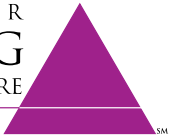


Protecting the Hospital Safety Net

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In 2000, the Institute of Medicine (IOM) released a report, "America's Health Care Safety net: Intact But Endangered," noting that in the absence of universal health care coverage, a patchwork of safety-net hospitals, clinics, and physicians' offices serves as the default system of care for millions of low-income and uninsured Americans. The IOM defined safety net providers as those that by legal mandate or stated mission offer care to all patients regardless of ability to pay, and thus have a substantial portion of uninsured, Medicaid, and other vulnerable patients.¹ The report found these providers to be neither uniformly available throughout the country nor financially secure, supported by complex financing options that vary dramatically from state to state and community to community.

There have been a number of more recent reports that raise additional flags about the current state of the health care safety net, in particular the hospital safety net. For example:

- In February 2007, the Lewin Group, in a report on Illinois' certificate of need (CON) program, noted that "of greatest concern to us is the financial health of safety-net hospitals. For certain of these hospitals, who may be struggling to survive already, such new pressures (increased competition) could lead to failure. This failure could force the remaining providers to serve an ever-larger number of less profitable patients, which could lead to a cascade of failures,

starting in the inner city and potentially radiating out to more distant areas ... "

- In March 2007, Standard & Poor's reported that "the credit gap between U.S. not-for-profit health care's haves and have-nots continues to widen. And if the general economic environment becomes less favorable ... this will likely trigger a new wave of mergers, closures, and bankruptcies."
- In May 2008, a researcher reported in the *Journal of the American Medical Association* that the quality of care in safety-net hospitals is lagging well behind that of other hospitals—a situation that will lead to payment penalties under pay-for-performance policies and which will further impair safety-net hospitals' abilities to improve quality.
- In July 2008, a *Washington Post* article reported that six nonprofit hospitals in New Jersey had closed in the past 18 months, with half of the remaining operating in the red. Some interviewed for the article said they favored the closures on the grounds that they represented a "period of consolidation to make the system more rational and efficient" others said they opposed the closures because they "smack of the final solution for urban centers ... genocide lite."

The gaps in financial health between have and have-not hospitals are confirmed in the most recent available data.² In 2006, the median (50th percentile) total income margin for all hospitals was 3.5%; however, the 25% of hospitals at the low end of the range had a total income margin of *less than 0.5%*, and the 25% of hospitals at the high end of the range had a total income margin of *more than 7.5%*. Thus, the gap in margins between these two categories was more than seven percentage points. For-profit hospitals showed significantly different margin levels and gaps: a total income margin of less than -1.6% for the lowest 25th percentile, and more than 12.8% for the highest 25th percentile, with a gap greater than 14 percentage points.

What accounts for these gaps? Are the have-not hospitals safety nets? Are there safety-net hospitals that are not have-nots, and if so, why? Should the current complex patchwork of federal, state, and local government policies that transfer revenues for various categories of hospitals be replaced? What role has and should the nonprofit health care sector play in protecting the

hospital safety net? These are among the issues explored in the following discussion, another in *Inquiry's* ongoing Dialogue series, cosponsored by the Alliance for Advancing Nonprofit Health Care to provide a variety of voices on important nonprofit health care issues.

The panelists for this discussion, held on October 22, 2008, were: **Ron Anderson, M.D.**, MACP, president and CEO, Parkland Health & Hospital System, Dallas, Tex.; **Peter Cunningham, Ph.D.**, senior fellow at the Center for Studying Health System Change, Washington, D.C.; **Paul Hofmann, Dr.P.H.**, president of the Hofmann Healthcare Group, Moraga, Calif. and former distinguished visiting scholar at Stanford University's Center for Biomedical Ethics; **Wayne Lerner, Dr.P.H.**, president and CEO of Holy Cross Hospital, Chicago, Ill.; and **Kevin Seitz**, executive vice president, health value enhancement, Blue Cross Blue Shield of Michigan, Detroit, Mich. **Bruce McPherson**, president and CEO of the Alliance for Advancing Nonprofit Health Care, moderated the discussion.

