending encouraged the growth of clinics in size and number. By the 1970s, more than 1,000 CHCs were serving clients.

Although CHCs show enormous variety, they share certain characteristics. In general, they emphasize family care and primary services. This emphasis responds to the difficulties of specialized and technologically oriented practice based in hospitals and medical centers. At CHCs, clients and their families can consult a primary care practitioner who acts as a generalist, caring for most problems and referring patients to specialists only as required. The clinics also encourage new roles for health workers. "Mid-level" practitioners—including physicians' assistants, nurse practitioners, midwives, and allied paraprofessionals—take on greater responsibility for patient care. Although these practitioners work under the supervision of physicians, they generally see patients on their own, develop a regular group of clients, and consult with a supervising doctor. Similarly, the clinics offer training and employment for community residents. People without formal professional education can obtain jobs as medical assistants, outreach workers, receptionists, laboratory aides, and related roles. In addition to employment opportunities, the education that clinics provide helps some workers later to enter professional schools of medicine, nursing, and allied health-care disciplines.

CHCs usually improve the accessibility of medical care. Many clinics have opened in urban or rural areas that previously lacked services. Most clinics charge low fees on a sliding scale for uninsured clients. The clinics seek external funding to supplement payments from patients, so that financial barriers do not prevent clients from receiving needed care. Clinics rarely if ever

turn away patients who are unable to pay, even though this policy creates continuing problems of financial stability.

The clinics' policy-making structures usually foster accessibility and responsiveness. A governing board, composed largely of "consumers" elected by the local community, sets formal policy for most clinics. The actual power exercised by these boards varies. Coupled with the employment of local residents as staff members, however, community boards offer a mechanism by which clients can make their needs felt and achieve greater accountability.

Despite these common characteristics, as shown in the Michigan study, CHCs are quite diverse. Many of them serve specific minority groups. Others are women's clinics. "Free" clinics often focus on alternative medicine; their clients usually are young people with countercultural concerns. Some clinics have organized to deal with the needs of the elderly and disabled. Funding comes from different sources. Most clinics adopt a sliding fee schedule for clients with low incomes; if patients have third-party coverage, the clinics usually submit bills to Medicare, Medicaid, and private insurance companies. Grants from government agencies and foundations often support clinics with indigent clients. There is also diversity in governance and policy making. Some clinics have formed as one of several projects started by minority organizations, women's groups, community associations, unions, and similar organizations whose purposes go beyond health care alone. Such clinics generally have strong governing boards that set policy. Other clinics have emerged from the initiative of government or philanthropic agencies. Although consumers usually sit on the boards of these institutions, major directions of policy frequently come from the external funding agencies.

CHCs face typical and chronic problems. The roots of many of these problems include the same social contradictions discussed earlier. For example, the private-public contradiction means that public support for CHCs remains constantly tenuous. Although government funding may increase temporarily, especially in response to political unrest, public money is always subject to cutbacks and therefore is undependable. Because of cutbacks in federal funding during the past decades, most CHCs have had to reduce services, and many closed altogether. Meanwhile, the public subsidies of private hospitals and private practice—including grants for construction, tax advantages from nonprofit status, and reimbursement under public insurance programs—have continued more or less unabated. CHCs' financial insecurity does not simply reflect short-term fluctuations in political climate or economic

conditions. Instead, this problem is an inherent feature of the private–public contradiction that affects the health-care system as a whole.

Uneven development is another social contradiction that perpetuates the CHCs' financial problems. The provision of services to poor people is usually one of the clinics' explicit goals. To increase accessibility, clinics usually are located in communities with a large proportion of minority and indigent residents. The communities most in need of accessible and inexpensive care are least able to provide direct financing for these services. Indigent communities lack medical facilities in large part because they lack financial resources. To a great extent, funds must come from outside these communities if local clinics are to survive. This dilemma means that CHCs are highly dependent on external funding sources and that financial self-sufficiency is extremely difficult to achieve. While wealthier communities can continue to support private practitioners and hospitals, economic underdevelopment leads to chronic insecurities for clinics in low-income communities.

In short, fund-raising becomes a constant struggle for CHCs. This struggle involves not only seeking financial support but also meeting the demands of funding agencies. Almost all external funding is contingent on the preparation of extensive reports documenting the services provided. Many agencies require audits of clinical practices, high standards of "productivity" (in numbers of patients seen per unit of time), evaluation procedures, and data collection. Such requirements differ by funding agency. To meet these provisions, clinics must use the time and energy of staff members in activities that funding sources demand but that may not be related to clients' needs. Financial dependency implies major administrative responsibilities, both to obtain funds and to meet funding agencies' requirements.

Administrative tasks add to the inherent difficulties of providing clinical services to clients who are poor and of minority background. Patients who use CHCs often present medical problems that are challenging, both technically and in their social dimensions. Because clients frequently have had little prior access to medical services, their problems tend to be complex and severe. The challenges that clients raise are both exciting and exhausting. Demand for accessible, inexpensive, and culturally sensitive services leads to arduous workloads. Workers at CHCs often take on advocacy roles to help clients meet their needs. Clinics also organize educational and outreach activities that emphasize prevention and participation in policy making. There are few financial rewards for working in CHCs; tight budgets and insecure funding constrain salaries. For workers committed to the goals of CHCs, patient care can be gratifying. But the burdens of administration, technically complex problems,

harsh working conditions, and low pay can be wearing. Even aside from other sources of instability, the nature of work in these clinics makes it hard to maintain continuity of staffing. "Burnout" of professional and nonprofessional workers is a common phenomenon.

The most important problem of CHCs is that they do not achieve a unified health-care system. Whether a clinic forms in a given geographic area depends largely on the initiative of local residents. Many areas still lack rudimentary facilities. CHCs rarely can provide comprehensive services to all residents of a locality. Clinics formed at local initiative inevitably leave gaps in care.

CHCs do not substitute for a comprehensive system of health care that would assure services regardless of geography, income, or ethnicity/race. As discussed earlier, other economically developed countries have integrated CHCs into a national health program. Although several proposals have called for a similar approach in the United States, there has been little progress toward this goal so far. Without a unified health system, the health-care safety net will remain isolated and vulnerable.

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