To say that the current U.S. health care “system” is a dysfunctional and costly patchwork of employer-based insurance, private markets, public programs, and special initiatives is, by any measure, an understatement. Fortunately, recognition of this reality has at last made major reform of the system not only inevitable, but imminent. Even without knowing the final details of the bill that will make its way to President Barack Obama’s desk, we can assume that it will make affordable insurance coverage available and required for many, but not all, of the 45 million people who are currently uninsured. But what will happen to Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP) — safety-net programs that serve some 100 million Americans?

The idea behind safety-net programs is to ensure that, regardless of social or economic conditions, no citizen’s access to essential services falls below a certain level. Today’s health care safety net is a complex array of entitlements, specialty services (such as renal dialysis and care for persons with HIV–AIDS), hospital-based programs, and emergency services that is designed to facilitate access to vital health care for many medically underserved, uninsured, or underinsured persons.

The country’s largest safety-net programs, Medicare and Medicaid, which are referred to as “entitlement” programs, were established in 1965 and are legally protected from having eligibility thresholds lowered below federally established standards. The State Children’s Health Insurance Program (SCHIP), which was created in 1997 (and reauthorized as CHIP in February 2009), represents the most recent addition to the safety net; its implementation has meant that increased numbers of children in the United States have a regular source of health care, including preventive services.

Laws requiring that hospitals that receive federal funds provide care for anyone seeking emergency treatment, regardless of citizenship status or ability to pay, are also part of the safety net, as is the Disproportionate Share Hospital program, under which facilities that provide a disproportionate share of otherwise uncompensated care to the poor and underinsured are able to receive at least partial compensation. Still, even with multiple safety-net options, including community health centers, public hospitals, and clinics, at least 22,000...
The Demise of a Dialysis Clinic in Atlanta

Grady Memorial Hospital is Atlanta’s main safety-net hospital — and a victim of the recession. In January 2008, Grady was faced with closure because of a $53 million deficit that it had incurred in part by providing uncompensated care to people without health insurance. Since the hospital and its nine community clinics are responsible for 850,000 outpatient visits and 30,000 inpatient stays per year, its closure would have had a devastating effect on other hospitals in Atlanta. Grady was not alone in facing such a crisis: many of the country’s 1300 public hospitals were similarly ailing. At the time, only 8% of Grady’s patients had private health insurance. Nearly a third were uninsured, and the Medicaid rate Grady received did not begin to cover its actual costs. Though the hospital receives some money to cover uncompensated care, the state’s formula for distributing these funds does not adequately compensate hospitals like Grady that provide extensive services to the uninsured.

In April 2008, the crisis was at least temporarily averted by the receipt of a large gift from the Woodruff Foundation. The state legislature offered some assistance, but not enough to protect Grady’s trauma care program, an essential service that always runs in the red. The trauma and emergency care centers were helped out a year later by a gift from the Marcus Foundation, but just a few months after that, the hospital determined that it needed to close its dialysis clinic. Uninsured people with diabetes were among those who had been able to receive free lifesaving care at this center. By this time, 40% of the hospital’s patients were uninsured, and the dialysis center had accounted for $2 million of the hospital’s 2008 budget deficit and was losing as much as $50,000 per patient every year.

The dialysis center was closed in October 2009, after litigation to keep it open proved unsuccessful. The foundation gifts that Grady had received did much to secure the hospital’s future, but they were “bricks-and-mortar” capital funds that did not provide the additional money necessary to continue the operation of community services at a deficit. The center’s patients who could be referred to other sites found other sources of care, but some — especially immigrants — did not have other options available. Their alternatives were to move to a state with more liberal “emergency Medicaid” rules or to return to their native country if health care was more freely available there.

people died in the United States in 2006 because they lacked health insurance and had limited access to medical care. And the number of deaths related to lack of coverage has been increasing by about 1000 every year.1

There are also components of the safety net that deal with workforce and facilities; these are administered by the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services. The HRSA was created in 1982 to improve access to medical care for medically underserved people, and by 2008, the agency’s annual budget exceeded $7 billion. A particularly effective, though underfunded, example of the HRSA’s programs is the National Health Service Corps, which provides tuition support and loan-repayment programs to encourage young medical professionals to practice in designated Health Professional Shortage Areas.

On a larger scale, the HRSA oversees the growing network of community health centers — known as federally qualified health centers (FQHCs) — that provide high-quality, comprehensive care to more than 17 million people each year. These centers accept public or private insurance and offer a sliding-fee scale for patients with inadequate or no insurance. Congress is likely to continue to expand the FQHC network substantially: in order to serve 30 million people by 2015, it is estimated that FQHCs will need nearly 16,000 additional primary care providers and 14,000 additional nurses.2

Nevertheless, with more than 45 million Americans uninsured and many more underinsured, with more than 65 million Americans living in federally designated Health Professional Shortage Areas, and with many communities lacking sufficient specialty-care services, the existing safety net is simply inadequate — and is continuing to deteriorate (see text box regarding a dialysis clinic in Atlanta). Many of its components are of insufficient scale to meet the ongoing need, and nonentitlement programs that are nevertheless part of the safety net are often unavailable, uncoordinated, or transient. Health care providers increasingly refuse to care for patients who are covered by safety-net programs because they consider the reimbursement levels too low.