Bruce McPherson: *Let's start with the basics. How would you define or distinguish those hospitals that are true safety nets? Are they the same as the so-called have-not hospitals that are in financial distress?*

Ron Anderson: In a recent article in *Texas Medicine*, we broke down all urban hospitals into categories. We defined three categories of safety nets, taking into consideration their charity care and Medicaid patient mix, relative geographic isolation, and provision of one or more of four service lines: trauma care, burn care, neonatal intensive care, and pediatric intensive care. We found that of the over 200 urban hospitals in Texas, only 54 fell into one of these three safety net categories. So less than 10 percent of the urban hospitals carry the lion's share—a disproportionate burden—of the charity care and care to Medicaid patients in the state. We did not categorize rural hospitals, because most in our state are generally recognized as safety nets, with perhaps even more problems than we urban safety nets face.

We need to avoid automatically equating distressed hospitals with safety-net hospitals. Some distressed hospitals are not safety nets, and some safety-net hospitals are not currently distressed.

Paul Hofmann: Also, there is often a mistaken impression that public hospitals are serving the role of safety nets exclusively—which, as Wayne Lerner’s hospital exemplifies, is not the case.

Kevin Seitz: In Michigan we have rural hospitals in some communities that probably shouldn’t have a hospital. Under Medicare we have tried to help rural safety-net hospitals through “critical access” provisions, but that effort has become largely a political football, with too many hospitals receiving such a designation. Some of these facilities are truly not essential for access, often amounting to no more than an outpatient surgical center with maybe one or two inpatient beds.

McPherson: *Where safety nets are in financial distress, are the reasons within or outside their control? What is your sense of what is really going on here?*

Wayne Lerner: In Illinois, inter- and intrapolitical warfare, paired with years of state budget shortfalls, has resulted in inadequate Medicaid provider payments. The hospitals that have resources continue to weather these storms, while the have-nots, which are mostly safety-net hospitals under Ron Anderson’s definition, are not. The latter, including our hospital, are operating with declining margins—if any at all—and shrinking cash resources. At the end of September (2008), we had six days cash on hand.

When Medicaid continues to cut back its funding, the haves are minimally affected, relatively speaking, and are able to continue to spend capital on facilities, equipment, and information technology—about which the rest of us can only dream. Medicaid does not recognize or reward our lower cost structure, so we are in this never-ending spiral, where the financial gaps among hospitals just continue to widen. It’s like an epidemic, but one which only affects a portion of the population at risk.

Since our private, tax-exempt hospital is financially separate from the religious order which sponsors us, we must make it on our own. To date, we have not received the proportion of special payments that other safety nets have, but we are working on this strategy. Legislators need to appreciate that we are located in the middle of Chicago, close to Midway Airport, have a primary service area of 450,000 people, and

are the only hospital in at least a four-mile radius. If we close, where will the 50,000 ER visits and 18,000 ambulance runs go that come to us? Some would say that we are fulfilling the same role as a public hospital, but without the taxing authority. To put our situation in layman’s terms, we operate our hospital eight days each month for free. Further, we have explained to the politicians that if we close, the inpatient per diem cost of caring for these patients in the nearest other hospitals will be almost \$1,000 higher than for the same services at Holy Cross.

It should be obvious to all that enactment of universal health care coverage legislation alone will not reduce the gap between the have hospitals and have-nots. We lack access to capital for even the basics—updating facilities and equipment, and acquiring electronic medical records and other health information technology to improve patient safety and quality, and funds to recruit and retain clinical specialists and subspecialists. Without special help, places like ours will always live on the edge.

Anderson: Some have-not safety-net hospitals are poorly managed. Also, some of the public hospitals have poor governance structures with a lot of political intrusion.

However, there are other hospitals with good boards and management that, in heeding their missions and caring for patients regardless of their ability to pay, are often placed at an enormous disadvantage. Well over half of Parkland’s patients are uninsured, and under Texas’s Medicaid program, which operates under decades-old payment formulas, we get paid worse for being a low-cost provider.

We provide needed wraparound services, like social services, interpreter services, and care coordination, which are not fully reimbursed. As a result, we get paid less than half of what some other hospitals get paid for some cases, such as a normal delivery. We also provide subspecialty care for uninsured and low-income patients, and have 11 clinics in the community serving as medical homes for the provision of the primary care. The more primary care we provide, the more subspecialty care needs we discover. In addition, the federally qualified community health centers in the city, as well as the 40 or so faith-based nonprofit clinics that provide episodic outpatient care, also refer to us. Compounding our

problem is the fact that only 38 percent of the doctors in Texas will take a new Medicaid patient, much less an uninsured patient.

We have also seen an outward migration of the poor into the suburbs to get housing as they become displaced by gentrification in the inner city. Recent studies have shown that for the first time in U.S. history, there are more poor people in America living in suburbs than in inner cities. Unfortunately, closure of some smaller hospitals in these poorer suburbs around Dallas has resulted in even greater burdens for remaining safety-net hospitals.

The Medicaid payment situation for safety-net hospitals will vary from state to state, but we are all struggling to secure and/or maintain “disproportionate share” or other special payment provisions that save us from financial ruin. One ill-advised pencil-swipe by policymakers could spell disaster. Had the Bush administration succeeded in taking away some special provisions, our doors would have closed. Those provisions get attacked as largess—when in fact they are essential gap fillers between our \$400 million in local tax subsidies and \$550 million in charity care each year. Our charity care is more than that of all the other hospitals in Dallas combined.

As a final point, which ties back to Wayne’s last comment, the deterioration you see in distressed safety nets is usually subtle and gradual, with the age of the plant increasing before services are cut. They’re basically giving up their future viability to maintain services. When we see hospitals close, it’s usually after a subsequent period of cutting back on services or queuing up of patients—long waits before service in the ER and long waits to get into a hospital bed from the ER. We’re seeing these trends in Texas. The margins for the private nonprofit safety nets have now come down to those of the public’s, and that’s a very scary situation.

Hofmann: Similar to the situation Ron described in Texas, Medicaid budget constraints in California have led to inadequate payments not only for hospitals but also for physicians. As a result, fewer physicians are willing to take Medicaid patients. With the fiscal crisis continuing, the situation is getting worse, putting even greater pressure on safety-net hospitals and their ERs.

A compounding factor for many of these safety-net hospitals is that because they have a poor payer mix and are often independent, they lack financial leverage in negotiating rates with private payers to cost-shift Medicaid payment shortfalls and uncompensated care. And, as both Wayne and Ron pointed out, they are also disadvantaged in terms of access to the capital market.

So there is this aggregation of forces that places safety-net hospitals in more financial jeopardy, a problem that will surely worsen in the environment we face today.

Peter Cunningham: I agree with everything that’s been said. We’re living in a health care environment characterized by intensifying competition and financial pressures—among all hospitals.

I would like to share what we at the Center for Studying Health System Change have learned from the latest round of site visits in our Community Tracking Study conducted in 12 metropolitan areas. We are seeing financially strong hospitals getting stronger, and financially weak hospitals, whether safety net or otherwise, getting weaker. The strong hospitals tend to be part of hospital systems, with the leverage to extract higher payments from private insurers because they are viewed as indispensable for their provider networks. Being part of a system and having greater private pay revenues, they generate and can access more capital, expand into more affluent areas, provide up-to-date facilities and equipment, invest in health information technology, and successfully compete for health care personnel.

We also are seeing some financially strong hospitals shedding unprofitable services and patients, such as by shutting down the ER or closing a psychiatric unit. All of this tends to place the weaker hospitals, which don’t have a good payer mix in the first place, in an even worse position. Increasingly, safety-net hospitals are the only place in the community now where the uninsured can go for services, not just primary care but also specialty services.