There are also serious regional disparities in the accessibility of safety-net programs (see text box regarding situation in California). The shortage of readily available health care resources, especially in rural states, is so severe that in 2007, 60% of federally designated medical shortage areas in the Midwest, 40% in the South, 37% in the Northeast, and 31% in the West did not have a health center. And people who live in an underserved area with a health center may have access to only a limited range of services.3

In the future, beyond the rise and fall of the political left and right, two overriding factors will fundamentally affect the structure, function, and mission of the safety net. First is the recession. Pressures on the federal budget have raised questions about the future viability of entitlement pro-
California Reels

By July 2009, California’s projected deficit for the coming fiscal year had grown to $26.3 billion. At the same time, more than 5.3 million state residents were living below the federal poverty level, including 20% of California’s children. The number of uninsured adults had soared to an estimated 7.1 million from 6.6 million in January 2007, when the recession officially began. This phenomenon was accompanied by a loss of private coverage for the children of the newly unemployed, with the result that many were forced into using safety-net health care programs that were already overextended.

But coping with the recession-driven shrinking budget revenues has put even greater pressure on public programs. Draconian cuts to Medi-Cal (the state’s Medicaid program) have had a profound effect on California’s children; Families USA reports that more than a quarter of a million children lost health coverage, and another 160,000 were vulnerable to proposed further cuts.

For example, in San Diego County, which has a population of approximately 3 million, a safety net that was already fragmented was further threatened by intolerably low payments to Medi-Cal providers. The likely result will be severely reduced access to specialists. Enrollment in the county’s indigent care program was held down by narrow eligibility requirements, causing costs for uncompensated care for the uninsured to be shifted from the public sector to private providers.

Los Angeles County, with 10.3 million residents, saw nearly $140 million in budget reductions for the 2008–2009 fiscal year. Senator Barbara Boxer’s report in December 2008 on the impact of the recession in California notes that these cuts have had substantial effects on Medi-Cal program administration and mental health services.

San Joaquin County is facing a $32 million loss of revenue owing to foreclosures and reduced home values. Requests for mental health care, especially for adults with depression (and their children), have increased substantially, but there are few additional resources available to accommodate the growing need.

By October 2009, on the basis of national economic trends, experts officially declared the recession over. But there were still 80,000 fewer jobs in Sacramento, California’s capital, than there had been before the recession, despite the effects of federal stimulus dollars. The situation was even worse elsewhere in the state, with 88,000 fewer jobs in the San Francisco–Oakland area and nearly a quarter of a million fewer jobs in the Los Angeles area. With such reduced employment, the state will continue to collect less tax revenue to sustain programs like Medi-Cal, even as an increasing number of people lose employer-provided private health insurance and enroll in public programs. And more children will live in poverty, with only a frayed safety net to meet their health care needs.

programs, and states worry about their ability to sustain the current levels of support for safety-net programs. At the same time, however, the demand for such services is skyrocketing. Severe unemployment and underemployment lead to loss of private health insurance. Many people who remain insured are finding it increasingly difficult to afford their copayments. In addition, pressures are mounting on the provider side. Hospitals are forced to make cutbacks as state budgets are negatively affected by decreases in federal funding and tax revenues. Cuts in Medicaid reimbursement may be necessary to help balance state budgets, and hospitals already find Medicaid rates too low to cover the cost of care.

In a survey released in April 2009 by the American Hospital Association, 9 of 10 hospitals reported service reductions because of the current economic conditions, and nearly half had cut staff. One fifth had reduced community services such as mental health care, patient education, and community clinics, and 8 of 10 had cut back on facility and technological upgrades, including upgrades in the area of electronic health records. The combination of increased demand and greatly diminished resources has placed enormous stress on the safety net. Between June 2008 and June 2009, visits to community health centers increased by 14%, and visits by uninsured patients by 21%. Many of these new patients have complex health care needs: a survey of community health centers and free clinics showed that almost 15% of their patients had diabetes, and nearly 60% of those patients were uninsured.

The second factor that will have a powerful impact on the safety net is looming health care reform. Although the reform means that health coverage will be required for almost all Americans and will be partially subsidized, it will not change our employer-centric, private-insurer-based system of financing and coverage. Nor will reform do much about the persistent underfunding of the public health system and of the nation’s schools of public health. Nevertheless, reform of the insurance industry will probably eliminate some of the more egregious corporate practices of exclusions and claim denials and alleviate the problem of loss of coverage resulting from a change in employment. These provisions, coupled with mandated coverage for individuals, will bring tens of millions of currently uninsured people into the health care system.

It is unlikely that health care reform will substantially change the Medicare and Medicaid pro-
The Emergency Use Authorization of Peramivir for Treatment of 2009 H1N1 Influenza
Debra Birnkrant, M.D., and Edward Cox, M.D., M.P.H.

On October 23, 2009, Food and Drug Administration (FDA) Commissioner Margaret Hamburg issued an Emergency Use Authorization (EUA) for peramivir for intravenous injection (BioCryst Pharmaceuticals). Peramivir is an unapproved investigational neuraminidase inhibitor that may be effective in treating certain hospitalized adult and pediatric patients with suspected or confirmed cases of 2009 H1N1 influenza. The EUA allows health care providers to use peramivir, subject to specified conditions. This is the first EUA that has been issued for an unapproved drug.

The legal standard for the authorization of an EUA during a declared public health emergency requires a finding that it is “reasonable to believe” that the product “may be effective,” as well as a finding that its known and potential benefits outweigh its known and potential risks. There must also be no other adequate, approved, and available treatment alternatives for the specific indication. This is a lower evidentiary standard than that used for marketing approval, which requires a finding of “substantial evidence” of efficacy for the proposed use based on adequate and well-controlled trials, as well as a robust safety evaluation (see table).

The FDA’s authority to issue an EUA was granted by Congress in the Project BioShield Act of 2004. An EUA can be issued only after the secretary of health and human services has declared a public health emergency. In the case of the 2009 H1N1 influenza pandemic, such a declaration was