Seitz: From a payer’s perspective, it is extremely critical that we keep safety-net hospitals in place. In Michigan, which may be unique, we are seeing a somewhat different situation. Virtually every hospital is private nonprofit, or public. Quite a few of the hospitals that I consider safety nets appear to be

doing quite well. They tend to have certain characteristics: they are often part of larger hospital systems, tend to have a strong teaching mission, and are usually blessed with a diverse payer mix.

In Detroit, for instance, there are now very few independent community hospitals. Most have been acquired over time by five or six different systems that are absolutely committed to serving their communities, including the inner city. But we are not seeing, as Wayne and Ron report, lower costs of care in our safety-net hospitals. What we are seeing among these systems is a costly medical arms race—building hospitals, surgical centers, and the like in the suburbs. The general theory, which has yet to be proven, is that if they can capture more affluent patients they will be able to better support their core missions and facilities and help counterbalance escalating uncompensated care costs.

McPherson: *What do you think are the prospects for collaboration among safety-net hospitals, or among safety net and other hospitals, to protect the safety net and those it cares for? For instance, do we need regional community benefit councils, where providers, payers, businesses, government, consumer groups, and others get together in a coordinated fashion to jointly assess and prioritize health status problems, and to agree on access and other strategies to address them?*

Cunningham: In the 12 communities we have been tracking there have been several instances in which major safety-net hospitals were able to garner the support of other hospitals in the community because they were able to recognize that it was in their self-interest to not let the safety net providers fail. So it has worked in some places.

We have also observed some of the safety-net hospitals taking actions on their own, sometimes defensively, such as discontinuing nonemergency care to uninsured patients from outside the immediate community or county. One could argue that such a strategy is contrary to their mission, but they may be doing what they have to do to survive and serve as many local residents as they can. In other cases, we see some safety nets trying to compete directly and proactively with other hospitals, by building or buying a suburban hospital or promoting selected specialty areas where they are considered particularly strong.

Anderson: We need to keep promoting collaboration as being in everyone's self-interest. We are all interrelated. Whatever charity care Parkland can't provide merely gets shifted to others—resulting in the most expensive types and levels of care—in the hospital ERs and acute care units. There must be broad community involvement and support to address the access problems.

Sadly, regional health planning for public health purposes has virtually gone away. The marketplace poorly distributes health care to the poor. In fact, it exacerbates problems, with boutique hospitals built in affluent areas that take away nurses with high salaries and sign-on bonuses. This further impairs the very safety net that makes them possible. Collaboration needs to coexist with competition for the community's benefit.

To achieve collaboration, you have to lean on self-interest to a degree; however, public and private nonprofit hospital boards are likely to understand that their organizations were all created to serve the community. I see a corporate conscience and connection to mission in many of the hospital systems worth tapping into, but we probably need regional planning forums to take advantage of corporate conscience. The problem must be owned broadly.

Lerner: Since we are in essence serving the same role as a public hospital, one logical strategy would be for us to become part of the Cook County (Ill.) Bureau of Health Services. That will not happen for several reasons, not the least of which is the current budgetary and political environment at the county level.

Other approaches have included talking to some of the faith-based and non-faith-based private nonprofit systems to explore collaborative relationships. To the extent that they help us stabilize our financial future, it keeps our ER population out of their hospitals. As Ron indicated, it's to their benefit to help us get better. However, to be frank, this has been the hardest uphill struggle I've ever experienced. I have said, "Do you understand what happens if places like ours close? You will get these patients one way or the other, and they're already the sickest folks in the community. So it's to your advantage to work with us." They listen, but they don't hear. They've got their eyes set on growing, on more

affluent markets, not on the communities with the most underserved people, which from one perspective I can understand.

We've also tried to make our case to the business community—the same businesspeople who sit on the boards of the large affluent hospitals. This subject (the health care crisis) is either not relevant to them or not high on their agendas. They are certainly not taking a look at this issue from a civic, broad community or societal point of view.

What we don't seem to have is the kind of health care statesmen that I remember from my early years in the field. In every city, there was someone who would step out of his or her institutional role and get people to work together for the greater good of the community. In the late 60s and early 70s, with Cook County Hospital bursting at the seams, one of the private academic medical centers advocated that all private hospitals take a fair share of the poor to eliminate the need for a public hospital system and multiple standards of care. Right or wrong, at least someone was looking at the region and putting ideas on the table to generate reasonable discussion ... and debate! Today the standard responses are: "We have too much on our plate," "Our balance sheets can't handle more," or "There are other communities we are trying to serve." Getting people to understand that our emergency is their emergency, when they have set their strategic direction, is a very difficult thing to do.

Yet we have to do it. We need to engage people at the board level to adopt a broad community perspective. We need to somehow get both public- and private-sector leaders to embrace the long-forgotten role and value of community-based health planning, jointly identifying and implementing preventive actions now to benefit both patients and the entire community.

Typically, board members focus on whatever we CEOs tell them. So if CEOs don't favor collaboration—voluntary community planning or whatever you want to call it—then someone on the board needs to bring that perspective to the table rather than perpetuate the typical competitive self-interest mentality. After all, public-private and/or private-private partnerships, supported by institutional leaders, could go far in addressing the vexing social issues before us.

There are examples where boards have gotten involved. My previous hospital in St. Louis was and is doing good work on public-private partnerships to try to address the needs of the underserved. But that is a smaller community, with a few big players, where with the right individual leaders you can make things happen. In the bigger and more diverse communities like Dallas, Chicago, New York, and Los Angeles, it's a much tougher challenge.

Seitz: I totally agree with Wayne and Ron that collaboration within the private sector, with business community participation, is the right way to go. Businesses are absolutely committed to trying to provide coverage to their employees and their dependents, but they are unbelievably stretched in their ability to do so. Unfortunately, what we are seeing is gradual erosion in this country of comprehensive, private group-sponsored health care coverage. The hottest private benefit plans are those with high deductibles, and the fastest growing market segment is individual, nongroup-sponsored coverage.

One thing that our plan is doing already, which we vetted with our major customers, is including an uncompensated care factor in our hospital payment formulas, so that hospitals with higher uncompensated care burdens automatically receive greater payments.

In addition, we have been very supportive of the CON program in our state, which we feel has helped to reduce costs and indirectly help our safety net, in particular by preventing a proliferation of unneeded hospital capacity and moderating the expansion of non-hospital-based lab, surgery, and radiology services. I see a strong CON program as a key reason why so many hospitals have been able to retain a diverse payer mix.

Hofmann: One of the greatest challenges I see is that, almost without exception, nonprofit hospitals and systems have comprehensive, eloquent, and well-intentioned vision, mission, and value statements. But there is a huge disconnect, at least in my experience, between the rhetoric and the reality. While the contents of these statements suggest that these organizations are focused on promoting community health status and demonstrating community benefit, their actual policy decisions and actions suggest otherwise.

We are now seeing the value of evidence-based medicine—the use of clinical protocols and pathways that have been proven to contribute to better patient outcomes. In a similar vein, I'm a strong advocate of promoting evidence-based governance and management. In some cases, boards aren't properly educated about the access problem and the plight of safety-net hospitals. In other cases, CEOs may be looking toward retirement, tired of trying to deal with these issues, or at a loss as to what to do.

One particularly impressive collaborative effort involves Palmetto Health in Columbia, South Carolina, which created a community coalition to design a health care delivery system specifically for low-income and uninsured residents in Richland County. The coalition consists of representatives from local hospitals, physicians, state and local governments, school districts, and others. The program is essentially a medical home network consisting of primary care, pharmaceuticals, specialty care, hospital care, mental health and substance abuse services, and disease management.

As another example, a program in San Francisco, Operation Access, has received exceptional support locally and from the American College of Surgeons. The program started about 15 years ago when two surgeons were concerned that they and some of their colleagues were donating their services outside our country and too often neglecting unmet surgical needs at home. They proposed organizing volunteer surgeons, anesthesiologists, and nurses to provide low-risk surgery services and other specialized care on an outpatient basis, with hospital support. The program has grown to the point where it now has over 600 medical volunteers and 23 hospitals taking referrals from about 60 community health clinics across six San Francisco Bay Area counties.

I lament that successful models like these are not more widely disseminated and replicated when there is clearly a need and rationale for doing so.

Seitz: I'd like to comment on Bruce's specific question about regional community benefit councils. In our regional planning efforts, we've focused on practice variation and health of the community, with the latter getting more and more into issues of the uninsured. The problem we have in making real progress, however, is that they are voluntary efforts, and

the parties at the table have differing levels of commitment. Additionally, state and local government agencies are often not participating and not providing a needed public health advocacy perspective, which would help to coalesce and advance these voluntary discussions.

Anderson: That's a very good point. Many of the public health departments have become providers of care to the poor, which they are not particularly good at, rather than pursuing their original missions.

But it doesn't have to be a zero-sum game, robbing Peter to pay Paul. If we work together, we can create resources to deal with some of these issues.

McPherson: *The board of the Alliance for Advancing Nonprofit Health Care recently voted to establish a national voluntary program for certifying the community benefit practices of nonprofit healthcare organizations. Do you think that kind of program, emphasizing collaboration as well as board and management commitment and involvement, could help to achieve the kind of voluntary community planning you all have been talking about?*

Seitz: I think so. I'm a firm believer in not just nonprofit hospital care, but also nonprofit health insurance, and all such organizations need to show in an objective way a commitment to community. I think that a certification program would create better accountability in the nonprofit sector, and that's a plus.

Hofmann: I was involved with a national commission that developed many years ago, under the leadership of Bob Sigmond and hosted by Tony Kovner at NYU, a set of four basic community benefit standards. The language was subsequently adopted verbatim by a number of states that required nonprofit hospitals to submit annual reports on their community benefit programs.

I strongly believe in the power of incentives, economic as well as noneconomic, to drive behavior and performance, so anything that can be done on either a voluntary or non-voluntary basis to get nonprofit health care organizations to improve their community benefit performance is worth encouraging.

McPherson: Last year, Senator Chuck Grassley (D-Iowa), ranking member of the Senate Finance Committee, floated a staff discussion paper calling for, among other requirements, a nonprofit hospital charity care threshold of 5 percent of total net revenues or costs. A hospital would be able to count toward that threshold any financial or in-kind support it gave to other health care providers for their charity care programs. Grassley has now announced that he intends to introduce a bill in 2009 along these lines. What is your reaction to this kind of approach?

Anderson: For many years in Texas, private nonprofit hospitals have had to meet at least one of several community benefit standards. One requires that total community benefits equal at least 5 percent of net patient revenues, with at least 4 percent involving charity care and care to patients of government-sponsored indigent care programs. Those that are truly acting as safety nets easily exceed them. Some of the suburban hospitals fall well short and are willing to pay a penalty. Maybe that's the answer. Maybe they should pay something into a pot that can help the safety nets. Whatever is done in this regard, the level of the standard should be reflective of the value of the tax exemption and not allow anyone to retrench in meeting community needs.

Hofmann: I agree with Ron that any such standard must not be set too low and that any shortfalls in performance should result in financial contributions that in some way go toward subsidizing care for the uninsured. This is definitely something worth exploring.

Hospitals that merely give lip service to community benefit, and use artificial or disingenuous ways to demonstrate their commitment, should not be allowed to continue that practice. There should be some sort of national or statewide mechanism that requires organizations to demonstrate their community benefit. Without it, I see the safety-net hospitals continuing to assume more and more of the burden without the resources to cover it.

Lerner: I generally favor voluntary approaches to promoting and assessing performance and competencies. But on this issue, because of the institutional parochialism to which I referred earlier, I think there needs to be some sort of stick

along with the carrot. Whether it involves a linkage to CON approval, tougher community benefit standards for tax exemption, some sort of carbon-credits approach, or a version of the Community Reinvestment Act for safety-net hospitals and their communities, there must be strong incentives to get people to take a broader, societal view and work with those most in need. Otherwise, why should those with resources ever care about those without them?

Cunningham: I agree. Mandating a minimum level of charity care as part of community benefit programs and activities might be a good idea, to make sure that the public is getting its money's worth from the tax exemptions granted to nonprofit hospitals.

But I don't think such a requirement is necessarily a solution for the safety-net hospitals. Even if a good standard could be enacted and enforced, there would undoubtedly be ways that some hospitals would find to get around it—for example, eliminating certain service lines that tend to attract a high proportion of Medicaid or uninsured patients, expanding into the suburbs while downsizing facilities in the central city.

Consequently, I think that direct support has to be targeted to the safety net providers themselves.

McPherson: Do you have any final thoughts?

Hofmann: The bottom line is that we must protect the safety net. Everyone should care. Otherwise, the existing socioeconomic disparities in access to services and health outcomes will be exacerbated. The problems afflicting medically indigent patients would become even greater and more expensive to treat due to the delay in receiving timely care. Specialized clinical services, such as trauma and burn care, would be less available to all members of the community. Essential training programs for physicians, nurses, and other clinicians would be adversely affected. The domino effect would be huge and ongoing, with other hospitals unable to accommodate the increased responsibilities. Finally, citizens would be faced with greater transportation challenges to obtain needed care.

Somehow we have to dramatize more effectively both the economic and noneconomic costs that will be encountered if the safety-net hospitals are not preserved and protected.

Anderson: That pretty much says it all for me. I would just add that the safety nets also have a tremendous economic impact in their communities. We are anchors for revitalization beyond patient care. Parkland, for instance, has 9,000 employees and a \$1.1 billion expense budget, which translates into \$4 billion flowing to the inner city and surrounding community. You don't fix problems in a community from deficits. You fix them from strengths, and safety-net hospitals represent critical assets for the vitality of the communities they serve.

Cunningham: I agree with all of that, and would just mention one other effort under way to address the financial needs of safety-net hospitals. In New Jersey, which has been over-bedded, a commission on rationalizing health care resources was established. It identified and targeted for special public support financially distressed, essential hospitals—that is, those providing a large number of services to financially vulnerable populations. Only time will tell if the state will fully implement the commission's recommendations, but at least conceptually this seems to be a more rational approach than just letting the strong survive and weak wither away.

Seitz: We can't lose sight of the end goal—making sure that vulnerable populations have access to needed care. I see the situation continuing to get worse unless we have fundamental reforms in health care financing and delivery. Otherwise, we are going to continue to have erosion in employer-based coverage, erosion in public health, and a Medicaid program that just isn't sustainable by state government.

Lerner: I recall the old adage, "You are where you sit." I've worked in many different settings in my career, starting in a very affluent organization and now in a resource-starved, safety net hospital. Like in the movie *Trading Places*, it is too bad that there isn't a way for hospital CEOs and governing board leaders to walk in the shoes of their counterparts in public and private safety-net hospitals so that they could viscerally grasp the gravity of the situation, break out of their self-interest perspective, and see the greater societal need. This exercise would open their eyes to what is actually happening in these hospitals and the communities they serve. Maybe then we would experience the kind of community collaboration we need to truly make a difference in people's lives.

Notes

1 A January 2007 report, "Serving the Uninsured: Safety-net hospitals, 2003," published by the Agency for Healthcare Research and Quality, defined these hospitals as the 10% of facilities that had between 9% and 50% of stays uninsured. It also identified another 20% as "secondary safety-net hospitals" with between 5% and 9% of stays uninsured. The top 10% represented almost one-third of all uninsured stays. About 56% of these hospitals were urban, 66% were in the South, 20% were teaching hospitals, over 50% had fewer than 100 beds, 45% were private nonprofit, 43% were public, and 12% were for-profit. They also had substantially more Medicaid patients and fewer privately insured and Medicare patients. About one-third experienced negative total income margins.

2 *Almanac of Hospital Financial and Operating Indicators*, 2008, Ingenix, pp. 3–6.